MENTAL HEALTH ATLAS

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Designed by Kellie Hopley.

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PROJECT TEAM AND PARTNERS

The Mental Health Atlas is a project of the World Health Organization (WHO). The overall vision and conceptualization of the project is provided by Dévora Kestel. The Mental Health Atlas 2020 is the latest in a series of publications that first appeared in 2001, with subsequent updates published in 2005, 2011, 2014 and 2017. This edition of the Mental Health Atlas is supervised and coordinated by Tarun Dua and Fahmy Hanna.

In WHO Member States, key project collaborators were the mental health focal points in ministries of health, who provided information and responses to the Atlas survey questionnaire. A full list of collaborators is provided as Appendix A of this report.

Mental Health Atlas team members from WHO Regional Offices, who contributed to the planning and collation of data and liaised with focal points in Member States, were: Florence Baingana (WHO Regional Office for Africa); Renato Oliveira E Souza, Maria del Carmen Martínez Viciana, Claudina Cayetano, Matías Irarrázaval (WHO Regional Office for the Americas); Khalid Saeed, Wafaa Elsawy (WHO Regional Office for the Eastern Mediterranean); Dan Chisholm, Ledia Lazeri, Elena Shevkun (WHO Regional Office for European Region); Nazneen Anwar, Manju Rani, Chencho Dorji (WHO Regional Office for South-East Asia); and Martin Vandendyck, Mary Joanne Biquera, Jennifer Hall, Yutaro Setoya (WHO Regional Office for the Western Pacific). The contribution and support of colleagues from WHO Country Offices is also gratefully acknowledged.

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The contribution of each of these team members and partners, which has been crucial to the success of this project, is very warmly acknowledged. IT support and advice for the online data collection platform was provided by Marcel Minke. Editing of this report was carried out by David Wilson.

PREFACE

I am pleased to present the the Mental Health Atlas 2020. Two decades ago, in 2000, the World Health Organization launched Project Atlas to address a gap in mental health information. The objectives of this project included the collection, compilation and dissemination of relevant information about mental health resources across all countries. The first set of publications from the project were *Atlas: Mental Health Resources in the World, 2001* and *Atlas: Country Profiles on Mental Health Resources in the World, 2001*. Several updates have been published subsequently. The WHO Mental Health Atlas has become the best-known and most comprehensive resource for information on mental health resources globally.

The 2020 version of the Mental Health Atlas tracks progress in implementing WHO's Comprehensive Mental Health Action Plan 2013–2030. The 2014 edition of the Mental Health Atlas provided baseline values or the Action Plan's targets for 2013, while the 2017 version provided interim values for its targets for 2016. During the Seventy-fourth World Health Assembly in May 2021, delegates endorsed the Comprehensive Mental Health Action Plan 2013–2030, including the plan's updated implementation options and indicators and targets. This 2020 edition is based on 2019 data and enables the monitoring of progress made towards meeting these targets by 2020. Specifically, the Mental Health Atlas 2020 provides baseline values for the agreed and updated indicators and targets of the newly extended Comprehensive Mental Health Action Plan 2013–2030; further editions of the Atlas will enable the monitoring of progress towards meeting these targets by 2030. The WHO Mental Health Atlas team is grateful to all Member States who submitted their data for the 2020 edition of the Atlas during the challenging times of the COVID-19 pandemic.

We see the Mental Health Atlas as an ongoing activity of WHO, one where more accurate information will become available as the concepts and definitions of resources become more refined and data sources become more organized and reliable. Overall, we hope that the Mental Health Atlas 2020 will assist health planners and policy-makers within countries and regions to identify areas that need urgent attention.

Dévora Kestel
Director, Department of Mental Health and Substance Use, WHO

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EXECUTIVE SUMMARY

The Mental Health Atlas project was initiated by the World Health Organization (WHO) to map mental health resources globally and to provide an up-to-date overview of mental health system profiles in different countries and regions. It aims to provide up-to-date information on the existence of mental health services and resources around the world, including mental health policies, legislation and financing, the availability and utilization of mental health services, human resources and information/data collection systems. The first assessment under the project was carried out in 2001, to construct global and regional databases, maps and profiles. A number of updates have been published subsequently.

The 2020 version of the Mental Health Atlas tracks progress in implementing WHO's Comprehensive Mental Health Action Plan 2013–2020. The 2014 edition of the Mental Health Atlas provided baseline values for the Action Plan's targets, while the 2017 version provided interim values for these targets. This 2020 edition of the Mental Health Atlas is based on 2019 data and enables monitoring of progress made towards meeting these targets by 2030. Additionally, it provides baseline values for the agreed and updated indicators and targets contained in the newly extended Comprehensive Mental Health Action Plan 2013–2030; further editions of the Mental Health Atlas will enable monitoring of progress towards meeting these targets by 2030.

The WHO Mental Health Atlas project is conducted in close collaboration with WHO's six Regional Offices and with WHO Country Offices worldwide. Information was obtained via a questionnaire sent to designated mental health focal points within the Ministries of Health in each WHO Member State. The key findings are presented in the box on pages 3–4.

Baseline, interim and progress values reported in 2014, 2017 and 2020 respectively are given in the table on page 5 for each of the six Comprehensive Mental Health Action Plan targets. Progress values for 2020 indicate that the targets committed to by WHO Member States have not been achieved. Also, the rates of progress for all targets (except suicide rate) between 2014, 2017 and 2020 were not satisfactory. Progress values for 2020 indicate that the global targets can be reached in 2030 only if there is a collective global commitment over the next 10 years across Member States to make massive investments and expanded efforts at the country level relating to mental health policies, laws, programmes and services.

Despite steady progress seen in the adoption of policies, plans and laws, as well as improvements in capacity to report regularly across years on a set of core mental health indicators, the Mental Health Atlas 2020 shows massive inequalities in the availability of mental health resources and their allocation between high- and low-income countries and across regions. It also shows significant gaps globally between the existence of policies, plans and laws and the implementation and monitoring of these and the allocation of resources. Similar gaps can be seen in the implementation of mental health services at the primary health care level. While guidelines for the integration of mental health into primary health care exist and have been adopted in most countries, with activities ongoing for training and supervision, the integration of interventions for service delivery, such as pharmacological and psychosocial interventions for mental health conditions, remains limited. The Mental Health Atlas 2020 also shows significant limitations in the capacity of countries' mental health information systems to report on specific indicators such as service utilization.

A significant limitation to this edition of the Mental Health Atlas was that data were collected from countries during the global COVID-19 pandemic, which affected the quality and quantity of the data collected. The second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic, conducted between January and March 2021, identified mental, neurological and substance (MNS) use disorders as being the programmes most disrupted (45% of responding countries).

Moreover, the list of countries responding to various data points within each question was sometimes different from those of previous years, which limits comparisons with previous editions of the Mental Health Atlas. Finally, it is important to acknowledge the limitations of self-reported data, which are often reported by a single focal point.

KEY FINDINGS

- 171 of WHO's 194 Member States (88%) at least partially completed the Mental Health Atlas 2020 questionnaire; the submission rate exceeded 73% in all WHO regions.

INFORMATION SYSTEMS AND RESEARCH FOR MENTAL HEALTH

- 31% of WHO Member States regularly compile mental health-specific data covering at least the public sector in their country. In addition, 40% of Member States reported the compilation of mental health data as part of general health statistics only.
- The percentage of countries reporting no mental health data compiled in the last two years has declined from 19% of responding countries in 2014 to 15% of responding countries in 2020.
- 76% of Member States were able to report on a set of five selected indicators that covered mental health policy, mental health law, promotion and prevention programmes, service availability and the mental health workforce. This is an increase from 60% of Member States in 2014.
- 64 646 articles on mental health were published in 2019. The global percentage of research output on mental health relative to total research output was 4.6% in 2019.

MENTAL HEALTH SYSTEM GOVERNANCE

- 75% of Member States have a stand-alone policy or plan for mental health, which is an increase from 68% in 2014. 57% of Member States have a stand-alone mental health law, which is an increase from 51% in 2014.
- 46% of WHO Member States have updated their mental health policy or plan and 27% have updated their mental health law since 2017.
- 99 countries, equivalent to 67% of responding countries, or 51% of WHO Member States, reported full alignment of their policy or plan for mental health with international and regional human rights instruments.
- 74 countries, equivalent to 64% of responding countries, or 39% of WHO Member States, reported full alignment of their law for mental health with international and regional human rights instruments.
- Human and financial resources allocated for the implementation of policies/plans are limited. In addition, only 19% of WHO Member States reported that indicators were available and used to monitor implementation of a majority of the components of their policies/plans.
- 45% of WHO Member States reported that a dedicated authority or independent body undertakes inspections of mental health services and responds to complaints about human rights violations.
- 21% of WHO Member States have a mental health policy or plan that is in the process of implementation and is fully compliant with human rights instruments.
- 28% of WHO Member States have a mental health law that is in the process of implementation and fully compliant with human rights instruments.
- 76% of responding countries have ongoing formal collaboration with at least one stakeholder group. Levels of collaboration with service users and family/caregiver advocacy groups are low (35% of responding countries).

FINANCIAL AND HUMAN RESOURCES

- Levels of public expenditure on mental health are low (a global median of 2.1% of government health expenditure) and particularly meagre in low- and middle-income countries.
- 80% of responding countries reported that care and treatment of persons with severe mental health conditions are included in national health insurance or reimbursement schemes and in insurance coverage for inpatient/outpatient mental health services.
- Globally, the median number of mental health workers is 13 per 100 000 population. There continues to be extreme variation between World Bank income groups (from below two workers per 100 000 population in low-income countries to over 60 in high-income countries).

SERVICE AVAILABILITY AND UPTAKE

- Only 49 countries, equivalent to 31% of responding countries, or 25% of WHO Member States, reported the integration of mental health into primary health care. This was estimated based on the adoption of guidelines for integration into primary care, the provision of pharmacological interventions, psychosocial interventions and training for mental health conditions at primary care level, and the involvement of mental health specialists in training and supervision of primary care professionals.
- The median number of mental hospital beds per 100 000 population ranges from below two in low-income countries to over 25 in high-income countries. Globally, the median number of mental hospital beds reported per 100 000 population increased from 6.5 beds in 2014 to 11 beds in 2020, while the median admission rate per 100 000 population increased from 36 admissions in 2014 to 72 admissions in 2020.
- Outpatient visits per 100 000 population ranged from 100 visits in low-income countries to over 5000 visits in high-income countries. Globally, the median rate of reported visits increased from 2014 to 2020, along with the median number of outpatient facilities.
- Globally, the median number of child and adolescent inpatient facilities is less than 0.5 per 100 000 population and less than two outpatient facilities per 100 000 population.
- 112 countries reported that, on average, 0.64 community-based mental health facilities exist per 100 000 population. There is extreme variation between income groups, with 0.11 facilities per 100 000 population in low-income countries and 5.1 facilities per 100 000 population in high-income countries.
- The service utilization rate for persons with psychosis per 100 000 population was 212.4, with considerable variation between high- and low-income countries.
- Service coverage for psychosis was estimated at 29% using 12-month service utilization data data collected for the Mental Health Atlas 2020. Service coverage for depression was estimated at 40% using the World Mental Health Surveys.

MENTAL HEALTH PROMOTION AND PREVENTION

- 101 countries, equivalent to 68% of those countries that responded, or 52% of WHO Member States, have at least two functioning national, multisectoral mental health promotion and prevention programmes. This is an increase from 41% of Member States in 2014.
- Of 420 reported functioning programmes, 18% were aimed at improving mental health awareness or combating stigma, 17% were school-based mental health prevention and promotion programmes and 15% were aimed at suicide prevention.
- 54 countries, corresponding to 39% of responding countries, or 28% of WHO Member States, reported programmes for mental health and psychosocial support integrated as a component of disaster preparedness and/or disaster risk reduction.
- The global age-standardized suicide rate in 2019 was estimated to be 9.0 per 100 000 population. This represents a 10% reduction in the rate of suicide since the 2013 baseline of 10 per 100 000 population.

Comprehensive Mental Health Action Plan 2013–2020: baseline and progress values for global targets and objectives

	Comprehensive Mental Health Action Plan 2013–2020 targets	Baseline values for 2013 (Mental Health Atlas 2014)	Interim values for 2016 (Mental Health Atlas 2017)	Progress achieved and values for 2019 (Mental Health Atlas 2020)
Objective 1 **To strengthen effective leadership and governance for mental health**	**Target 1.1** 80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments (by 2020)	88 countries, 45% of WHO Member States Value is based on a self-rating checklist	94 countries, 48% of WHO Member States Value is based on a self-rating checklist	99 countries, 51% of WHO Member States Value is based on a self-rating checklist
	Target 1.2 80% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by 2020)	65 countries, 34% of WHO Member States Value is based on a self-rating checklist	76 countries, 39% of WHO Member States Value is based on a self-rating checklist	74 countries, 39% of WHO Member States Value is based on a self-rating checklist
Objective 2 **To provide comprehensive, integrated and responsive mental health and social care services in community-based settings**	**Target 2** Service coverage for mental health conditions will have increased at least by half (by 2020)	Not computable from Mental Health Atlas 2014 data	Not computable from Mental Health Atlas 2017 data	A global median of 29% of persons with psychosis are receiving mental health services A global median of 40% of persons with depression are receiving mental health services
Objective 3 **To implement strategies for promotion and prevention in mental health-based settings**	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by 2020)	80 countries, 41% of WHO Member States Value is based on a self-completed inventory of current programmes	87 countries, 45% of WHO Member States Value is based on a self-completed inventory of current programmes	101 countries, 52% of WHO member states Value is based on a self-completed inventory of current programmes
	Target 3.2 The rate of suicide will be reduced by 10% (by 2020)	10.0 per 100 000 population Value is based on an age-standardized global estimate Source: WHO Suicide worldwide in 2019: Global Health Estimates (WHO, 2021)	9.2 per 100 000 population Value is based on an age-standardized global estimate Global age-standardized suicide rate reduced by 8% Source: WHO Global Health Estimates 2000–2019 (WHO, 2021)	9.0 per 100 000 population Value is based on an age-standardized global estimate Global age-standardized suicide rate reduced by 10% Source: WHO Global Health Estimates, 2000–2019 (WHO, 2021)
Objective 4 **To strengthen information systems, evidence and research for mental health**	**Target 4** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by 2020)	64 countries, 33% of WHO Member States, compile mental health-specific data at least for the public sector Additionally, 62 Member States, equivalent to 32% of WHO Member States, compile mental health data as part of general health statistics only Value is based on self-rated ability to compile mental health-specific data covering at least the public sector	71 Member States, 37% of WHO Member States, compile mental health-specific data at least in the public sector Additionally, 57 Member States, equivalent to 29% of WHO Member States, compile mental health data as part of general health statistics only Value is based on self-rated ability to regularly compile mental health-specific data covering at least the public sector	62 Member States, 31% of WHO Member States, compile mental health-specific data at least in the public sector Additionally, 78 Member States, equivalent to 40% of WHO Member States, compile mental health data as part of general health statistics only Value is based on self-rated ability to regularly compile mental health-specific data covering at least the public sector

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INTRODUCTION

The WHO Mental Health Atlas is an ongoing project of the WHO Department of Mental Health and Substance Use that is designed to collect, compile and disseminate data on mental health worldwide in order to improve informed decision-making on mental health services at global, regional and country levels. The Mental Health Atlas provides information on mental health policies, legislation, financing, care delivery, human and financial resources, promotion and prevention programmes and information systems. These resources are required if countries are to provide comprehensive care for people with mental health conditions.

The Mental Health Atlas was first produced in 2001, and information was updated in 2005, 2011, 2014 and 2017.[1] The Atlas project is a public health global good and a valuable global resource of information on mental health, and serves as an essential tool for developing and planning mental health services within countries and regions.

This new edition of the Mental Health Atlas, for which data were collected in 2019, serves as a repository of mental health information from WHO Member States, and illustrates the progress made to date based on the targets and indicators contained in the Comprehensive Mental Health Action Plan 2013–2020.[2] The Action Plan was adopted by the Sixty-sixth World Health Assembly in May 2013 to help countries achieve Sustainable Development Goal (SDG) target 3.4 and promote mental health and well-being. At the Seventy-second World Health Assembly in May 2019, it was extended to 2030 to align with the 2030 Agenda for Sustainable Development.[3] The 2020 edition of the Mental Health Atlas assumes additional importance because it provides new baseline data against already existing indicators and also includes new ones, based on the extension of the Comprehensive Mental Health Action Plan 2013–2030. The Seventy-fourth World Health Assembly recommended endorsement of the updated Action Plan, with

[1] World Health Organization. Mental Health and Substance Use. Mental Health Atlas. https://www.who.int/teams/mental-health-and-substance-use/data-research/mental-health-atlas

[2] World Health Organization. Comprehensive Mental Health Action Plan 2013–2020. Geneva: WHO; 2013. https://www.who.int/publications/i/item/9789241506021

[3] World Health Organization. Comprehensive Mental Health Action Plan 2013–2030. Geneva: WHO; 2021. https://www.who.int/publications/i/item/9789240031029

due consideration for its updated implementation options and indicators, given the ongoing need to support recovery from the COVID-19 pandemic, including through promoting mental health and psychosocial well-being, building mental health services and psychosocial supports and strengthening preparedness, response capacity and resilience to the ongoing pandemic and future public health emergencies.

A total of 10 global targets, including four new targets and corresponding indicators, have been developed. Some existing targets have been updated for the four objectives of the Action Plan to measure collective actions and achievements by Member States towards the plan's overall goals (see Table 1).

As stated in the Action Plan, the indicators underpinning the 10 global targets are the result of consultations with Member States and non-state actors through online consultations and a series of regional teleconferences. These indicators represent only a subset of the information and reporting needs required to monitor mental health policies and programmes. Thus, in addition, the WHO Secretariat prepared a more complete set of indicators (Mental Health Atlas questionnaire) for Member States for data collection and reporting to WHO.

The Mental Health Atlas survey was carried out during 2020, and reflects the situation in countries in 2019. It will be followed by another survey in 2023, so that progress towards meeting the targets of the Comprehensive Mental Health Action Plan can be measured over time.

Table 1 Updated core mental health indicators, by indicators and targets of the WHO Comprehensive Mental Health Action Plan 2013–2030

Comprehensive Mental Health Action Plan objectives	Targets/ indicators	Status (revised/ new)	Revised and new targets and indicators	New baseline values (Mental Health Atlas 2020)
Objective 1 **To strengthen effective leadership and governance for mental health**	**Target 1.1**	Revised	80% of countries will have developed or updated policies/plans for mental health in line with international and regional human rights instruments **by 2030**	
	Indicator 1.1	Revised	Existence of a national policy/plan for mental health that is **being implemented** and is in line with international human rights instruments	41 countries, 21% of WHO Member States Value is based on a self-rating checklist (see Section 2.1)
	Target 1.2	Revised	80% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments **by 2030**	
	Indicator 1.2	Revised	Existence of a national law covering mental health that is **being implemented** and is in line with international human rights instruments	54 countries, 28% of WHO Member States Value is based on a self-rating checklist (see Section 2.2)

Comprehensive Mental Health Action Plan objectives	Targets/ indicators	Status (revised/ new)	Revised and new targets and indicators	New baseline values (Mental Health Atlas 2020)
Objective 2 To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2.1**	Revised	Service coverage for mental health conditions will have increased by at least half by 2030	
	Indicator 2.1.1	Revised	The proportion of persons with **psychosis** using services **over the last 12 months** (%)	A global median of 29% of persons with psychosis using mental health services
	Indicator 2.1.2	Revised	The proportion of persons with **depression** using services **over the last 12 months** (%)	A global median of 40% of persons with depression using mental health services
	Target 2.2	New	80% of countries will have doubled their number of community-based mental health facilities by 2030	
	Indicator 2.2	New	Number of community-based mental health facilities	0.64 community-based mental health facilities per 100 000 population
	Target 2.3	New	80% of countries will have integrated mental health into primary health care by 2030	
	Indicator 2.3	New	A system is in place for the integration of mental health into primary care	49 countries, 25% of WHO Member States Value is based on a self-rated checklist (see Section 4.1)
Objective 3 To implement strategies for promotion and prevention in mental health-based settings	**Target 3.1**	Revised	80% of countries will have at least **two** functioning national, multisectoral mental health promotion and prevention programmes **by 2030**	
	Indicator 3.1	Revised	Functioning programmes of multisectoral mental health promotion and prevention in existence	101 countries, 52% of WHO member states Value is based on a self-completed inventory of current programmes (see Section 5.1)
	Target 3.2	Revised	The rate of suicide will be reduced by **one third by 2030**	
	Indicator 3.2	Revised	Suicide mortality rate (per 100 000 population)	9.0 per 100 000 population (age-standardized rate for 2019)
	Target 3.3	New	80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters **by 2030**	
	Indicator 3.3	New	A system is in place for mental health and psychosocial preparedness for emergencies/disasters	54 countries, 28% of WHO Member States

Comprehensive Mental Health Action Plan objectives	Targets/ indicators	Status (revised/ new)	Revised and new targets and indicators	New baseline values (Mental Health Atlas 2020)
Objective 4 **To strengthen information systems, evidence and research for mental health**	**Target 4.1**	Revised	80% of countries will routinely be collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems **by 2030**	
	Indicator 4.1	Revised	Core set of identified and agreed mental health indicators routinely collected and reported every two years	62 countries, 31% of WHO Member States, compile mental health-specific data at least in the public sector Additionally, 78 countries, equivalent to 40% of WHO Member States, compile mental health data as part of general health statistics only Value is based on self-rated ability to regularly compile mental health-specific data that cover at least the public sector (see Section 1)
	Target 4.2	New	The output of global research on mental health doubles **by 2030**	
	Indicator 4.2	New	Number of published articles on mental health research (defined as research articles published in databases)	64 646 published articles, 4.6% of total research output Value is based on number of published articles on mental health research relative to general health research Source: Bibliometric data for 2019

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METHODOLOGY

The Mental Health Atlas 2020 required a number of administrative and methodological steps, starting with updating the questionnaire sent to country focal points and ending with statistical analysis and presentation of the data. The steps followed were similar to those taken for previous editions and are briefly outlined here.

STAGE 1: DEVELOPMENT AND TESTING OF THE QUESTIONNAIRE

Questions included in the 2020 questionnaire were developed in line with the recently updated and extended Comprehensive Mental Health Action Plan target indicators (Table 1) and other complementary sets of service development indicators. They were based on consultations with Member States and WHO Regional Offices and experts in the measurement of mental health care.

The review of the questionnaire in 2020 led to some questions being modified based on previous response rates for each of its sections, the quality of the reported data and feedback from Member States and WHO Regional and Country Offices, e.g. questions on service coverage and on prevention and promotion. Other questions were added based on the extension and updating of targets and indicators in the Comprehensive Mental Health Action Plan 2013–2030, e.g. indicators on the integration of mental health into primary health care and the existence of systems for mental health and psychosocial preparedness for emergencies/disasters. The questionnaire was drafted in English and translated into Chinese, French, Portuguese, Russian and Spanish.

Alongside the questionnaire, a glossary (see Appendix B) and completion guide were developed and integrated into the online data collection platform. The glossary and the completion guide provided general tips, explanations and recommendations to help facilitate the collection and completion of data and to ensure the standardization of definitions and descriptions of services. WHO's standard data collection platform (LimeSurvey) was used to host the questionnaire and to collect the data.

STAGE 2: DISSEMINATION AND SUBMISSION OF THE QUESTIONNAIRE

WHO asked Ministries of Health or other responsible ministries in each country to nominate a focal point to complete the Mental Health Atlas questionnaire. The focal point was encouraged to contact other experts in the country to obtain relevant information to answer the survey questions.

Close contact with focal points was maintained during their nomination and throughout the questionnaire submission process. A WHO staff member was available to respond to inquiries, provide further advice and assist focal points to complete the Atlas questionnaire. The questionnaire was available online, and countries were strongly encouraged to use this method for submission. However, an offline Microsoft Word version of the questionnaire was available whenever this was preferred.

STAGE 3: DATA CLARIFICATION, CLEANING AND ANALYSIS

Once a completed questionnaire was received, it was screened for incomplete and inconsistent answers (particularly in comparison with 2014 and 2017 responses). To ensure data quality, respondents were (re)contacted and asked for clarification or correction of their responses as appropriate. The majority of countries that submitted completed questionnaires responded actively and engaged in the quality-checking process, ensuring optimal data quality. Upon receipt of the final questionnaires, data were aggregated according to WHO regions and World Bank income groups for 2019[4] see Appendix A for a list of participating countries). As of 1 July 2019, low-income economies are defined as those with a gross national income (GNI) per capita of US$ 1025 or less, calculated using the World Bank Atlas method for 2019; lower-middle-income economies are those with a GNI per capita of between US$ 1026 and US$ 3995; upper-middle-income economies are those with a GNI per capita of between US$ 3996 and US$ 12 375; and high-income economies are those with a GNI per capita of US$ 12 376 or more.

Data on age-standardized suicide rates per 100 000 population were taken from the WHO Health Observatory.[5] Estimates of service coverage for depression come from the World Mental Health Surveys.[6]

Frequency distributions and measures of central tendency (e.g. means, medians) were calculated as appropriate for these country groupings. Rates per 100 000 population were calculated for a range of data points and for specific age groups, e.g. children and adolescents, using the official United Nations population estimates revision for 2019.[7] Comparisons were made with 2014 and 2017 data concerning global targets and service development indicators. Along with the text, results are presented in tables and graphs, with N referring to denominators and n to numerators where appropriate.

[4] World Bank Group. Data: Country classification. Washington (DC): World Bank Group; 2020. https://datahelpdesk.worldbank.org/knowledgebase/topics/19280-country-classification
[5] World Health Organization. Global Health Observatory (GHO) data; 2019. http://www.who.int/gho/en/
[6] Thornicroft G et al. Undertreatment of people with major depressive disorder in 21 countries. The British Journal of Psychiatry, 2017; 210(2):119–124. doi:10.1192/bjp.bp.116.188078
[7] United Nations Department of Economic and Social Affairs. World Population Prospects 2019. https://population.un.org/wpp/

LIMITATIONS

A number of limitations should be kept in mind when examining the results. While best attempts have been made to obtain information from countries on all variables, some countries could not provide data for a number of indicators. A significant limitation to this edition of the Atlas was that data were being collected from countries during the COVID-19 pandemic. This affected the speed of data collection, the number of countries submitting data for some sections and the completion rate. The pandemic is also likely to have affected in-country consultation processes with various departments within ministries.

The most common reason for data being missing is that such data simply do not exist within the country concerned. For example, some countries had problems providing precise data about service utilization and the mental health workforce in voluntary/non-governmental organization (NGO) and private (for-profit) mental health facilities. Also, some countries had difficulties reporting information in the manner explicitly requested in the Atlas questionnaire. For instance, some countries faced issues in providing information about their mental health budgets in the requested format because mental health care is integrated within the primary care system or is broken down using different categories of expenditure or disease. In some situations, the data required to complete a question might have been available at the district or regional level but not aggregated centrally at the national level. For example, in some countries health budgets are devolved down to the subnational level, which can significantly complicate the estimation of consolidated expenditure at a federal level. Each table or figure in this report details the number of countries that were able to respond to an item in the questionnaire, or an equivalent percentage of a total of responding countries or of the 194 WHO Member States. Expenditure figures in the mental health finances section might be slightly different from WHO health accounts figures. This may be due to the mixing of budget data with expenditure data, differences in country sampling or different data sources e.g. reliance on a single respondent.

A critical limitation of the Mental Health Atlas is that most of the information provided relates to each country as a whole, thereby overlooking potentially substantial variability within countries concerning, for example, the extent of policy implementation, the availability of services or the existence of promotion or prevention programmes in rural versus urban areas or in remote versus central parts of the country. Similarly, few of the reported data provide breakdowns by age, sex or disease category, despite the importance attached to equality of access and universal health coverage in the articulation of the Comprehensive Mental Health Action Plan. This makes it challenging to assess resources and services for specific populations within a country, such as children, adolescents or elderly people.

While best attempts have been made to highlight progress made during the timeframe of the Comprehensive Mental Health Action Plan, some information should be compared with caution over time, because of changes in the structure of questions' variables based on response rates in previous editions and feedback from WHO Regional and Country Offices in Member States, e.g. questions on the main types of promotion and prevention programme. Moreover, the list of countries completing different data points for each of the questions was sometimes different. This imposes some constraints for data comparisons over time between the three versions of the Atlas – 2014, 2017 and 2020.

The Mental Health Atlas aims to provide a comprehensive overview of mental health policies, laws, services and resources. Therefore, it usually includes all countries responding to the questions at different time points. Utilizing Mental Health Atlas datasets at successive time points can provide important information and insights into emerging trends. However, reporting changes in global or regional values based on differing country datasets has methodological limitations. Accordingly, such data comparisons over time are heavily constrained by the requirement of having the same countries reporting available

data at all relevant time points. Although this method was used internally for some variables to understand trends across the different editions of the Mental Health Atlas, e.g. mental health expenditures, the information presented for this edition included all responding countries. Other sections underwent a validity check process whenever reported median values differed significantly from the median values obtained for the same variables reported in similar sections of the 2014 and 2017 Mental Health Atlas reports.

Finally, it is vital to acknowledge the limitations associated with self-reported data, particularly relating to qualitative assessments or judgements (which were often made by a single focal point); for example, respondents were asked to self-report on the functionality of prevention and promotion programmes as well as on formal collaboration with stakeholders. They were also asked to provide an informed response concerning the implementation status of mental health policies and laws and the extent to which these conformed with international (or regional) human rights instruments. However, we know that policies, plans and laws do not fully align with international human rights standards. Apart from the fact that they allow involuntary admission and treatment, and seclusion and restraint, most policies, plans or laws do not promote supported decision-making, advance planning or alternatives to coercive practices. For some of these items, it is possible to compare self-reported responses with publicly available information for a country (such as published mental health policies or budgets); however, in other cases the opportunity for external validation is more limited.

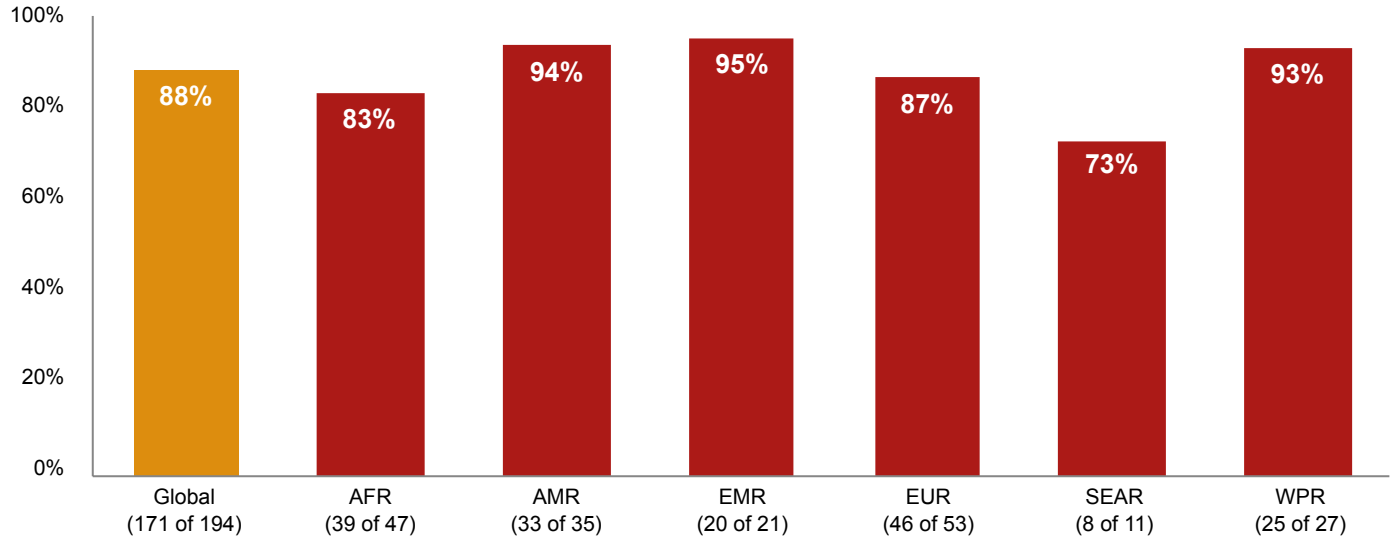
MENTAL HEALTH ATLAS 2020

1 INFORMATION SYSTEMS AND RESEARCH FOR MENTAL HEALTH

The Mental Health Atlas represents a global mechanism for the measurement of progress towards achievement of the objectives and targets contained in the Comprehensive Mental Health Action Plan. The Mental Health Atlas 2020 provides a comprehensive overview of whether targets set by the year 2020 were met, and compares progress with baseline and interim values provided in the 2014 and 2017 editions of the Atlas. It also acts as the baseline for the new extension phase of the Comprehensive Mental Health Action Plan up to 2030.

WHO and the Member States have made considerable efforts to gather information on indicators for the Mental Health Atlas 2020, including mental health policy and law, workforces and the availability of services. In total, 171 of WHO's 194 Member States (88%) were able to at least partially complete the Atlas questionnaire in 2020, and the participation or submission rate of Member States was 73% or greater in all WHO regions (Figure 1.1). The breakdown of submission rates by World Bank income groups illustrates participation rates greater than 80% for all income categories and 90% or more for upper-middle- and high-income countries (Figure 1.2).

FIGURE 1.1 Mental Health Atlas 2020: submission rates by Member States, by WHO region



Note: WHO Member States are grouped into six regions: Africa (AFR), the Americas (AMR), Eastern Mediterranean (EMR), Europe (EUR), South-East Asia (SEAR) and Western Pacific (WPR).

FIGURE 1.2 Mental Health Atlas 2020: submission rates by Member States, by World Bank income group

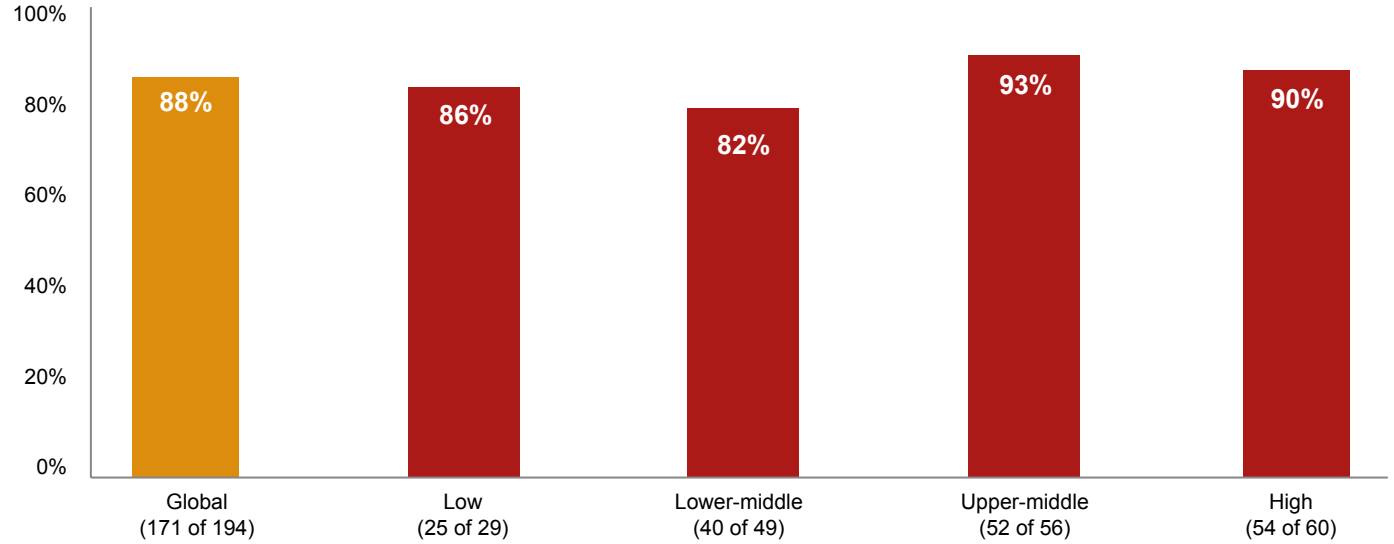
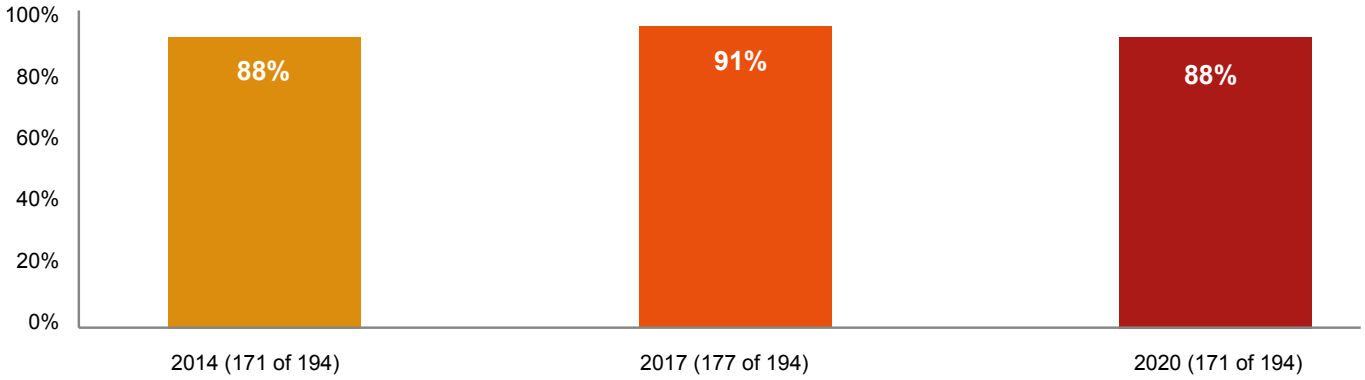


FIGURE 1.3 Global submission rates: comparison of Mental Health Atlas 2014, 2017 and 2020



As shown in Figure 1.3, the submission rates of Member States have been consistent across the three editions of the Mental Health Atlas, with a slightly higher rate observed in 2017 (91%). There was a minor fall in the percentage of countries participating in the exercise in 2020 (88%) compared with 2017, which could be attributed to difficulties in collecting data against the backdrop of the COVID-19 pandemic, but the submission rate was still relatively high. This reflects countries' ongoing willingness and commitment to collect, share and report data on their mental health situation even during a time of pandemic.

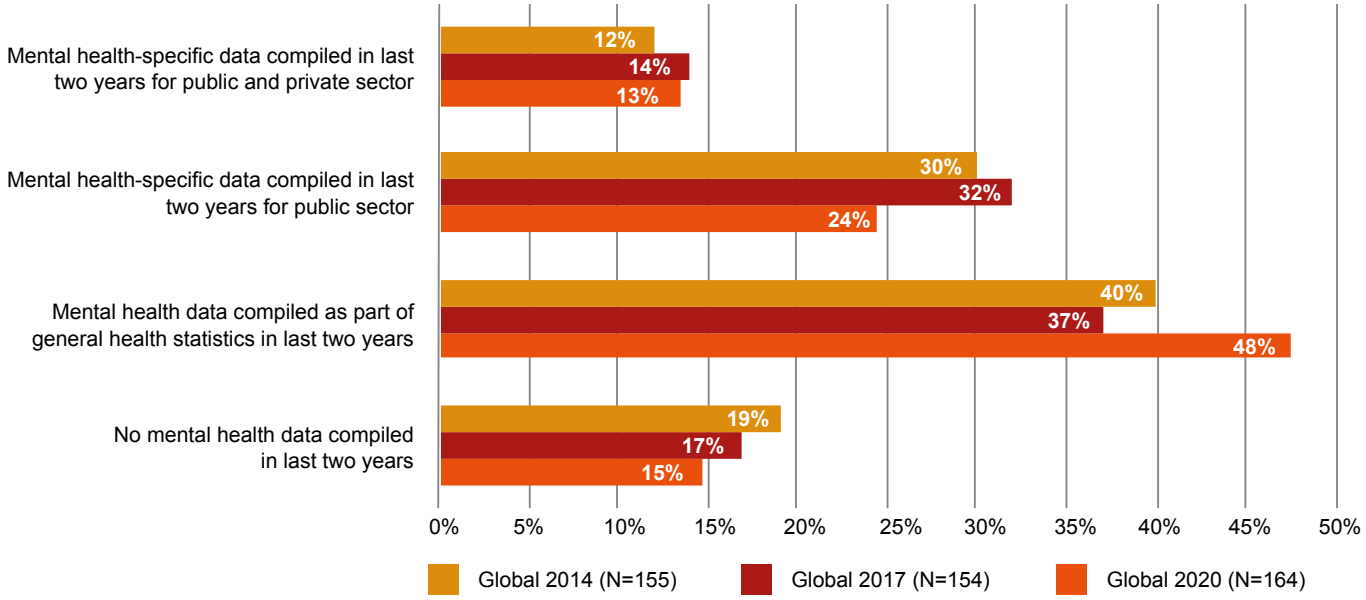
Availability and reporting of mental health data

The questionnaire for the Mental Health Atlas 2020 requested Member States to report on the availability or status of mental health reporting in their country. Figure 1.4 compares global figures from previous years (2014 and 2017) with 2020. Of 194 WHO Member States, 164 countries responded to this question (84% of WHO Member States). Fifteen per cent of responding countries, corresponding to 12% of WHO Member States, reported that they had not compiled mental health data into any report for policy, planning or management purposes in the last two years. This figure has decreased, from 19% of responding countries in 2014 and 17% in 2017, indicating that more countries are compiling mental health data either in specific reports or as general health statistics (Figure 1.4).

On the other hand, 85% of responding countries, equivalent to 71% of WHO Member States, reported that mental health data had been compiled in the last two years either as part of general health statistics reports or in reports specific to mental health. Countries with mental health-specific data available in the last two years, at least for either the public or the private sector, represented 37% of responding countries and 31% of WHO Member States. The percentage of Member States reporting that mental health-specific data had been compiled for either the public or the private sector in the last two years decreased from 46% in 2017 to 37% in 2020, while those reporting mental health data compiled as part of general health statistics increased from 37% in 2017 to 48% in 2020. Reporting on mental health-specific data compiled in the last two years for public and private sectors remained a challenge, with this figure remaining largely unchanged since the Mental Health Atlas 2014 (13% of responding countries).

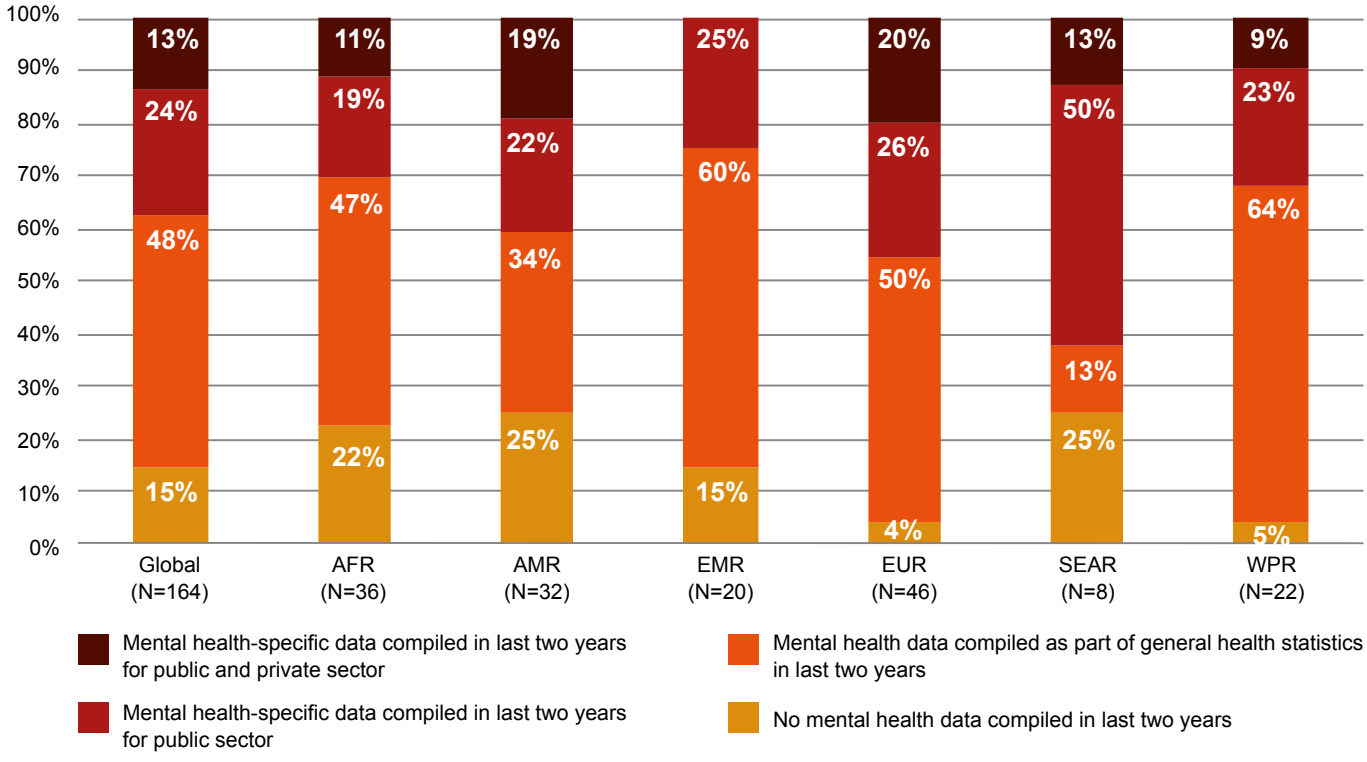
Consequently, special efforts will be required to reach Target 4 of the Comprehensive Mental Health Action Plan, which aims for 80% of countries to routinely collect and report on at least a core set of mental health indicators every two years through their national health and social information systems by 2030.

FIGURE 1.4 Availability and reporting of mental health data (global figures for 2014, 2017 and 2020)



The availability and reporting of mental health data varied across WHO regions and World Bank income groups, as reflected in Figures 1.5 and 1.6. In the European and Western Pacific Regions, 5% or fewer of responding countries reported that no mental health data had been compiled in the last two years, compared with over 20% in the African and the South-East Asia Regions and the Region of the Americas (Figure 1.5). Since 2014, there has been a decline in the percentage of countries reporting that no mental health data had been compiled in the last two years in all regions, except for the Region of the Americas, which reported an increase from 21% in 2014 to 25% in 2020, and the Eastern Mediterranean region, which reported an increase from 5% in 2014 to 15% in 2020.

FIGURE 1.5 Availability and reporting of mental health data in responding countries, by WHO region



As shown in Figure 1.6, a quarter of responding countries in both the low-income and lower-middle-income groups reported no compilation of mental health statistics for the last two years, compared with 8% and 10%, respectively, in upper-middle- and high-income countries.

The proportion of Member States with a mental health-specific data report compiled in the last two years for both public and private sectors was less than 20% globally and for all income groups, which reflects the limited availability of mental health information and reporting systems, regardless of region and income levels (Figure 1.6).

Comparisons across years show that the proportion of countries in the upper-middle-income group with no mental health data compiled in the last two years decreased substantially, from 16% of responding countries in 2017 to 8% in 2020. Ten per cent of high-income countries reported no mental health data compiled in the last two years, a figure almost unchanged from 2017; however, this marked a substantial increase from 2% in 2014 (Table 1.1).

FIGURE 1.6 Availability and reporting of mental health data (percentage of responding countries), by World Bank income group

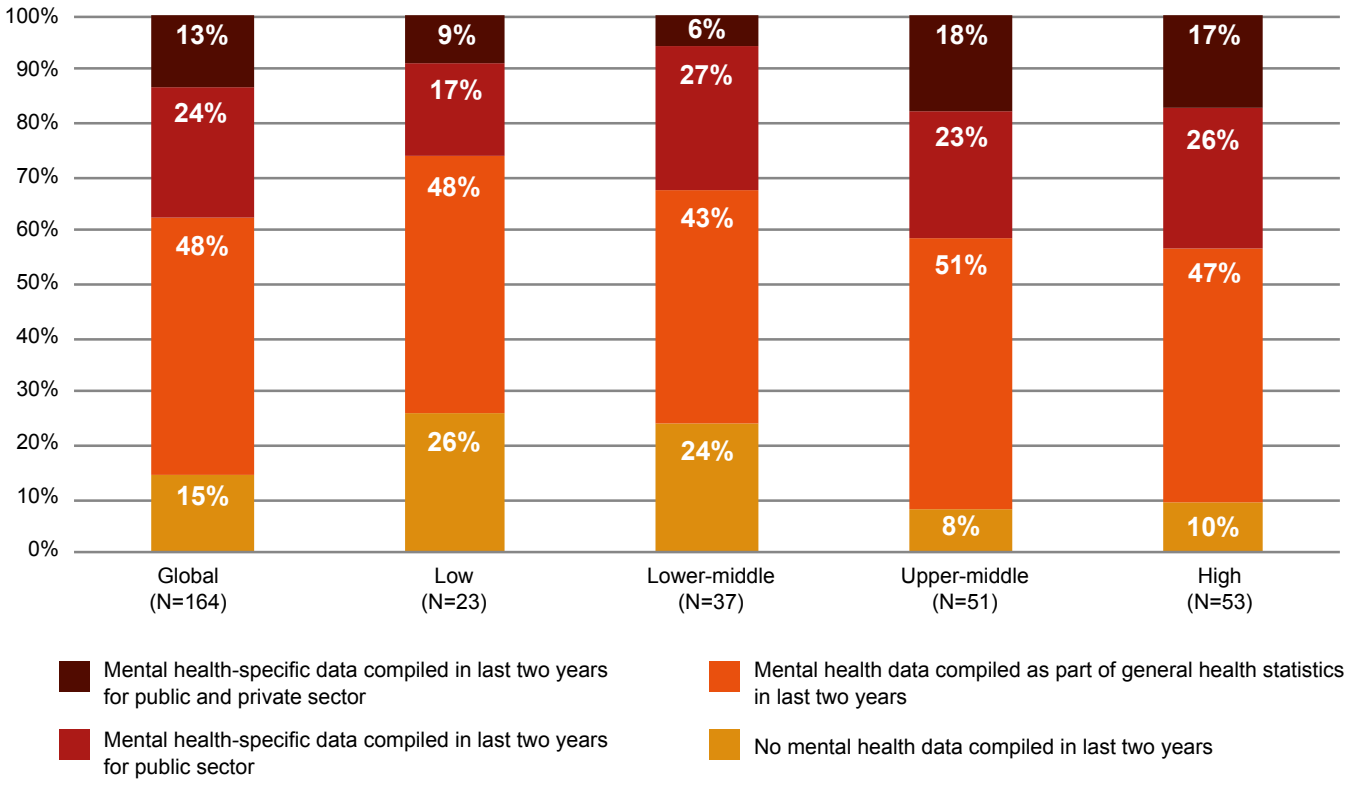


TABLE 1.1 Availability and reporting of mental health data: percentage of responding countries reporting no mental health data compiled in last two years, by WHO region, World Bank income group and year (2014, 2017 and 2020)

	Proportion of responding countries reporting that no mental health data were compiled in the last two years		
	2014 (N=155)	**2017 (N=154)**	**2020 (N=164)**
Global	19% (n=29)	17% (n=26)	15% (n=24)
WHO region			
AFR	39% (n=13)	24% (n=9)	22% (n=8)
AMR	21% (n=6)	24% (n=6)	25% (n=8)
EMR	5% (n=1)	19% (n=3)	15% (n=3)
EUR	5% (n=2)	9% (n=4)	4% (n=2)
SEAR	40% (n=4)	20% (n=2)	25% (n=2)
WPR	13% (n=3)	10% (n=2)	5% (n=1)
World Bank income group			
Low	31% (n=10)	22% (n=6)	26% (n=6)
Lower-middle	31% (n=12)	23% (n=9)	24% (n=9)
Upper-middle	17% (n=8)	16% (n=7)	8% (n=4)
High	2% (n=1)	9% (n=4)	10% (n=5)

Data disaggregation by age and sex

Over 30% of responding countries reported that they did not compile and/or report data disaggregated by age and sex. On the other hand, a little under 70% of countries did compile and/or report data disaggregated by age and sex, with the highest percentages reported by the Region of the Americas and the Eastern Mediterranean Region (80% or more).

The capacity of information systems to disaggregate data by age and sex declined consistently across income groups, with 54% of low-income countries disaggregating data by age and fewer than 50% of countries in this group disaggregating data by sex (Figure 1.7 and Table 1.2).

FIGURE 1.7 Mental health data compiled and/or reported, disaggregated by age and sex

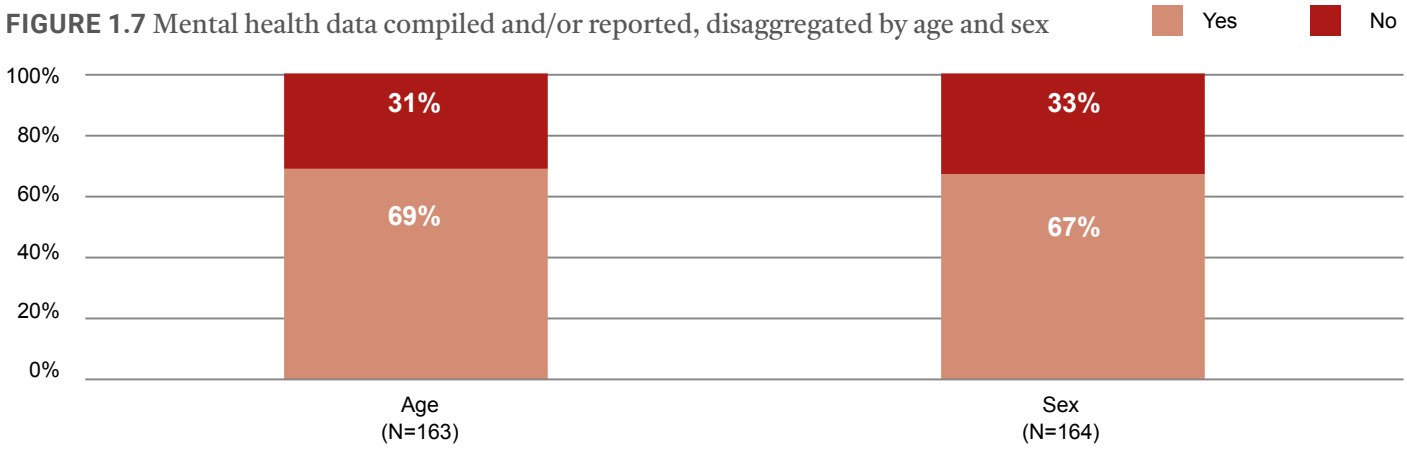


TABLE 1.2 Mental health data compiled and/or reported, disaggregated by age and sex, by WHO region and World Bank income group

	Percentage of responding countries with data compiled and/or reported by age and sex	
	Age (N=163)	**Sex (N=164)**
Global	**69% (n=113)**	**67% (n=110)**
WHO region		
AFR	54% (n=19)	43% (n=15)
AMR	79% (n=26)	82% (n=27)
EMR	79% (n=15)	84% (n=16)
EUR	74% (n=34)	65% (n=30)
SEAR	50% (n=4)	63% (n=5)
WPR	68% (n=15)	74% (n=17)
World Bank income group		
Low	54% (n=13)	46% (n=11)
Lower-middle	51% (n=18)	61% (n=22)
Upper-middle	76% (n=38)	70% (n=35)
High	82% (n=44)	78% (n=42)

Reporting on a minimum set of indicators for mental health

Based on data submitted to WHO through the Mental Health Atlas 2020 questionnaire, an assessment was also made of countries' ability to report on a defined minimum set of indicators for mental health. The percentages of WHO Member States that reported on the five specific mental health indicators were as follows:1) stand-alone mental health policy or plan (yes or no): 99% of responding countries or 87% of WHO Member States; 2) stand-alone mental health law (yes or no): 100% of responding countries or 88% of WHO Member States; 3) mental health workforce (available data for at least some types of workers): 93% of responding countries or 82% of WHO Member States; 4) service availability (data for at least some care settings): 98% of responding countries or 86% of WHO Member States; 5) mental health promotion and prevention (completion of the checklist, including if no programmes present): 93% of responding countries or 82% of WHO Member States. An additional key indicator, service utilization for psychosis, was added to the defined minimum set of mental health indicators. Just 70% of responding countries or 62% of all Member States reported on this additional indicator.

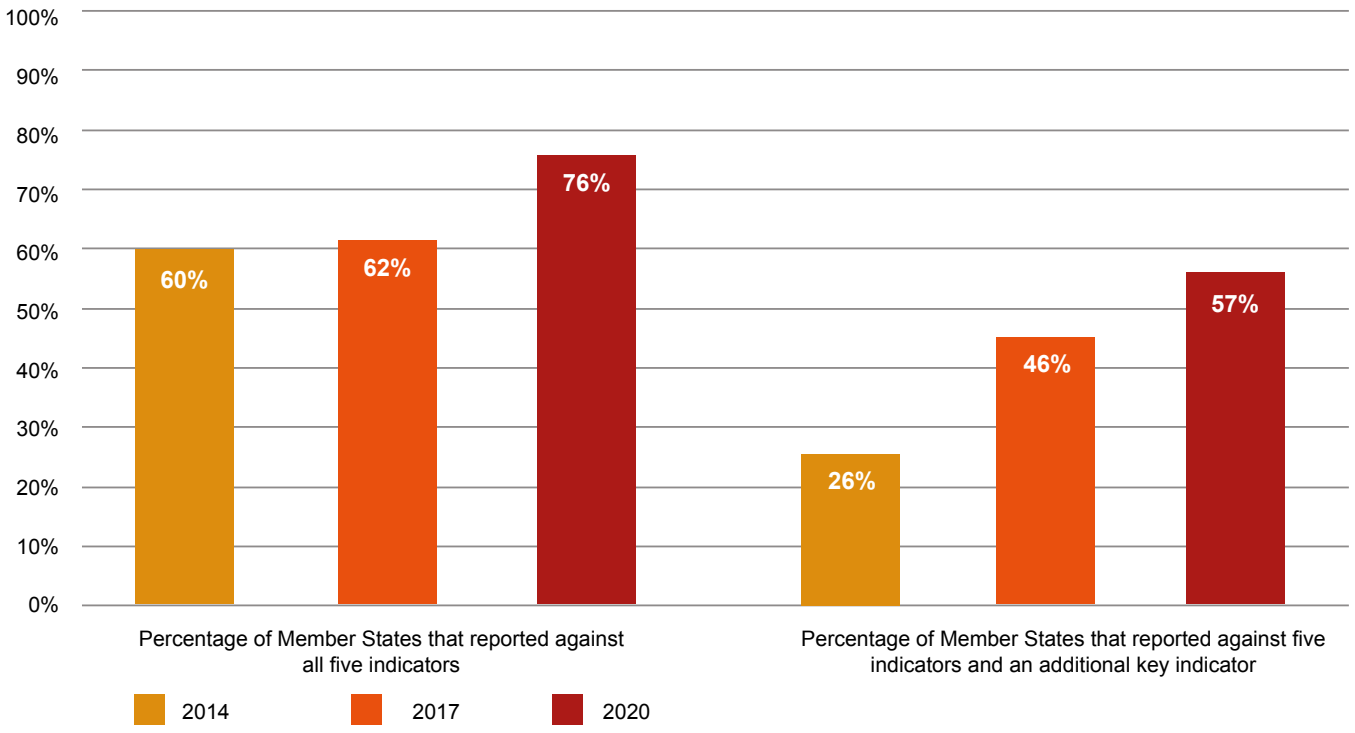
As shown in Table 1.3, 76% of WHO Member States (or 87% of responding countries) confirmed their ability to report against these five core mental health indicators. This indicates a considerable improvement in reporting since the 2014 and 2017 editions of the Atlas when, respectively, 60% (117 countries) and 62% (131 countries) of all Member States were able to report against the five core indicators (Figure 1.8). This reflects the importance of the Mental Health Atlas exercise as a tool for monitoring and improving the availability and quality of data on mental health resources in individual countries.

Adding service utilization as a further key indicator for mental health to the defined set reduced the global number of countries and the number of countries across WHO regions responding positively by between 20% and 30%. Only 57% of all Member States (110 countries) reported that they were able to report on service utilization and the five core indicators (Figure 1.8). This constitutes a more accurate threshold and gives results closer to the percentage of countries that self-reported their ability to regularly compile mental health-specific data covering at least the public sector (31% of all Member States). Percentages varied across regions and income groups, ranging from 49% in countries in the African region to 66% in countries in the Region of the Americas, and from 49% in the lower-middle-income group to 64% in the upper-middle-income group (data not shown).

TABLE 1.3 Number and percentage of responding countries and of WHO Member States reporting against all five mental health indicators, by WHO region and World Bank income group

	Number and percentage of countries reporting against all five mental health indicators (N=171)		
	Number of countries	**Percentage of responding countries**	**Percentage of WHO Member States**
Global	**148**	**87%**	**76%**
WHO region			
AFR	31	80%	66%
AMR	30	91%	86%
EMR	19	95%	91%
EUR	38	83%	72%
SEAR	8	100%	73%
WPR	22	88%	82%
World Bank income group			
Low	22	88%	76%
Lower-middle	32	80%	65%
Upper-middle	46	89%	82%
High	48	89%	80%

FIGURE 1.8 Proportion of WHO Member States reporting against a defined set of core indicators for mental health (2014, 2017 and 2020)



Output of global research on mental health

This new indicator measures the output of mental health research, as defined by the number of published research studies in biomedical and life science research databases. The annual published research output in peer-reviewed and indexed journals is used as a proxy for the amount (and quality) of mental health research that is being conducted or is related to a given country. It indirectly assesses a country's commitment to mental health research, ultimately having impacts on outcomes for people with mental health conditions.

In line with the global target for Objectvie 4 of the WHO Comprehensive Mental Health Action Plan, the following search strategy in PubMed was developed for obtaining bibliometric data on global mental health research output: "(mental health [MeSH Terms] OR mental disorders [MeSH Terms]) AND "country name/global"[MeSH Terms] AND ("year/month/day"[PDAT]:"year/month/day"[PDAT])".

The goal of the search strategy was to create a methodology for replicable, consistent searches of peer-reviewed publications in mental health research. To produce a comparable indicator, the mental health output was standardized against the overall general health research output at the global and country levels. This search methodology is intended to be repeated periodically to measure differences in research output over time. This will determine whether countries are collectively approaching Global Target 4.2 of doubling the amount of mental health research done by 2030.

A total of 64 646 research papers on mental health were published in 2019, corresponding to 4.6% of the total general health research output. This represented a notable increase since 2013, when 57 491 articles on mental health were published.

Although the absolute values for mental health research outputs in 2019 showed an increase of 12.4% compared with the baseline of 2013, the relative indicator has been decreasing consistently over time, indicating a slower pace of mental health research compared with overall general health research output (5% of total general health research output in 2013 and 4.6% of total general health research output in 2019) (Figure 1.9).

The percentage of mental health research in total research output varied considerably between WHO regions (Figure 1.10). The highest percentage was reported in the European Region (8.2% of total research output) and the lowest percentage in the Africa Region (2.0% of total research output).

FIGURE 1.9 Percentage of global mental health research output in total research output in 194 WHO Member States: a comparison across years (N=194)

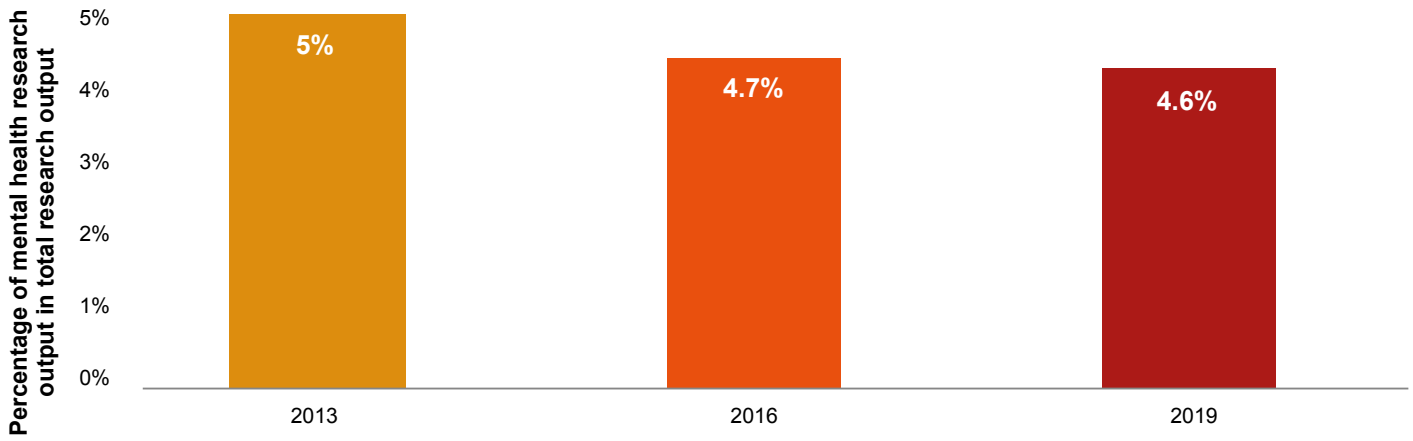
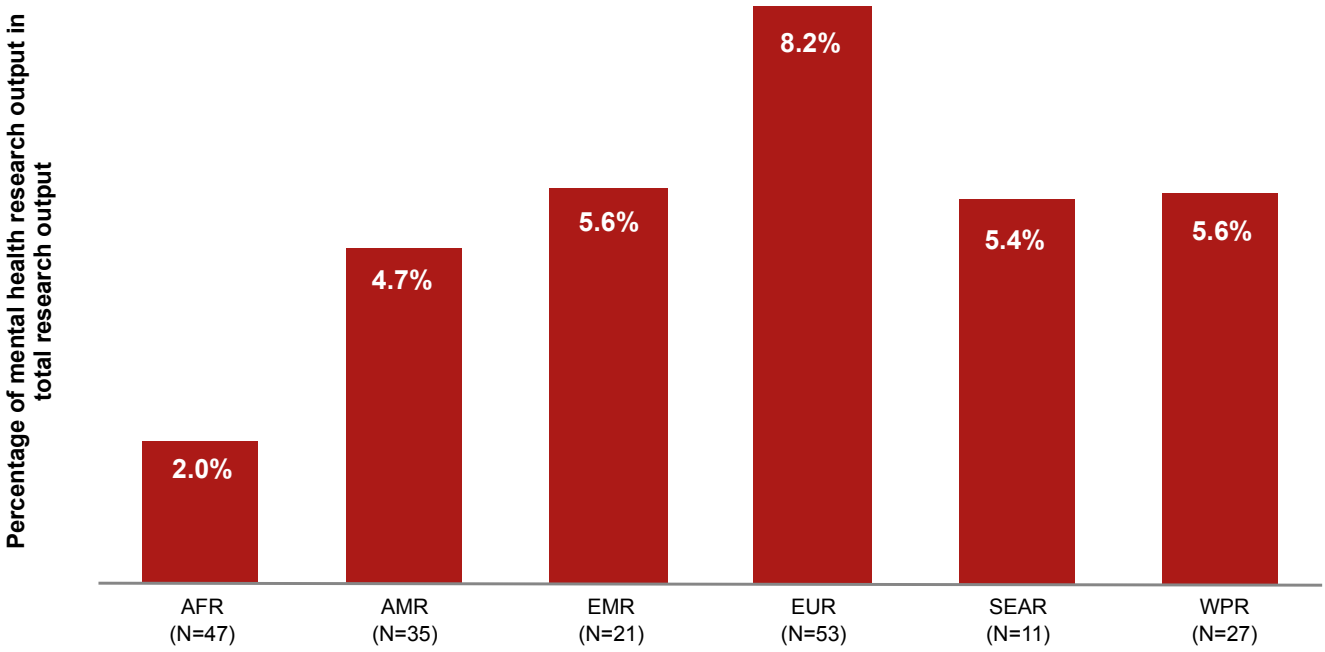
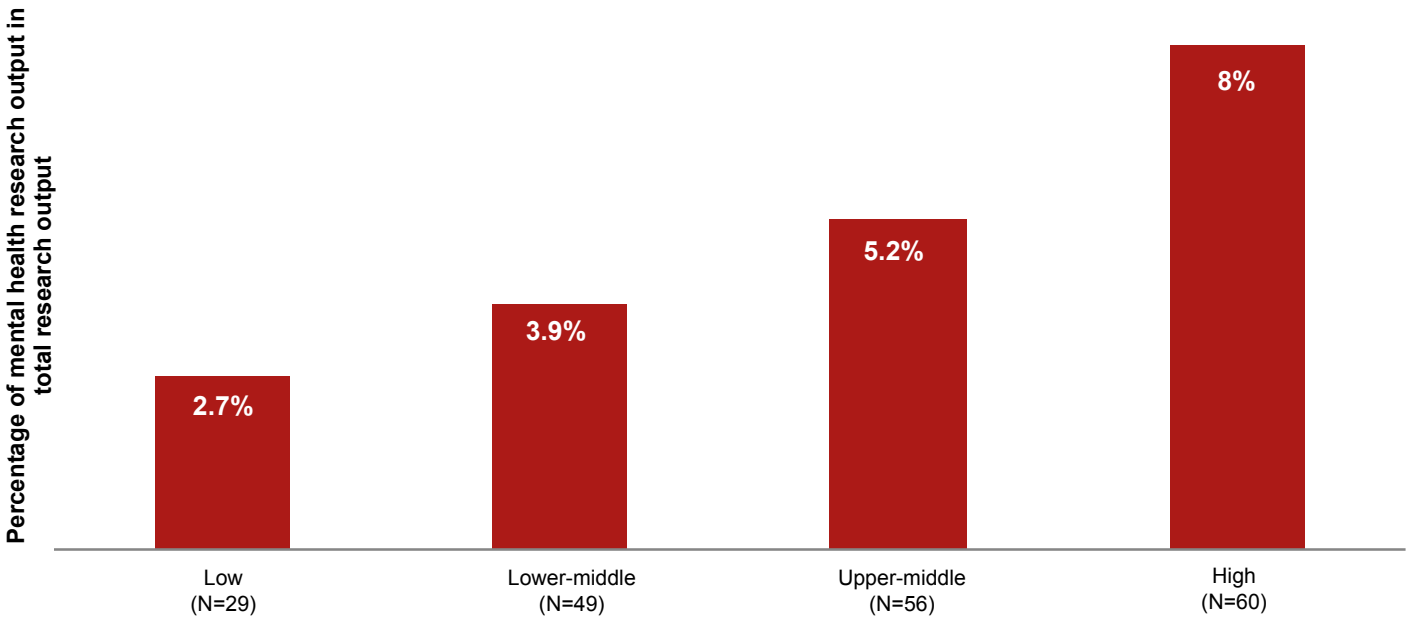


FIGURE 1.10 Percentage of mental health research output in total research output, by WHO region (2019)



The percentage of country-level mental health research output across World Bank income groups increased with countries' income levels (Figure 1.11). The percentage was three times greater in high-income countries (8% of total research output) than in low-income countries (2.7% of total research output).

FIGURE 1.11 Percentage of mental health research output in total research output, by World Bank income group (2019)



MENTAL HEALTH ATLAS 2020

2 MENTAL HEALTH SYSTEM GOVERNANCE

2.1 MENTAL HEALTH POLICIES/PLANS

The Comprehensive Mental Health Action Plan defines effective governance and strong leadership as crucial factors for developing effective policies and plans addressing mental health. A mental health policy is an official statement by a government that defines a vision with a set of values, principles and objectives and an overall plan of action to achieve that vision and improve the mental health of a population. The policy should have a detailed plan with concrete strategies and activities that will be implemented with established timelines and the resources needed. Policies and plans for mental health may be stand-alone or may be integrated into other general health or disability policies or plans. They are considered valid if they have been approved or published by the ministry of health, other line ministries or the country's parliament.

As with previous editions, the Mental Health Atlas 2020 questionnaire assessed whether countries had stand-alone and/or integrated mental health policies/plans and whether these policies/plans had been updated. In order to evaluate the compliance of policies/plans with international human rights instruments, countries completed the following checklist: 1) transition towards mental health services based in the community (including mental health care integrated into general hospitals and primary care); 2) respect of the rights of people with mental health conditions and psychosocial disabilities as well as at-risk populations; 3) full range of services and supports to enable people to live independently and be included in the community (including rehabilitation services, social services, educational, vocational and employment opportunities, housing services and supports); 4) a recovery approach to mental health care which emphasizes support for individuals to achieve their aspirations and goals, with mental health service users driving the development of their treatment and recovery plans; and 5) participation of persons with mental health conditions and psychosocial disabilities in decision-making processes about issues affecting them (e.g. policies, laws, service reform, service delivery). Additionally, the 2020 questionnaire inquired about the implementation of policies and plans in WHO Member States. Mental health plans/policies were considered to be in the process of implementation only if at least two of the following three criteria were fulfilled: 1) human resources are estimated and allocated for the implementation of mental health policies/plans; 2) financial resources are estimated and allocated for the implementation of mental health policies/plans; 3) indicators/targets are available and used for evaluation/monitoring of implementation of some/all components of current mental health policies.

Finally, for the first time, the Mental Health Atlas 2020 evaluated the available human and financial resources allocated for the implementation and monitoring of policies/plans through a self-rated checklist.

If both a mental health policy and plan were available, countries were asked to assess both documents as one entity and report the latest publication or revision year. Countries with a federated system were asked to refer to policies/plans or laws covering most states and provinces or most of the population in the country.

In total, 146 countries (86% of responding countries, 75% of WHO Member States) reported the existence of stand-alone policies/plans for mental health (Table 2.1.1). The South-East Asia region had the highest percentage (100% of responding countries, 73% of WHO Member States); the Africa Region had the lowest (76% of responding countries, 62% of WHO Member States). The percentages of responding countries with stand-alone mental health policies/plans have steadily increased for all regions since the Mental Health Atlas 2014 and 2017.

While the questionnaire acknowledged the importance of integrating mental health policies/plans into other general health or disability policies or plans, mental health issues can also be included in other relevant sectors/policies e.g. social protection policies, employment, education, etc.

TABLE 2.1.1 Existence of stand-alone mental health policies/plans: Mental Health Atlas 2014, 2017 and 2020, by WHO region

	Percentage of responding countries reporting the existence of stand-alone mental health policies or plans		
	2014 (N=170)	**2017 (N=175)**	**2020 (N=170)**
Global	**77% (n=131)**	**79% (n=139)**	**86% (n=146)**
WHO region			
AFR	71% (n=27)	72% (n=31)	76% (n=29)
AMR	80% (n=24)	82% (n=27)	91% (n=30)
EMR	67% (n=14)	78% (n=14)	80% (n=16)
EUR	79% (n=38)	81% (n=39)	91% (n=42)
SEAR	80% (n=8)	90% (n=9)	100% (n=8)
WPR	83% (n=20)	83% (n=19)	84% (n=21)

Of responding countries, 56% (46% of WHO Member States) reported that policies/plans had been published/updated since the previous Mental Health Atlas in 2017; the biggest proportions were in the Eastern Mediterranean and South-East Asia Regions (more than 70% of responding countries). This represents an important finding compared with 29% of responding countries (24% of WHO Member States) publishing/updating their policies/plans between 2013 and 2016 and 11% of responding countries (9% of WHO Member States) between 2007 and 2013 (Table 2.1.2).

Of 24 countries stating that they did not have a stand-alone policy or plan, 18 confirmed that policies/plans for mental health were integrated into policies/plans for general health or disability.

TABLE 2.1.2 Revision status of mental health policies/plans, by WHO region and World Bank income group

	Year that stand-alone or integrated policy or plan was published or last revised (percentage of responding countries) (N=162)			
	Before 2007	2007–2012	2013–2016	Since 2017
Global (N=162)	6%	11%	29%	56%
WHO region				
AFR (N=36)	11%	6%	36%	48%
AMR (N=32)	13%	19%	22%	47%
EMR (N=17)	0%	6%	24%	71%
EUR (N=45)	2%	9%	24%	64%
SEAR (N=8)	0%	0%	25%	75%
WPR (N=24)	0%	17%	38%	46%
World Bank income group				
Low (N=24)	0%	4%	38%	58%
Lower-middle (N=38)	8%	13%	32%	47%
Upper-middle (N=49)	6%	12%	33%	49%
High (N=51)	6%	10%	18%	67%

BOX 1: EXISTENCE OF MENTAL HEALTH POLICIES/PLANS FOR CHILDREN AND ADOLESCENTS, BY WHO REGION

Countries were asked whether they had a policy/plan for child and adolescent mental health. Of 168 WHO Member States responding to the question, 53% reported the existence of stand-alone or integrated mental health plans/policies for both children and adolescents (Table 2.1.3). A majority of responding countries (over 60%) reported that they had updated their policies/plans for children and adolescents since 2017. The South-East Asia region had the highest percentages of responding countries with policies/plans for children and adolescents (88% for children and 100% for adolescents).

TABLE 2.1.3 Existence and revision status of child and/or adolescent mental health policies/plans, by WHO region

	Child mental health policy or plan			Adolescent mental health policy or plan		
	Number of countries reporting the existence of a stand-alone or integrated policy/plan (N=168)	Percentage of responding countries reporting the existence of a stand-alone or integrated policy/plan (N=168)	Percentage of these countries reporting that the policy/ plan has been updated since 2017 (N=90)	Number of countries reporting the existence of a stand-alone or integrated policy/plan (N=169)	Percentage of these countries reporting the existence of a stand-alone or integrated policy/plan (N=169)	Percentage of responding countries reporting that the policy/ plan has been updated since 2017 (N=89)
Global	**90**	**53%**	**63%**	**89**	**53%**	**66%**
AFR	11	29%	55%	11	29%	55%
AMR	20	61%	45%	19	58%	42%
EMR	10	53%	70%	10	50%	70%
EUR	31	67%	68%	30	65%	70%
SEAR	7	88%	71%	8	100%	75%
WPR	11	46%	82%	11	46%	82%

Compliance of mental health policies/plans with human rights instruments

Regarding the degree of compliance of a country's mental health policy/plan with human rights instruments, Figure 2.1.1 illustrates responding countries' self-rating of the five items in the checklist constructed for this purpose. The majority of responding countries considered that their policies/plans promoted at least one of the following human rights standards: 1) transition towards mental health services based in the community (including mental health care integrated into general hospitals and primary care) (98%); 2) respect of the rights of people with mental health conditions and psychosocial disabilities as well as at-risk populations (98%); 3) full range of services and supports to enable people to live independently and be included in the community (including rehabilitation services, social services, educational, vocational and employment opportunities, housing services and supports, etc.) (86%); 4) a recovery approach to mental health care, which emphasizes support for individuals to achieve their aspirations and goals, with mental health service users driving the development of their treatment and recovery plans (76%); 5) participation of persons with mental health conditions and psychosocial disabilities in decision-making processes about issues affecting them (e.g. policies, laws, service reform, service delivery) (81%).

There has been a gradual increase over time in positive responses for three of these five standards. Compared with 2014 and 2017, more countries reported in 2020 that their policies promoted a transition towards mental health services based in the community, respect of the rights of people with mental health conditions and psychosocial disabilities as well as at-risk populations, and a full range of services and support to enable people to live independently and be included in the community. On the other hand, the percentages of countries reporting that their policies/plans promoted a recovery approach to mental health care and that they promoted the participation of persons with mental health conditions and psychosocial disabilities in decision-making processes about issues affecting them both decreased slightly from 2017 (Figure 2.1.1).

FIGURE 2.1.1 Compliance of mental health policies/plans with human rights instruments (2014, 2017 and 2020)

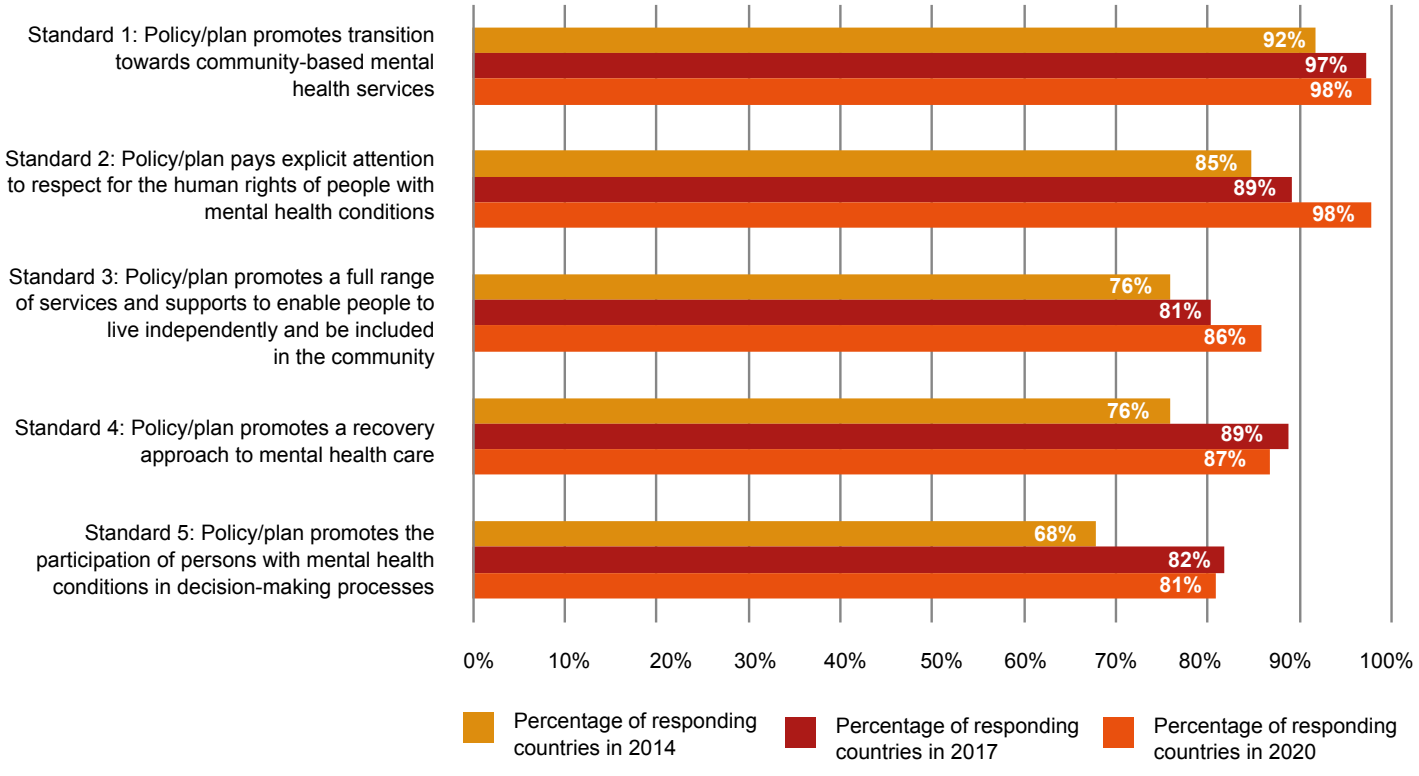
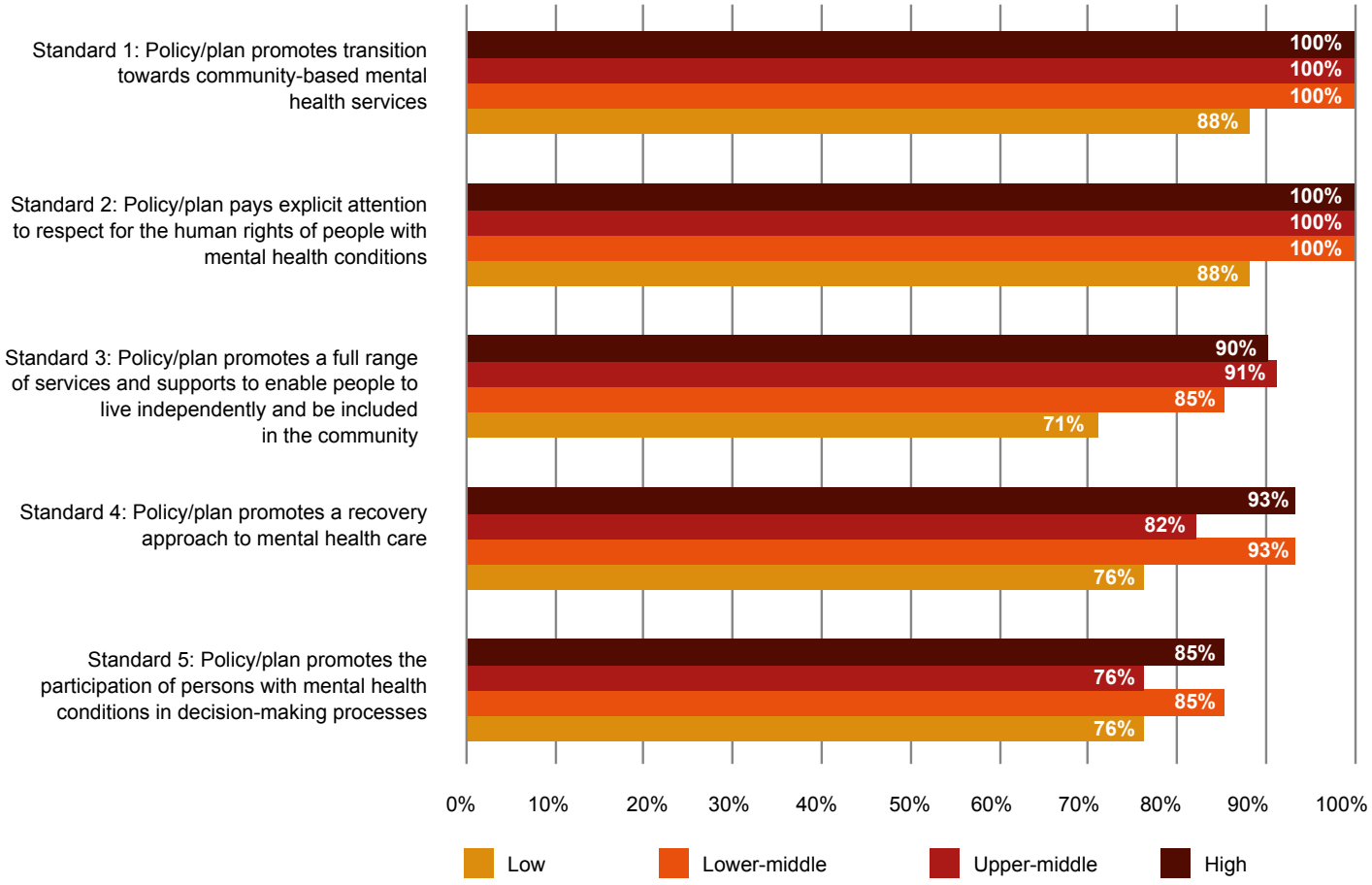


Figure 2.1.2 provides a breakdown by World Bank income group; globally, it shows better compliance with most standards in high-, upper-middle- and lower-middle-income countries compared with low-income countries. There was 100% compliance with two of the five standards and at least 80% compliance with all of the five standards in the high-, upper-middle- and lower-middle-income groups. Compliance with the standard promoting the participation of persons with mental health conditions in the decision-making process was lower than for other standards in almost all World Bank income groups.

FIGURE 2.1.2 Compliance of mental health policies/plans with human rights instruments (% of responding countries), by World Bank income group



Adding up the checklist items provides a score ranging from zero (no compliance) to five (full compliance), which measures the extent to which countries consider their mental health policies/plans to be in line with human rights instruments (Figure 2.1.3). The majority of responding countries scored at least 3 (93%) or 4 (86%), indicating partial compliance. Only 67% of responding countries met all five items, which corresponds to 51% of WHO Member States achieving full compliance. Although a small but steady degree of progress has been observed from the baseline values of 2014, when 45% of Member States achieved full compliance, the global target of 80% set in the Comprehensive Mental Health Action Plan is a long way from being reached.

Figure 2.1.4 compares full compliance of mental health policies/plans with human rights instruments by WHO region. The percentage of countries indicating full compliance of their mental health policies/plans with human rights instruments has increased notably in all WHO regions since 2014, except in the European Region, where full compliance decreased slightly, from 74% in 2014 to 70% in 2020. Other regions reported a decrease in compliance in 2020 compared with 2017, such as the Africa Region (from 80% to 68% of responding countries) and the Western Pacific Region (from 77% to 67% of responding countries). This might reflect, paradoxically, an increase in countries' awareness of human rights and a more critical attitude towards the compliance of their policies/plans with international human rights instruments.

FIGURE 2.1.3 Mental health policies/plans and human rights: checklist score (percentage of responding countries), by WHO region

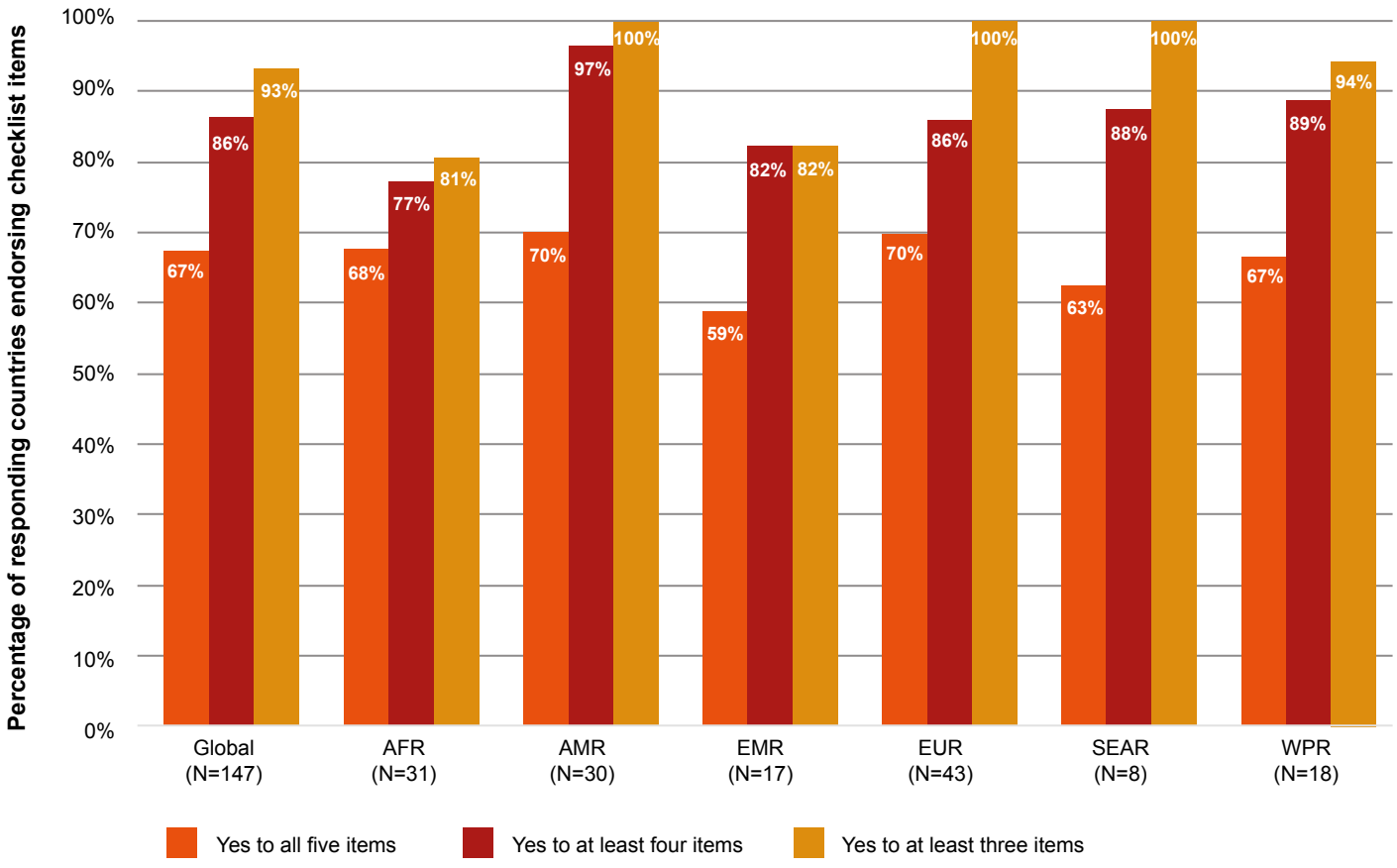
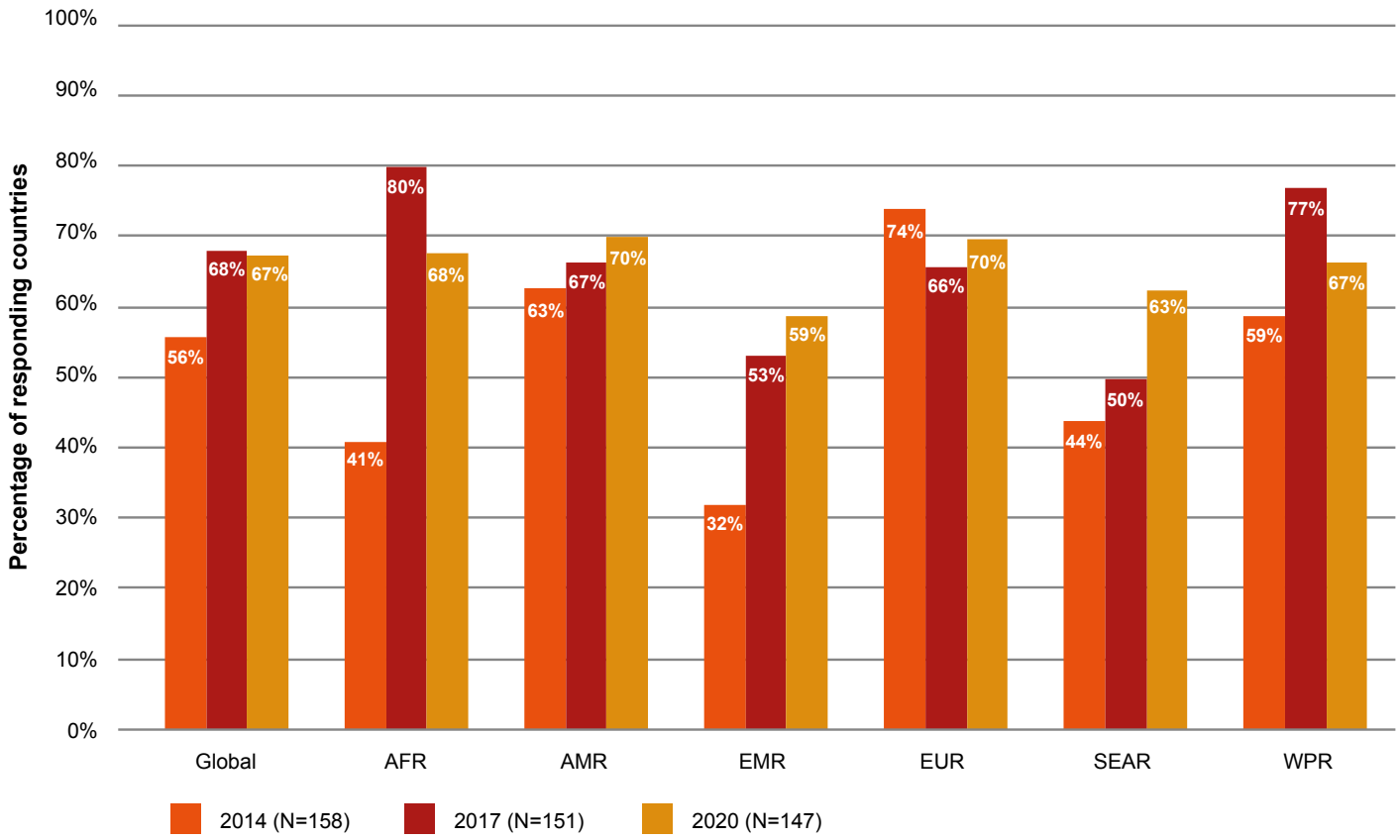


FIGURE 2.1.4 Percentage of responding countries indicating full compliance of mental health policies/plans with human rights instruments, by WHO region (2014, 2017 and 2020)



Human and financial resources in mental health policies/plans

The Mental Health Atlas questionnaire asked whether countries included estimates of required human and financial resources in their policies/plans and whether resources had been allocated for implementation. Table 2.1.4 shows countries' reporting of their estimated and allocated human and financial resources, by WHO region and World Bank income group.

Of the 168 countries that answered this question, 60% reported that their mental health policies/plans included estimates of required human resources. In contrast, only 39% reported that these human resources had been allocated for implementation according to an assessment of needs. Table 2.1.4 shows disparities between WHO regions and World Bank income groups, with countries in the low-income group reporting the widest gap between estimated and allocated human resources. The low-income group had the highest percentage of responding countries with an available estimation of their human resources (68%) yet had the lowest percentage of responding countries with human resources allocated for implementation in line with resources contained in their policies/plans (29%). The proportion of countries reporting that human resources were allocated to implementing mental health policies and plans in 2020 was higher than the proportion of countries reporting that both human and financial resources had been allocated in 2017, across all income groups.

Regarding financial resources, 52% of responding countries reported that their mental health policies/plans included estimates of such resources, while 34% reported that these resources had been allocated. While 40% of low-income countries were able to estimate the needed financial

resources, just 8% reported that these resources were available and had been allocated to implement their mental health policies/plans. The proportion of countries reporting that financial resources had been allocated to implement mental health policies and plans in 2020 was higher than the proportion of countries reporting that either human or financial resources had been allocated in 2017 across all WHO regions and World Bank income groups, except for the Africa region and the low-income country group.

Globally, financial resources for mental health policies/plans were both estimated and allocated to a lesser extent than human resources for all regions and income groups. These discrepancies between the estimation and allocation of human and financial resources demonstrate the challenges that countries face in making resources available to implement their policies/plans.

TABLE 2.1.4 Mental health policies/plans: estimated and allocated human and financial resources, by WHO region and World Bank income group

	Human and/or financial resources (2017)	Human resources (2020)		Financial resources (2020)	
	Percentage of responding countries reporting that an estimate of human and/or financial resources is available and allocated to implement mental health policy/plan (N=169)	Percentage of responding countries reporting that an estimate of human resources needed to implement mental health policy/ plan is available (N=168)	Percentage of responding countries reporting that an estimate of human resources is available and allocated to implement mental health policy/plan (N=158)	Percentage of responding countries reporting that an estimate of financial resources needed to implement mental health policy/ plan is available (N=168)	Percentage of responding countries reporting that an estimate of human resources is available and allocated to implement mental health policy/plan (N=159)
Global	**29% (n=49)**	**60% (n=100)**	**39% (n=61)**	**52% (n=87)**	**34% (n=54)**
WHO region					
AFR	17% (n=7)	59% (n=23)	24% (n=8)	44% (n=17)	11% (n=4)
AMR	26% (n=8)	44% (n=14)	29% (n=9)	38% (n=12)	32% (n=10)
EMR	12% (n=2)	70% (n=14)	59% (n=10)	55% (n=11)	47% (n=8)
EUR	43% (n=20)	61% (n=27)	44% (n=19)	60% (n=27)	46% (n=20)
SEAR	25% (n=3)	88% (n=7)	63% (n=5)	88% (n=7)	63% (n=5)
WPR	49% (n=11)	60% (n=15)	40% (n=10)	54% (n=13)	29% (n=7)
World Bank income group					
Low	14% (n=4)	68% (n=17)	29% (n=7)	40% (n=10)	8% (n=2)
Lower-middle	26% (n=11)	55% (n=22)	33% (n=12)	43% (n=17)	27% (n=10)
Upper-middle	36% (n=18)	67% (n=35)	49% (n=25)	64% (n=33)	43% (n=22)
High	36% (n=18)	51% (n=26)	36% (n=17)	53% (n=27)	43% (n=20)

Existence of indicators and targets to monitor implementation of mental health policies/plans

Countries were also asked whether they used indicators/targets to monitor the implementation of their mental health policies/plans. Of the 167 countries that responded, 23% stated that indicators were not available, while 22% stated that indicators were available but not used, 32% stated that indicators were used for some/a few components and 23% stated that indicators were used for most or all components (Table 2.1.5). The proportion of countries with indicators that were available and had been used in the last two years for some/a few or most/all components was less than 70% in all WHO regions; the lowest proportions were reported in the African Region and the Region of the Americas (32% and 47% of responding countries respectively). In comparison, the highest proportion was reported in the Eastern Mediterranean region (70% of responding countries). The proportions of countries with indicators that were available and had been used in the last two years for some/a few or most/all components varied between World Bank income groups, but were less than 50% in low- and lower-middle-income countries.

The proportion of countries with indicators available and that had been used in the last two years for some/a few or most/all components has not changed since 2017. More efforts will be needed by Member States to develop and strengthen strategies and mechanisms to adequately monitor the protection of human rights and the implementation of policies and laws, in line with evidence and best practice and in compliance with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

TABLE 2.1.5 Existence of indicators/targets to monitor implementation of policies/plans, by WHO region and World Bank income group

	Percentage of responding countries indicating existence of indicators/targets to monitor implementation of policies/plans (N=167)			
	Indicators not available	Indicators available but not used	Indicators available and have been used in the past two years for some/a few components	Indicators available and have been used in the past two years for most or all components
Global (N=167)	**23%**	**22%**	**32%**	**23%**
WHO region				
AFR (N=38)	22%	46%	27%	5%
AMR (N=32)	34%	19%	22%	25%
EMR (N=20)	15%	15%	35%	35%
EUR (N=45)	20%	11%	40%	29%
SEAR (N=8)	13%	25%	25%	38%
WPR (N=25)	24%	16%	40%	20%
World Bank income group				
Low (N=24)	13%	42%	33%	13%
Lower-middle (N=40)	25%	30%	40%	5%
Upper-middle (N=52)	24%	18%	31%	28%
High (N=52)	25%	12%	27%	37%

Status of mental health policies/plans, implementation and compliance with human rights instruments

In total, 164 countries (corresponding to 86% of WHO Member States) reported the existence of stand-alone and/or integrated policies/plans for mental health (Table 2.1.6). Proportionally, 51% of WHO Member States reported that their policies/plans were fully compliant with human rights instruments, and 31% of WHO Member States reported that their policies/plans were in the process of implementation. Only 21% of WHO Member States reported that they had mental health policies/plans that were in the process of implementation and were fully compliant with human rights instruments, which is a relatively low figure compared with the 2030 global target of 80%. The South-East Asia Region had the highest percentage (36% of all WHO Member States), while the Africa Region had the lowest (4% of all WHO Member States). There were significant variations between income groups, with 32% of countries in the upper-middle income group reporting mental health policies/plans that were in the process of implementation and were fully compliant with human rights instruments compared with 3% of countries in the low-income group.

TABLE 2.1.6 Status of mental health policies/plans, implementation and compliance with human rights instruments, by WHO region and World Bank income group

	Status of WHO Member States' mental health policies/plans, implementation and compliance with human rights instruments				
	Number of Member States with a stand-alone and/or integrated policy/plan	Percentage of Member States with a stand-alone and/or integrated policy/plan	Percentage of Member States with a mental health policy/plan that is compliant with human rights instruments (5/5 on the checklist)	Percentage of Member States with a mental health policy/plan that is in the process of implementation (2/3 on the checklist)	Percentage of Member States with a mental health policy/plan that is in the process of implementation and fully compliant with human rights instruments
Global	**164**	**86%**	**51% (n=99)**	**31% (n=61)**	**21% (n=41)**
WHO region					
AFR	36	77%	45% (n=21)	10% (n=5)	4% (n=2)
AMR	32	91%	60% (n=21)	32% (n=11)	26% (n=9)
EMR	17	81%	48% (n=10)	43% (n=9)	24% (n=5)
EUR	46	87%	57% (n=30)	42% (n=22)	34% (n=18)
SEAR	8	73%	45% (n=5)	45% (n=5)	36% (n=4)
WPR	25	82%	44% (n=12)	33% (n=9)	11% (n=3)
World Bank income group					
Low	24	83%	45% (n=13)	10% (n=3)	3% (n=1)
Lower-middle	38	78%	45% (n=22)	24% (n=12)	14% (n=7)
Upper-middle	50	89%	50% (n=28)	45% (n=35)	32% (n=18)
High	52	87%	60% (n=36)	35% (n=21)	25% (n=15)

2.2 MENTAL HEALTH LEGISLATION

Mental health legislation is a crucial component of good governance and concerns specific legal provisions relating to mental health. These provisions should be aligned with the fundamental principles, values and objectives of policies for mental health by promoting the human rights of people with mental health conditions and psychosocial disabilities and establishing oversight mechanisms for monitoring alignment with international human rights standards and limiting coercive practices and treatments. Legislation for mental health must comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

As with previous editions of the Atlas, the 2020 questionnaire assessed whether countries had a stand-alone and/or integrated mental health law and whether that law had been updated. As they had done for mental health policies/plans, countries completed a checklist designed to evaluate the compliance of their legislation with international human rights instruments: 1) transition towards community-based mental health services (including mental health integrated into general hospitals and primary care); 2) promotion of the rights of people with mental health conditions and psychosocial disabilities to exercise their legal capacity; 3) promotion of alternatives to coercive practice; 4) provision for procedures to enable people with mental health conditions and psychosocial disabilities to protect their rights and file appeals and complaints to an independent legal body; 5) provision for regular inspections of human rights conditions in mental health facilities by an independent body.

Additionally, the updated indicators and targets for the Comprehensive Mental Health Action Plan emphasize the importance of implementing legislation. Since it is difficult to estimate the implementation status of mental health law through a self-reported questionnaire, WHO developed a simple checklist as a proxy indicator in order to understand the status of implementation of mental health legislation in Member States. Mental health legislation was considered to be in the process of implementation only if at least two of the following three criteria were met: 1) a dedicated authority or independent body exists; 2) it undertakes regular inspections of mental health services; 3) it systematically responds to complaints and reports its findings at least once a year.

A total of 111 countries (65% of responding countries, 57% of WHO Member States) reported the existence of a stand-alone law for mental health (Table 2.2.1). More than 70% of responding countries in the Western Pacific, Eastern Mediterranean and European Regions reported the existence of stand-alone mental health laws, compared with only 49% of Member States in the African Region. The percentage of responding countries with a stand-alone mental health law has increased for almost all regions since the Mental Health Atlas 2014, apart from the African Region (where the figure fell from 55% of responding countries in 2014 to 49% of responding countries in 2020). For the European Region, the proportion has remained unchanged since the baseline value of 2014 (70% of responding countries).

While the Mental Health Atlas questionnaire acknowledged the importance of integrating mental health laws into other general health or disability laws, mental health issues can also be included in other relevant sectors such as criminal justice, capacity-related legislation, civil codes, etc.

TABLE 2.2.1 Comparison of reported existence of stand-alone mental health laws (2014, 2017 and 2020), by WHO region

	Percentage of responding countries stating that they have a stand-alone mental health law		
	2014 (N=158)	**2017 (N=175)**	**2020 (N=171)**
Global	**63% (n=99)**	**63% (n=111)**	**65% (n=111)**
WHO region			
AFR	55% (n=18)	44% (n=19)	49% (n=19)
AMR	50% (n=14)	61% (n=20)	61% (n=20)
EMR	67% (n=12)	61% (n=11)	70% (n=14)
EUR	70% (n=33)	77% (n=37)	70% (n=32)
SEAR	60% (n=6)	50% (n=5)	63% (n=5)
WPR	73% (n=15)	83% (n=19)	80% (n=20)

In addition, 52 countries (34% of responding countries, 27% of WHO Member States) reported that their law had been updated since 2017. The South-East Asia Region reported the highest percentage of updated mental health laws (63% of responding countries), followed by the European Region (48% of responding countries). When countries were categorized by World Bank income group, slight variations were observed between groups (Table 2.2.2).

Nearly three quarters of countries (44 out of 60) that reported having no stand-alone law for mental health confirmed that their mental health legislation was integrated into general health or disability law (data not shown).

TABLE 2.2.2 Mental health legislation: revision status, by WHO region and World Bank income group

	Year that stand-alone or integrated mental health law was published or last revised (percentage of responding countries) (N=152)			
	Before 2007	**2007–2012**	**2013–2016**	**Since 2017**
Global (N=152)	26%	16%	24%	34%
WHO region				
AFR (N=28)	43%	21%	11%	25%
AMR (N=31)	29%	19%	32%	19%
EMR (N=16)	38%	13%	19%	31%
EUR (N=46)	17%	9%	26%	48%
SEAR (N=8)	25%	0%	13%	63%
WPR (N=23)	13%	26%	30%	30%
World Bank income group				
Low (N=16)	44%	19%	6%	31%
Lower-middle (N=34)	38%	15%	15%	32%
Upper-middle (N=49)	18%	16%	33%	33%
High (N=53)	21%	15%	26%	38%

Compliance of mental health law with human rights instruments

Regarding the degree of compliance of mental health laws with international human rights instruments, Figure 2.2.1 shows that the majority of responding countries considered that their law promotes at least one of the following standards: 1) transition towards community-based mental health services (including mental health integrated into general hospitals and primary care) (82% of responding countries); 2) promotion of the rights of people with mental health conditions and psychosocial disabilities to exercise their legal capacity (84% of responding countries); 3) promotion of alternatives to coercive practice (89% of responding countries); 4) provision for procedures to enable people with mental health conditions and psychosocial disabilities to protect their rights and file appeals and complaints to an independent legal body (88% of responding countries); 5) provision for regular inspections of human rights conditions in mental health facilities by an independent body (79% of responding countries). Compared with the Mental Health Atlas 2014, the proportion of countries reporting that their laws comply with human rights instruments increased for all five standards (Figure 2.2.1). However, positive responses have declined since the Mental Health Atlas 2017 for four of the five standards. This is probably explained by increasing critical awareness about this issue, leading to countries scoring the compliance of their legislation with international mental health instruments more strictly.

FIGURE 2.2.1 Compliance of mental health legislation with human rights instruments (2014, 2017 and 2020)

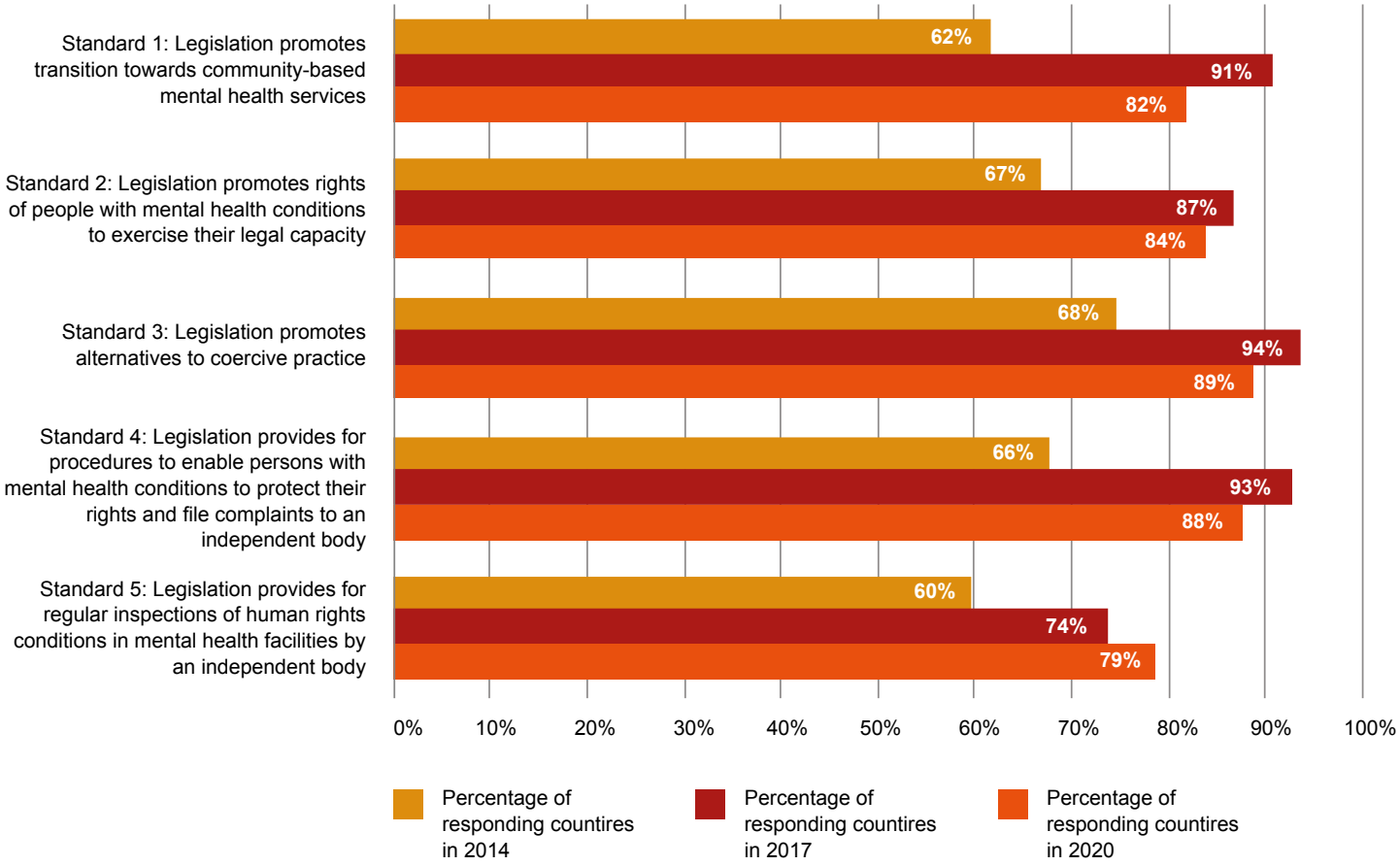


Figure 2.2.2 provides a breakdown by World Bank income group and shows globally high compliance for most standards in all income groups. There was 100% compliance for two of the five standards by countries in the low-income group and at least 90% for countries in the high- and upper-middle-income groups for several of the standards. In regard to this specific question, it is important to acknowledge the limitations associated with self-reported data, where there is a risk of overestimating compliance.

Adding up scores on the checklist standards provides an overall score ranging from 0 (no compliance) to 5 (full compliance) that measures the extent to which countries consider their mental health laws to be in line with human rights instruments. Ninety per cent of responding countries (55% of WHO Member States) scored at least 3, and 80% of responding countries (48.5% of WHO Member States) scored at least 4, indicating partial compliance (Figure 2.2.3). All five standards were endorsed by 64% of responding countries, which corresponds to 39% of WHO Member States achieving full compliance.

FIGURE 2.2.2 Proportion of responding countries indicating compliance of mental health legislation with human rights, by World Bank income group

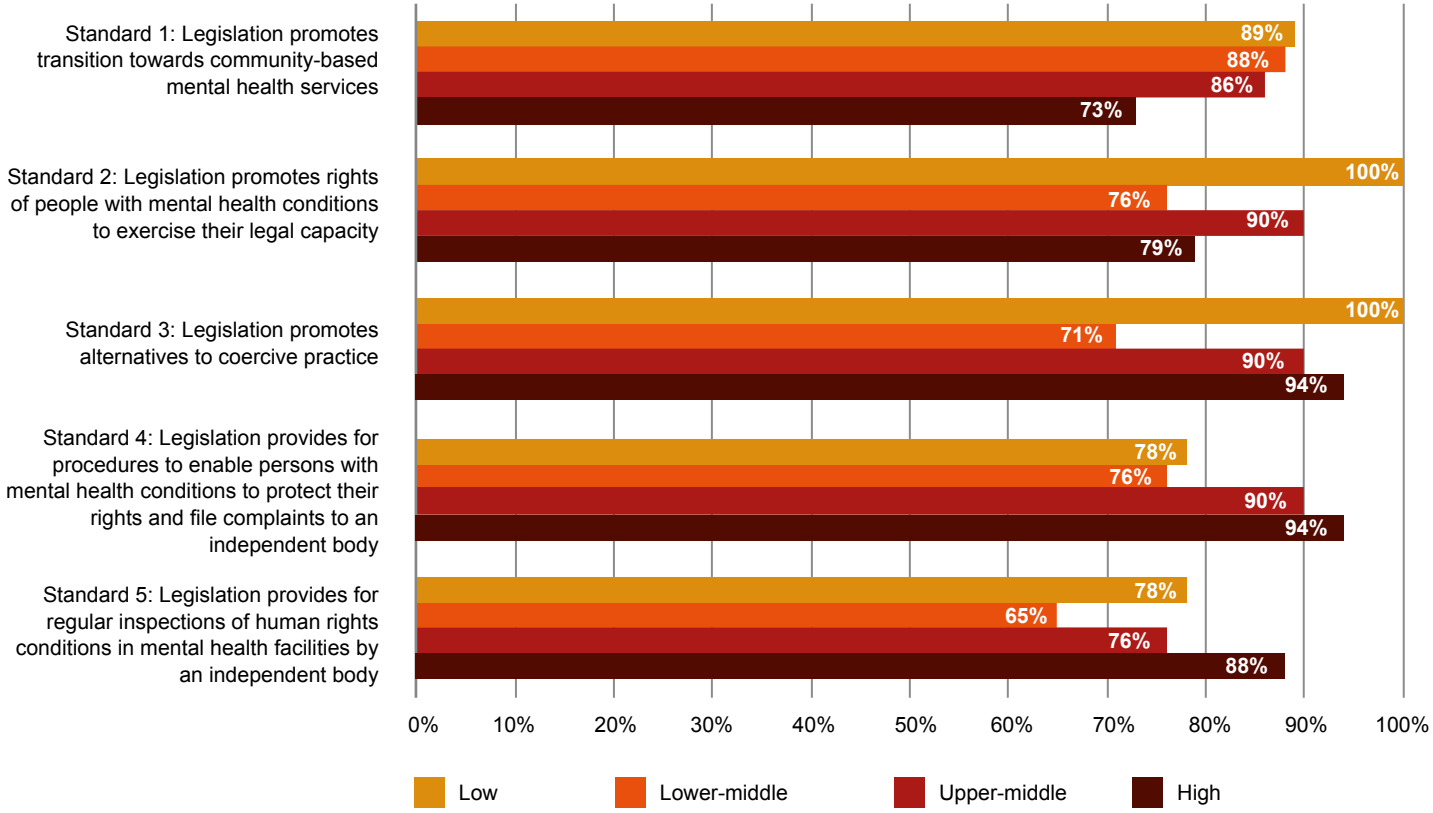


FIGURE 2.2.3 Mental health legislation and human rights: checklist scores (percentage of responding countries), by WHO region

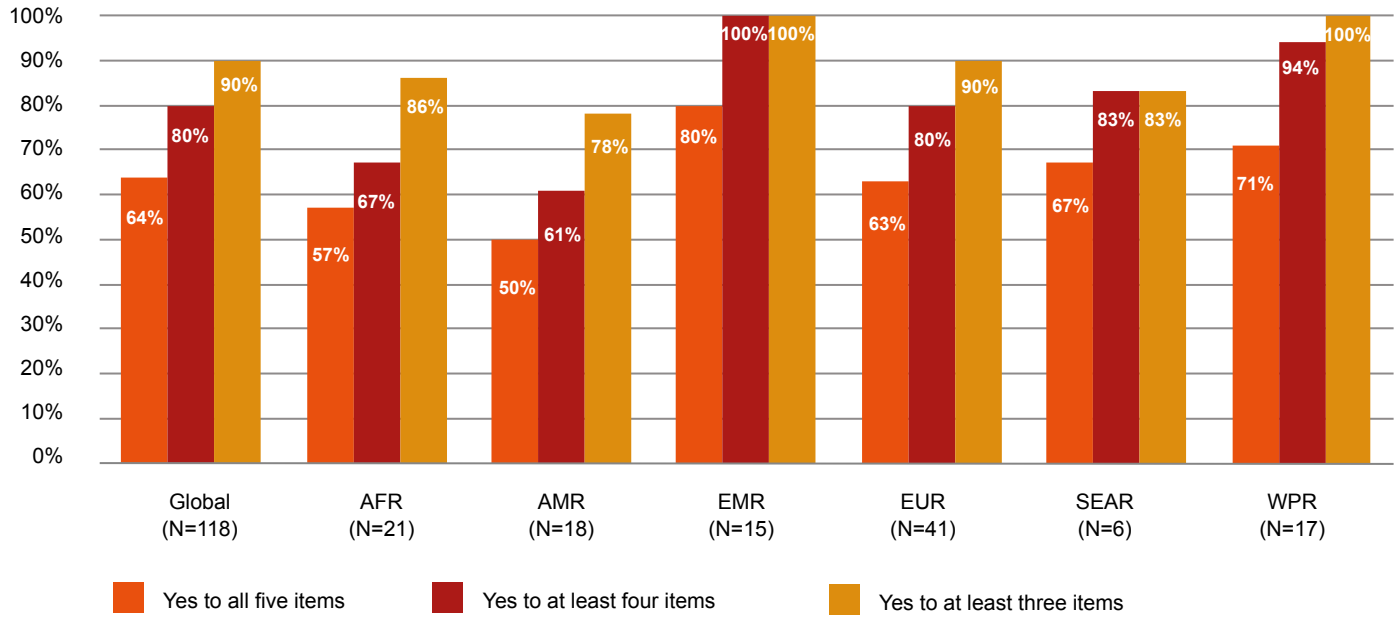


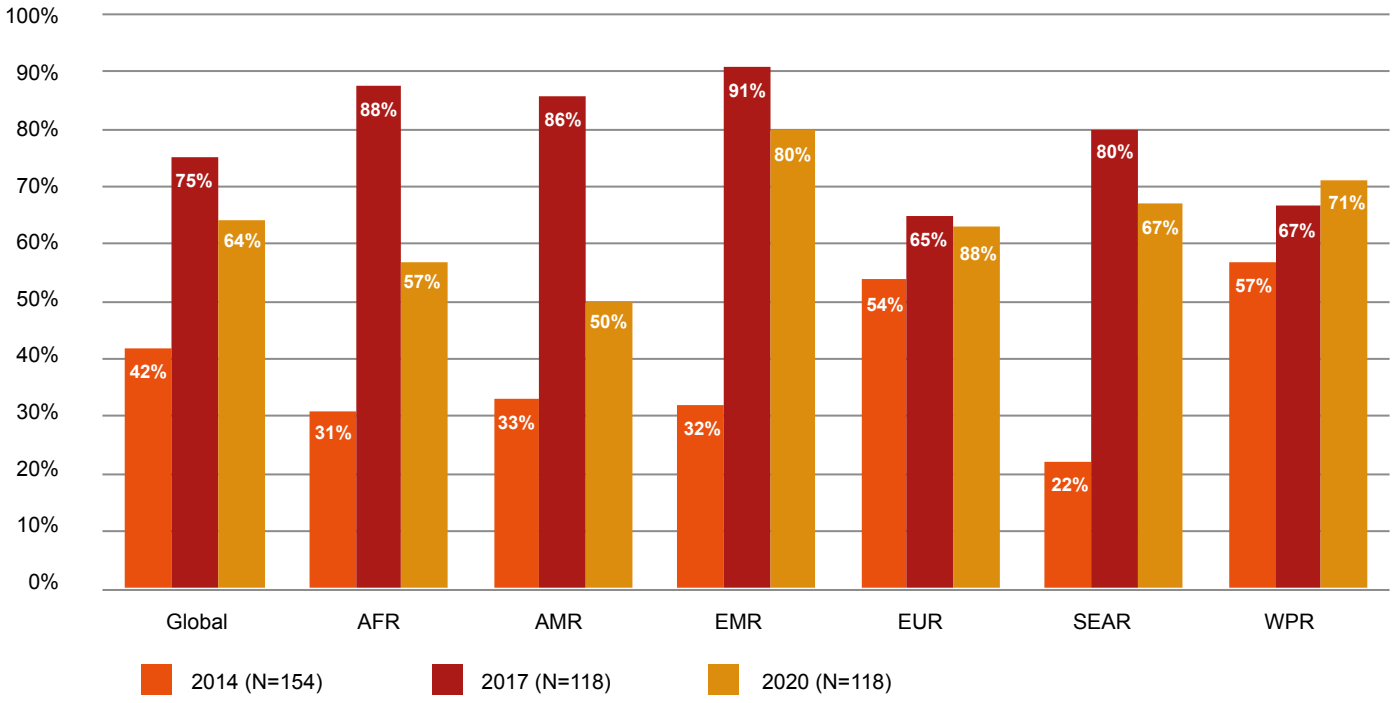
Figure 2.2.4 compares full compliance of mental health laws with human rights instruments by WHO region across the 2014, 2017 and 2020 editions of the Mental Health Atlas. The percentage of responding countries that replied "Yes" to all five standards increased from 42% in 2014 (33% of WHO Member States) to 75% (46% of WHO Member States) in 2017, but then fell back to 64% (39% of WHO Member States) in 2020. The percentages for different regions followed a similar trend, with the most notable variations observed in the African Region and the Region of the Americas. The proportion of countries in these two regions reporting full compliance increased from a little under 35% in 2014 to over 86% in 2017, then dropped to less than 60% in 2020. Unlike other regions, the percentage of countries in the Western Pacific Region reporting full compliance increased steadily, from 57% in 2014 to 71% in 2020. When looking at these results, the limitations of of self-reported checklists should be kept in mind. The decline in 2020 may reflect progress in awareness regarding human rights principles, leading to countries having a more critical attitude towards the compliance of their policies/plans with international instruments.

To further assess progress towards ensuring that mental health legislation conforms with international human rights instruments, countries were asked to self-rate the existence and level of functioning of a dedicated authority or independent body to assess such compliance.

The proportion of responding countries reporting that a dedicated authority or independent authority did not exist decreased from 40% in 2017 to 30% in 2020. Meanwhile, the reported existence of an independent authority or body providing regular or irregular inspections increased by 10 percentage points from 48% in 2017 to 58% in 2020 (Table 2.2.3). The African and South-East Asia Regions had the highest percentages of countries reporting that they had no existing or no functioning authority or body assessing the compliance of mental health legislation with international human rights instruments (74% and 62% respectively) (Table 2.2.3 and Figure 2.2.5).

In the low- and lower-middle-income groups, the proportions of countries reporting that an independent authority did not exist decreased, respectively, from 62% and 56% in 2017 to 50% in 2020. However, the

FIGURE 2.2.4 Percentage of responding countries that responded "Yes" to all five items on the human rights checklist, by WHO region (2014, 2017 and 2020)



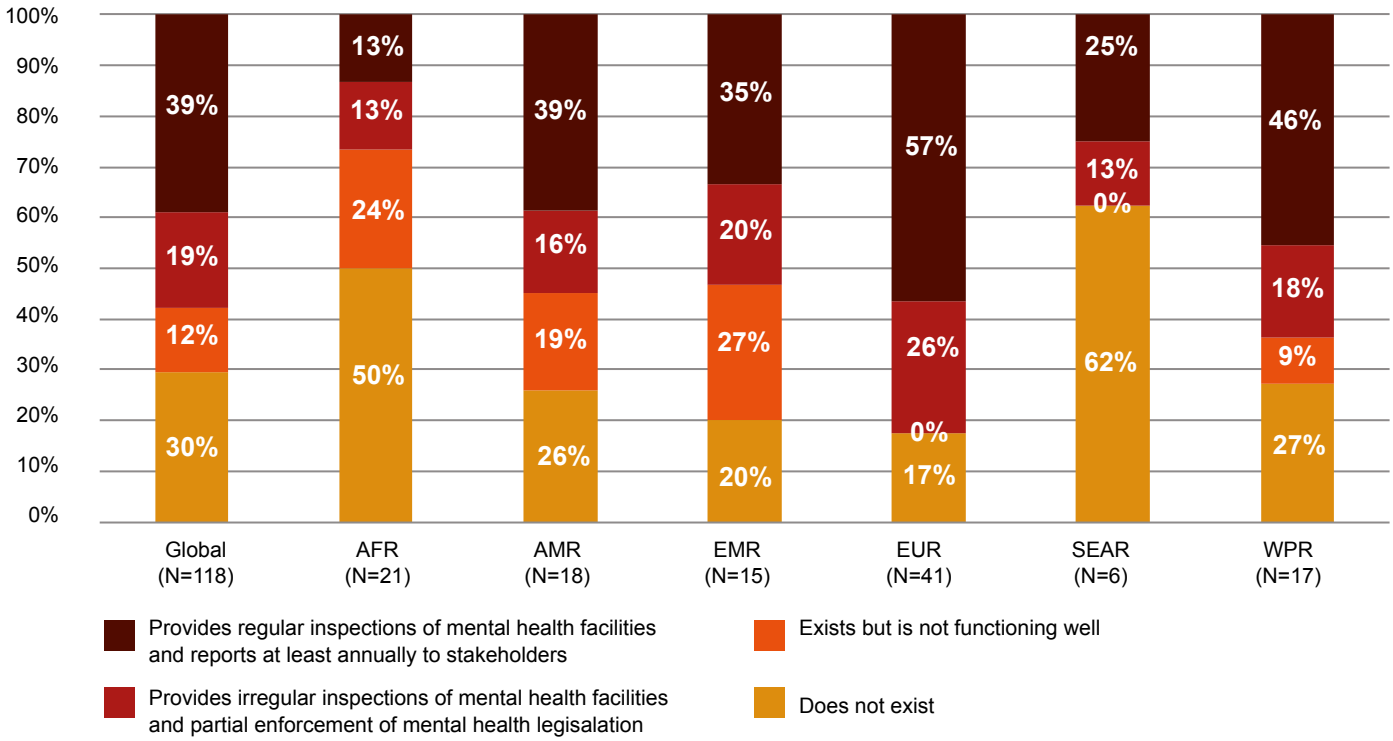
proportion of countries in these two groups reporting that an authority existed but was not functioning well increased, respectively, from 17% and 10% in 2017 to 31% and 14% in 2020. In the upper-middle-income group, the proportion of countries reporting that an independent authority did not exist decreased from 35% in 2017 to 23% in 2020, while the proportion reporting that a dedicated authority existed and provided irregular or regular inspections increased from 54% in 2017 to 65% in 2020. Where such authorities existed, they were generally reported to be functioning well (Table 2.2.3 and Figure 2.2.6).

TABLE 2.2.3 Existence of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights instruments, by WHO region and World Bank income group (2017 and 2020)

	Countries reporting the existence of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights instruments									
	Number of responding countries		Does not exist		Exists but is not functioning well		Provides irregular inspections of mental health facilities and partial enforcement of mental health legislation		Provides regular inspections of mental health facilities and reports at least annually to stakeholders	
	2017	**2020**	**2017**	**2020**	**2017**	**2020**	**2017**	**2020**	**2017**	**2020**
Global	**159**	**152**	**40%**	**30%**	**11%**	**12%**	**20%**	**19%**	**28%**	**39%**
WHO region										
AFR	42	30	55%	50%	17%	24%	10%	13%	19%	13%
AMR	30	31	37%	26%	7%	19%	30%	16%	27%	39%
EMR	17	15	47%	20%	18%	27%	12%	20%	24%	33%
EUR	40	46	23%	17%	8%	0%	25%	26%	45%	57%
SEAR	9	8	67%	62%	11%	0%	22%	13%	0%	25%
WPR	21	22	33%	27%	10%	9%	24%	18%	33%	46%
World Bank income group										
Low	29	16	62%	50%	17%	31%	3%	13%	17%	6%
Lower-middle	39	36	56%	50%	10%	14%	13%	11%	21%	25%
Upper-middle	46	48	35%	23%	11%	12%	24%	19%	30%	46%
High	45	52	18%	15%	9%	6%	33%	27%	40%	52%

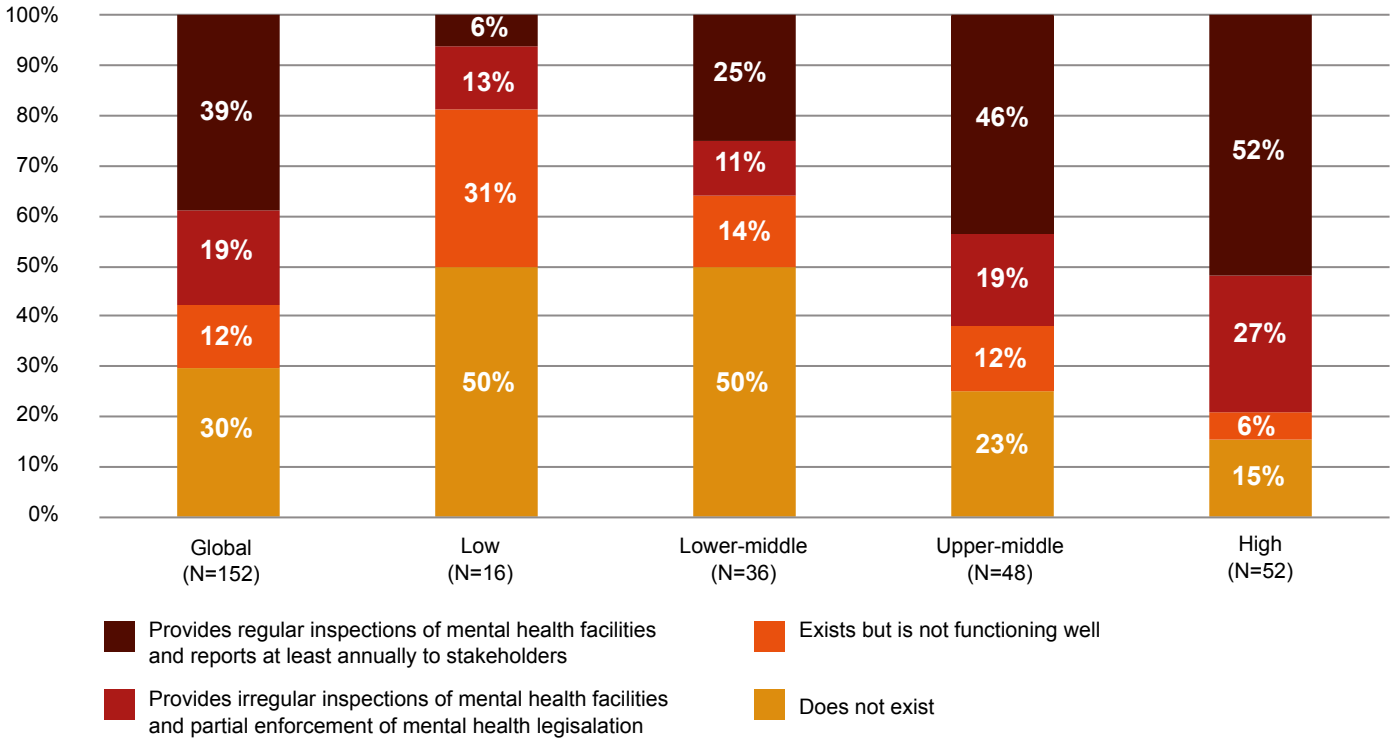
Note: N=countries that have a stand-alone law or mental health legislation integrated into general health/disability law.

FIGURE 2.2.5 Existence of a dedicated authority or independent body to assess the compliance of mental health legislation with international human rights instruments, by WHO region



Note: N=countries that have a stand-alone law or mental health legislation integrated into general health/disability law.

FIGURE 2.2.6 Existence of a dedicated authority or independent body to assess the compliance of mental health legislation with international human rights instruments, by World Bank income group



Note: N=countries that have a stand-alone law or mental health legislation integrated into general health/disability law.

Status of mental health legislation, implementation and compliance with human rights instruments

In total, 156 countries, corresponding to 80% of WHO Member States, reported the existence of a stand-alone and/or integrated law for mental health (Table 2.2.4). Based on this, 38% of WHO Member States reported that their laws were fully compliant with human rights instruments, and 46% of Member States stated that their laws were in the process of implementation. However, only 28% reported having a mental health law that was in the process of implementation and was fully compliant with human rights instruments. The European Region had the highest percentage (49% of WHO Member States), while the African Region had the lowest (11% of WHO Member States). There was a wide gap between income groups, with 40% of countries in the high-income group reporting that they had mental health legislation that was in the process of implementation and fully compliant with human rights instruments, compared with just 3% of countries in the low-income group.

TABLE 2.2.4 Status of mental health legislation, implementation and compliance with human rights instruments, by WHO region and World Bank income group

	Status of WHO Member States' mental health legislation, implementation and compliance with human rights instruments				
	Number of Member States with a stand-alone and/or integrated law (N=194)	Percentage of Member States with a stand-alone and/or integrated law	Percentage of Member States with a law that is compliant with human rights instruments (5/5 on the checklist)	Percentage of Member States with a law that is in the process of implemetation (2/3 on the checklist)	Percentage of Member States with a law that is in the process of implementation and fully compliant with human rights instruments
Global	**156**	**80%**	**38% (n=74)**	**46% (n=88)**	**28% (n=54)**
WHO region					
AFR	32	68%	26% (n=12)	17% (n=8)	11% (n=5)
AMR	31	89%	26% (n=9)	49% (n=17)	20% (n=7)
EMR	16	76%	58% (n=12)	39% (n=8)	29% (n=6)
EUR	46	87%	49% (n=26)	72% (n=38)	49% (n=26)
SEAR	8	73%	36% (n=4)	27% (n=3)	18% (n=2)
WPR	23	85%	44% (n=12)	22% (n=14)	30% (n=8)
World Bank income group					
Low	16	55%	27% (n=8)	10% (n=3)	3% (n=1)
Lower-middle	38	78%	30% (n=15)	26% (n=13)	14% (n=7)
Upper-middle	49	88%	46% (n=26)	55% (n=31)	39% (n=22)
High	53	88%	43% (n=26)	68% (n=41)	40% (n=24)

2.3 STAKEHOLDER COLLABORATION

The implementation of mental health policies/plans and laws requires collaboration between multiple sectors. This includes a country's ministry of health partnering within and beyond the health sector in order to develop a people-centred system, improve the coordination of services and the implementation of programmes, and strengthen mental health care pathways. Successful stakeholder collaboration requires strong leadership and intersectoral engagement. This includes a range of stakeholders, such as service users and family or carer advocacy groups, social affairs/social welfare, justice, education, housing, employment, government and non-government agencies, media, academia, local and international NGOs that deliver or advocate for mental health services, the private sector, professional associations, faith-based organizations/institutions and traditional/indigenous healers.

Multisectoral collaboration

The Comprehensive Mental Health Action Plan outlines multisectoral collaboration as one of its six cross-cutting principles and approaches. It emphasizes that partnership with all relevant sectors, adapted to the country context and specific conditions, is a significant requirement in achieving a comprehensive and coordinated mental health response. The Action Plan encourages Member States to motivate and engage with stakeholders from all relevant sectors and backgrounds, including engagement with and the involvement of persons with mental health conditions, family members and carers and their organizations, to participate actively in developing and implementing mental health policies, laws and services. Stakeholder involvement should be managed through formalized and coordinated structures and mechanisms to ensure effective and sustainable collaboration and effective results.

Countries were asked to identify ongoing collaborations between government mental health services at the national level and other ministries, services and sectors. They were also asked to identify the number and type of stakeholder groups currently collaborating with government mental health services in the planning and/or delivery of mental health promotion, prevention, treatment and rehabilitation services.

Stakeholder collaborations were considered to be "formal" or "functioning" when at least two of the three following checklist items applied: 1) existence of a formal agreement or joint plan with this partner; 2) availability of dedicated funding from or to this partner for service provision; 3) regular meetings conducted with this partner (at least once per year).

Table 2.3.1 shows the global findings relating to the number of countries with formal stakeholder collaborations. Of the 164 countries that answered this question, 124 had a formal collaboration with at least one partner (76% of responding countries). The proportion of countries with a formal collaboration was above 60% for all WHO regions and World Bank income groups. However, there was a global decrease

TABLE 2.3.1 Percentage of countries reporting ongoing collaborations with a formalized structure and/or mechanism, by WHO region and World Bank income group

	Percentage of responding countries reporting formal collaboration with at least one stakeholder group	
	2017 (N=156)	2020 (N=164)
Global	**81% (n=126)**	**76% (n=124)**
WHO region		
AFR	68% (n=23)	63% (n=24)
AMR	74% (n=23)	74% (n=23)
EMR	88% (n=15)	75% (n=15)
EUR	89% (n=39)	80% (n=36)
SEAR	89% (n=8)	100% (n=8)
WPR	86% (n=18)	82% (n=18)
World Bank income group		
Low	60% (n=15)	60% (n=15)
Lower-middle	87% (n=33)	76% (n=28)
Upper-middle	85% (n=39)	78% (n=40)
High	83% (n=39)	80% (n=41)

in the reported number of formal collaborations since the 2017 edition of the Mental Health Atlas. The main reason for this could be the composition and number of participant countries responding for each edition, with 2020 having a higher response rate (N=164 in 2020 versus N=156 in 2017). It is important to acknowledge the limitations of self-reporting of "formal" or "functioning" collaboration by governments. Since partners were not directly contacted for their feedback on this item, this may be an overestimation of what actually constitutes a genuine and effective collaboration

There were significant variations in types of formal collaboration across regions and income groups for some stakeholders (Table 2.3.2). The proportion of responding countries that identified a formal collaboration with the social affairs and social welfare sector ranged from 26% in the African Region to 88% in the South-East Asia Region, and from 24% of responding countries in the African Region to 63% of responding countries in the South-East Asia Region for both the education and justice sectors.

TABLE 2.3.2 Percentage of responding countries identifying a formal collaboration with a specific stakeholder group by WHO region and World Bank income group

	Percentage of responding countries identifying a formal collaboration with a specific stakeholder group						
	Ministry/ department of social affairs/ social welfare (N=169)	Ministry/ department of education (N=165)	Ministry/ department of justice (N=166)	Ministry/ department of labour/ employment (N=164)	Ministry/ department of housing/ urban welfare (N=162)	Service users' or similar associations and organizations and family or caregiver advocacy groups (N=165)	Non-governmental organizations (local/ international NGOs) (N=166)
Global	**46% (n=78)**	**42% (n=70)**	**39% (n=65)**	**24% (n=39)**	**13% (n=21)**	**35% (n=58)**	**55% (n=92)**
WHO region							
AFR	26% (n=10)	24% (n=9)	24% (n=9)	8% (n=3)	0% (n=0)	33% (n=13)	49% (n=19)
AMR	44% (n=14)	47% (n=14)	37% (n=11)	20% (n=6)	13% (n=4)	36% (n=11)	65% (n=20)
EMR	55% (n=11)	60% (n=12)	40% (n=8)	30% (n=6)	6% (n=1)	20% (n=4)	70% (n=14)
EUR	59% (n=27)	48% (n=22)	44% (n=20)	41% (n=19)	22% (n=10)	46% (n=20)	46% (n=20)
SEAR	88% (n=7)	63% (n=5)	63% (n=5)	25% (n=2)	13% (n=1)	38% (n=3)	75% (n=6)
WPR	38% (n=9)	35% (n=8)	50% (n=12)	14% (n=3)	24% (n=5)	30% (n=7)	54% (n=13)
World Bank income group							
Low	24% (n=6)	12% (n=3)	12% (n=3)	8% (n=2)	0% (n=0)	16% (n=4)	60% (n=15)
Lower-middle	41% (n=16)	37% (n=14)	40% (n=15)	11% (n=4)	3% (n=1)	33% (n=13)	46% (n=18)
Upper-middle	53% (n=27)	56% (n=28)	51% (n=26)	28% (n=14)	16% (n=8)	32% (n=16)	65% (n=33)
High	54% (n=29)	48% (n=25)	40% (n=21)	37% (n=19)	25% (n=12)	49% (n=25)	51% (n=26)

The main partners identified by most countries were local/international NGOs (55% of responding countries), ministries of social affairs/social welfare (46% of responding countries) and ministries of education (42% of responding countries) (Figure 2.3.1). Collaboration with service users and family/caregiver advocacy groups was low globally (35% of responding countries) and in all regions (less than 50%), particularly in the Eastern Mediterranean Region, where only 20% of responding countries reported formal collaboration with service users and their families and caregivers (Figure 2.3.2). The proportion was similarly low across income groups, not exceeding 50% in any of them, with only 16% of countries in the low-income group reporting formal collaboration with service users or family and advocacy groups (Figure 2.3.3).

There was an overall decrease globally in reported collaboration with service users and family and advocacy groups since 2017, with a significant reduction in the Eastern Mediterranean Region (from 60% of responding countries in 2017 to 20% in 2020). However, as mentioned above, it is important to note that response rates for this question were higher in 2020 (N=165) than in 2017 (N=104) (data not shown).

FIGURE 2.3.1 Global percentage of responding countries identifying formal collaboration with stakeholder groups

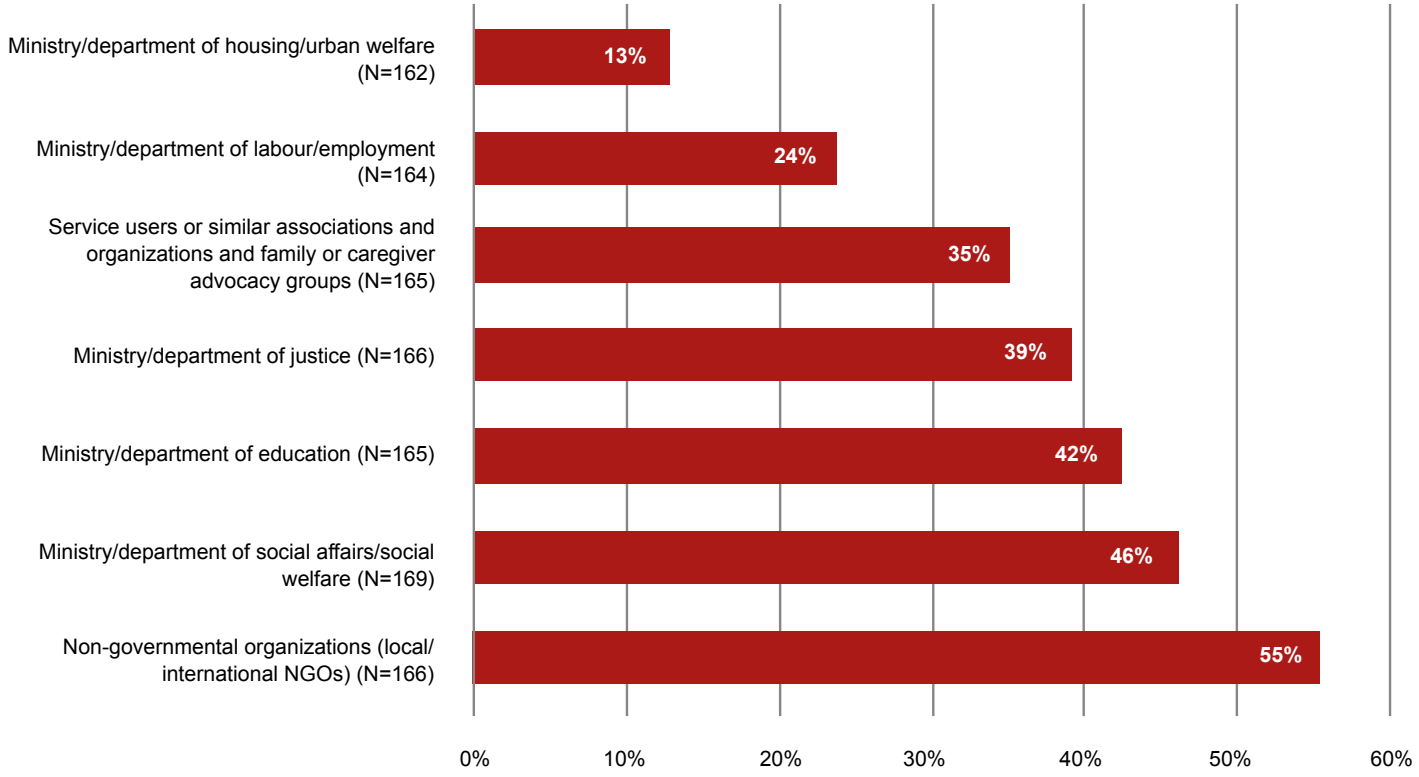


FIGURE 2.3.2 Percentage of countries that report having a formal collaboration with service users' or similar associations and organizations and family or caregiver advocacy groups, by WHO region

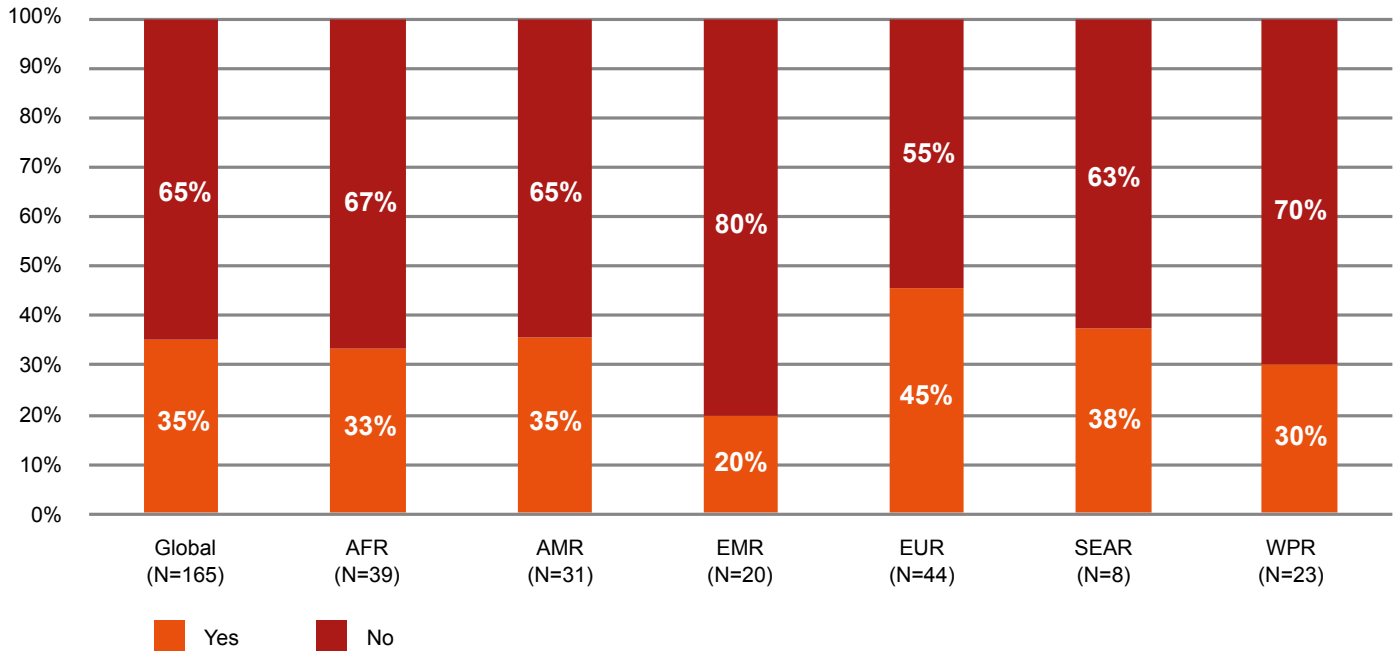
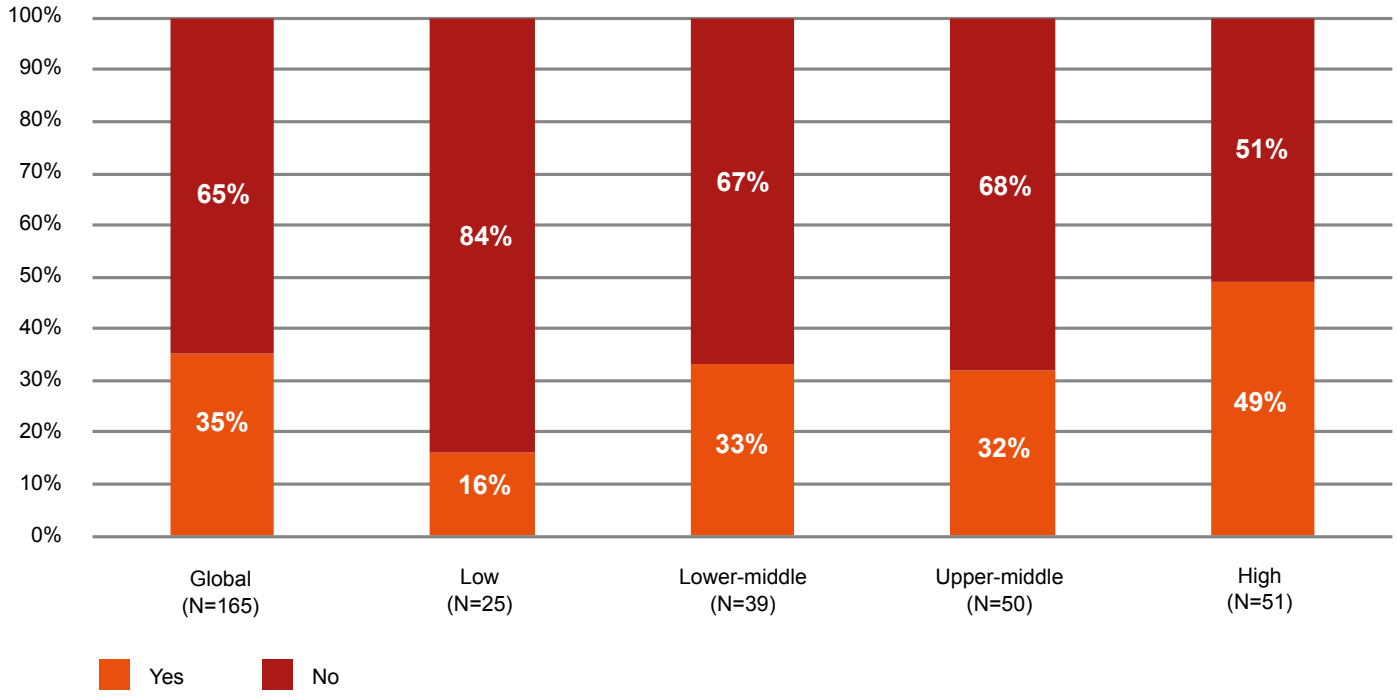


FIGURE 2.3.3 Percentage of countries that report having a formal collaboration with service users' or similar associations and organizations and family or caregiver advocacy groups, by World Bank income group



MENTAL HEALTH ATLAS 2020

3 FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

3.1 FINANCIAL RESOURCES

The availability of dedicated financial resources for mental health is critical in developing, implementing and maintaining mental health services and making progress towards programme goals. Spending on mental health can include a range of activities, including activities delivered in primary or general care and specialist/secondary health care and in social care. It may also include programme costs such as administration/management, training and supervision, and mental health prevention and promotion activities. Estimating mental health expenditure in a country, however, is complex due to the range of potential funding sources (employers and households as well as governmental and non-governmental agencies), diverse sets of service providers (specialist mental health services, general health services and social care services) and the diversity of services provided. In general, availability of financial resources for mental health, and equity in their distribution and efficiency in their use, are core requirements for enhanced performance of mental health systems.

Government expenditure on mental health

In the Mental Health Atlas 2020 questionnaire, countries were asked to estimate their government's total expenditure on mental health (combined national and subnational government expenditure). Details of mental health expenditure may be available from national health accounts or from other government data sources. Reporting on these data remained at a low level, with only 67 countries responding to the question. Even fewer countries were able to report on total government spending on mental health broken down by care setting. In all, around one third of WHO Member States were able to report on indicators related to mental health expenditure, representing a significant limitation for this data point.

The annual global median government expenditure per capita on mental health reported by responding countries was US$ 7.49 (Table 3.1.1). Based on the WHO Global Health Expenditure Database (GHED), for responding countries the global median of domestic government expenditure on health in general in 2018 was US$ 367 per capita, thus making government expenditure on mental health 2.1% of the global median of government expenditure on health overall. Although reported median government mental health expenditure per capita increased from US$ 2.50 in 2017 to US$ 7.49 in 2020, it did not change as a percentage of total government health expenditure, which remained close to 2% in 2020. It is difficult to compare these data points between the three editions of the Mental Health Atlas, and discrepancies could be explained by methodological factors, with different sets of countries reporting data in 2014, 2017 and 2020. It is equally important to interpret these data bearing in mind the limitation that a small number of countries reported on this data point (N=67).

TABLE 3.1.1 Government expenditure on mental health, per capita

	Median government expenditure on mental health per capita (US$)			Mental health expenditure as percentage of GGHE-D* per capita
	2014 (N=40)	**2017 (N=80)**	**2020 (N=67)**	**2020 (N=67)**
Global	**	**2.50**	**7.49**	**2.13%**
WHO region				
AFR	**	0.10 (n=10)	0.46 (n=8)	2.10%
AMR	**	11.80 (n=18)	7.81 (n=14)	1.80%
EMR	**	2.00 (n =4)	12.08 (n=4)	1.30%
EUR	**	21.70 (n =31)	46.49 (n=22)	3.60%
SEAR	**	0.10 (n =5)	0.10 (n=7)	0.50%
WPR	**	1.10 (n=12)	5.81 (n=12)	1.60%
World Bank income group				
Low	***	0.02 (n=11)	0.08 (n=2)	1.05%
Lower-middle	1.53 (n=7)	1.10 (n=19)	0.37 (n=13)	1.10%
Upper-middle	1.96 (n=16)	2.62 (n=21)	3.29 (n=23)	1.60%
High	58.73 (n=17)	80.24 (n=29)	52.73 (n=29)	3.80%

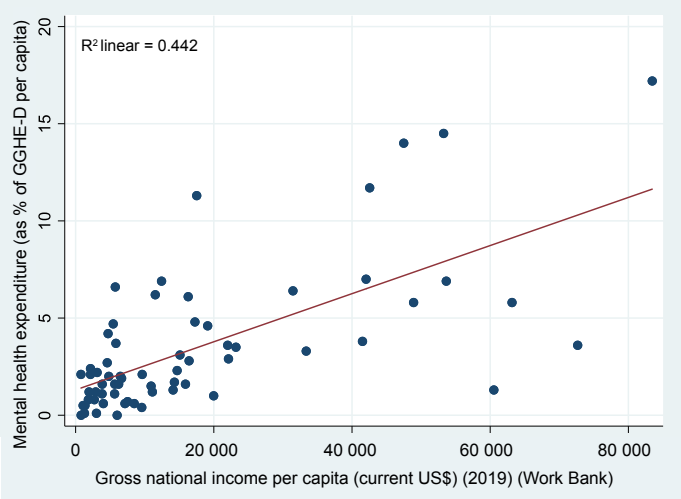
* GGHE-D: Domestic General Government Health Expenditure.
** Data not available.
*** Low-income countries were not represented in 2014 due to a low sample size (n=1).

Association between mental health expenditure and gross national income

As shown in Figure 3.1.1, there is a significant positive correlation between total government spending per capita on mental health and gross national income (GNI) (r=0.79; p<0.01; n=64); countries with a higher GNI also have a higher mental health expenditure. This association explains 63% of the observed variance. However, expressed as a proportion of total health expenditure (as illustrated in Figure 3.1.2), the association is weaker (r=0.66; p<0.01; n=64), and less than 44% of the variance is explained. This reflects the fact that a certain number of low- and lower-middle-income countries allocate a significant proportion of total health spending to mental health (even if not a significant amount in absolute dollar terms), while the opposite is true for some high-income countries, which devote a small proportion of their relatively large health budgets to mental health.

FIGURE 3.1.1 Association between per capita expenditure on mental health and gross national income

FIGURE 3.1.2 Association between expenditure on mental health (as a percentage of total health expenditure) and gross national income



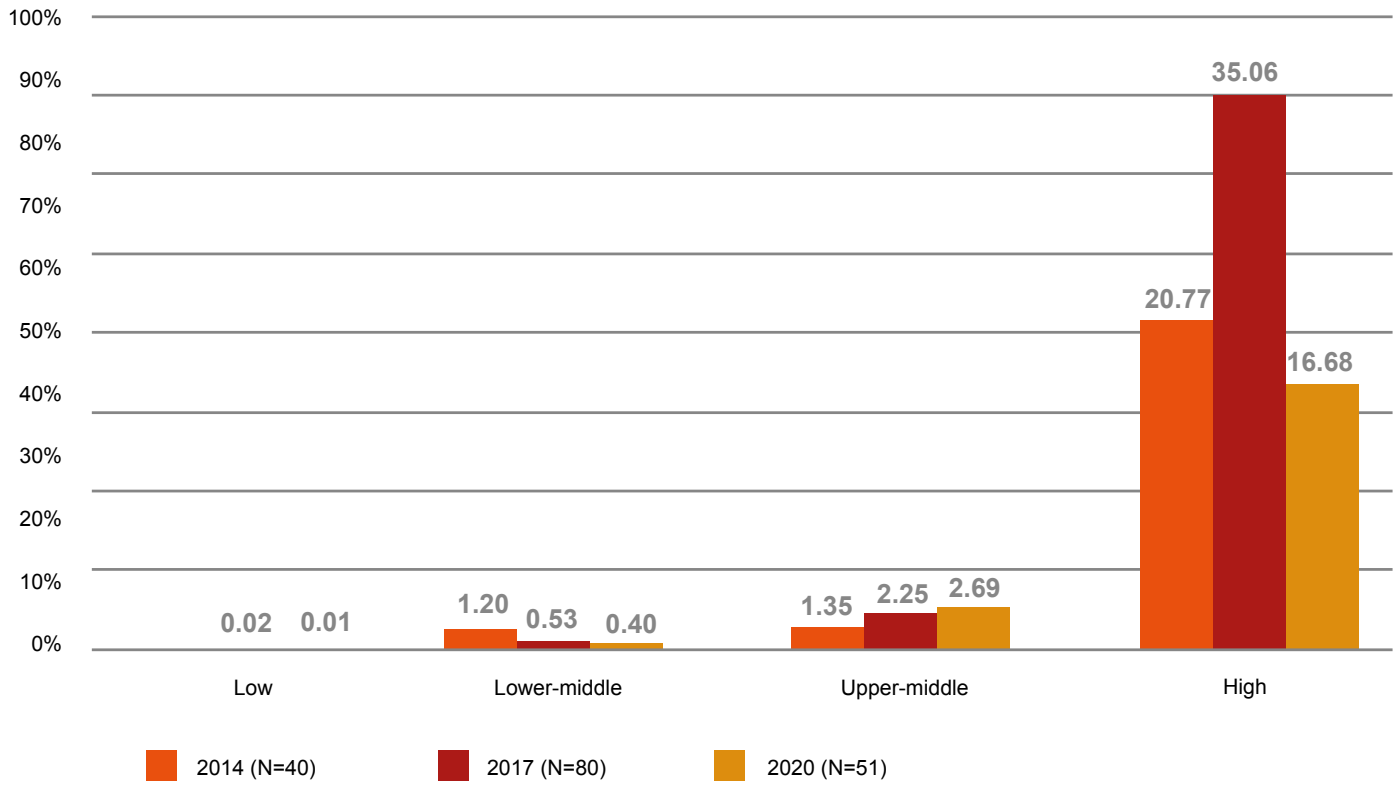
Expenditure on mental hospitals

Only 51 countries reported on their government's total expenditure on mental hospitals for the latest year that data were available. The global median expenditure on mental hospitals was US$ 2.77 per capita, which corresponds to 66% of total government spending on mental health.

Over 70% of total government expenditure on mental health was allocated to mental hospitals in upper- and lower-middle income countries, compared with 35% in high-income countries. This possibly reflects a situation where centralized mental hospitals and institutional inpatient care still represent the main costs for mental health services, and which shows that there is an urgent need for deinstitutionalization. The number of responding countries in the low-income group was very small in comparison with the previous edition of the Mental Health Atlas, which may be attributed to reporting limitations due to the COVID-19 pandemic.

As shown in Figure 3.1.3, there has been an overall reduction in the total government expenditure per capita on mental health allocated to mental hospitals in lower-middle- and high-income countries since 2014, while in upper-middle-income countries there has been an increase. Data from low-income countries are not reported here for 2014 due to the fact that very few countries responded to this question. In 2017, government expenditure on mental hospitals per capita in the high-income group was much higher, which could be explained by differences in the sets of countries reporting data across the years as well as fewer countries reporting such data in 2020.

FIGURE 3.1.3 Government expenditure on mental hospitals per capita (US$), by World Bank income group (2014, 2017 and 2020)



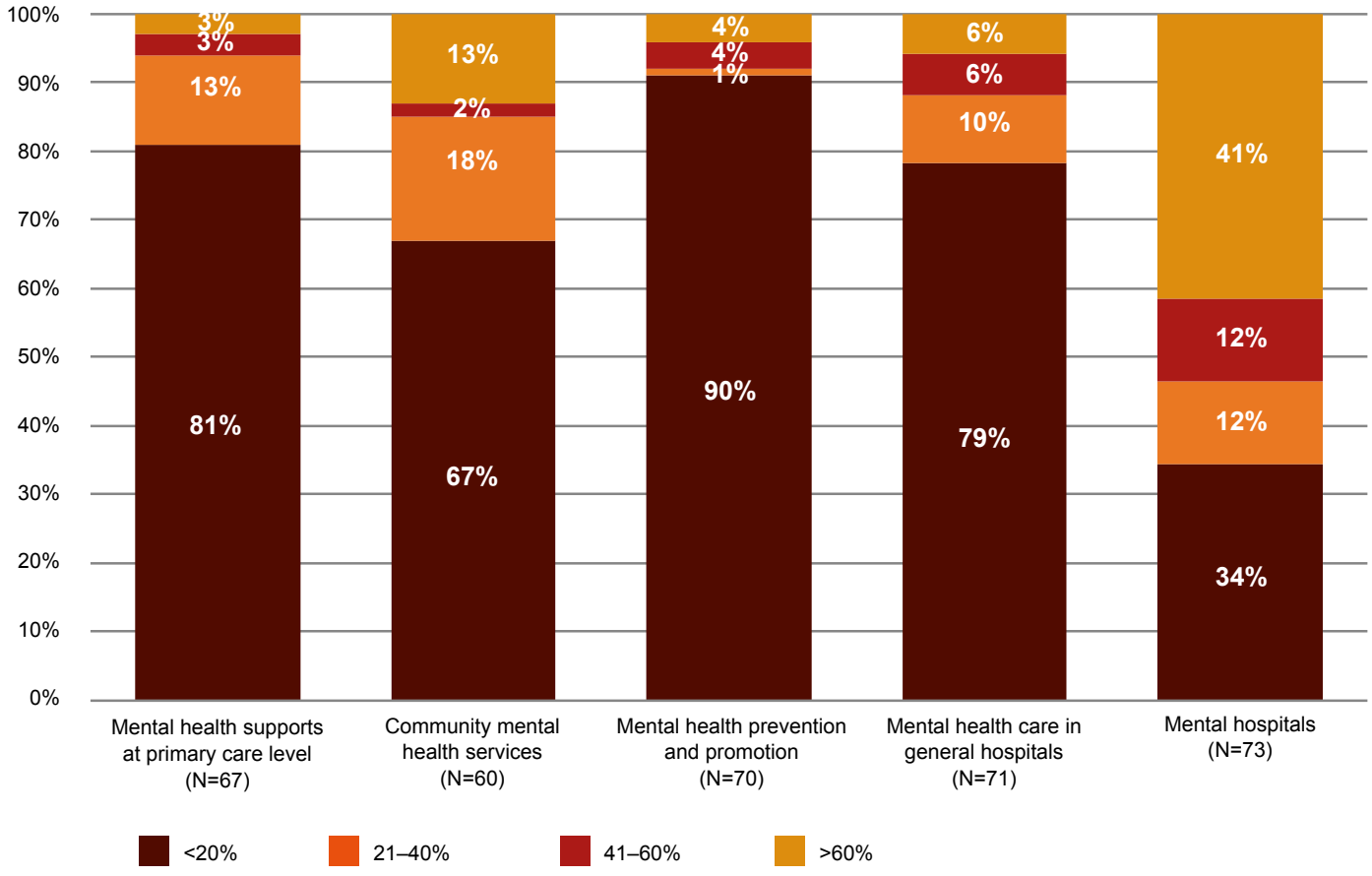
* Data from low-income countries are not reported due to the low number of responding countries in 2014.

Mental health expenditure attributed to specific mental health services

Another question asked Member States to indicate, on a pre-defined scale, the percentages attributed to specific types of expenditure, including government expenditures on mental hospitals, mental health care in general hospitals, mental health prevention and promotion, community mental health services and mental health supports at primary health care level (Figure 3.1.4). The scale provided was a ratio scale with seven variables ranging from “Less than 5%” to “Over 80%” and included “Not applicable” as an option.

Over 80% of countries reported allocating less than 20% of their total government mental health expenditure to primary health care and mental health prevention and promotion programmes. Similarly, 79% of countries reported allocating no more than 20% to mental health care in general hospitals, and 67% of countries reported allocating no more than 20% to community mental health services. Based on self-reporting, 46% of responding countries stated that they allocated at most 40% of their mental health expenditures to mental hospitals, while 41% of countries allocated more than 60% of their budgets for such facilities. The data reflect the importance of redistributing financial resources across the different components of the mental health system, including reducing expenditure on mental hospitals and increasing focus on the development of primary and community mental health care and support for mental health prevention and promotion programmes.

FIGURE 3.1.4 Total government mental health expenditure attributed to specific mental health services and programmes



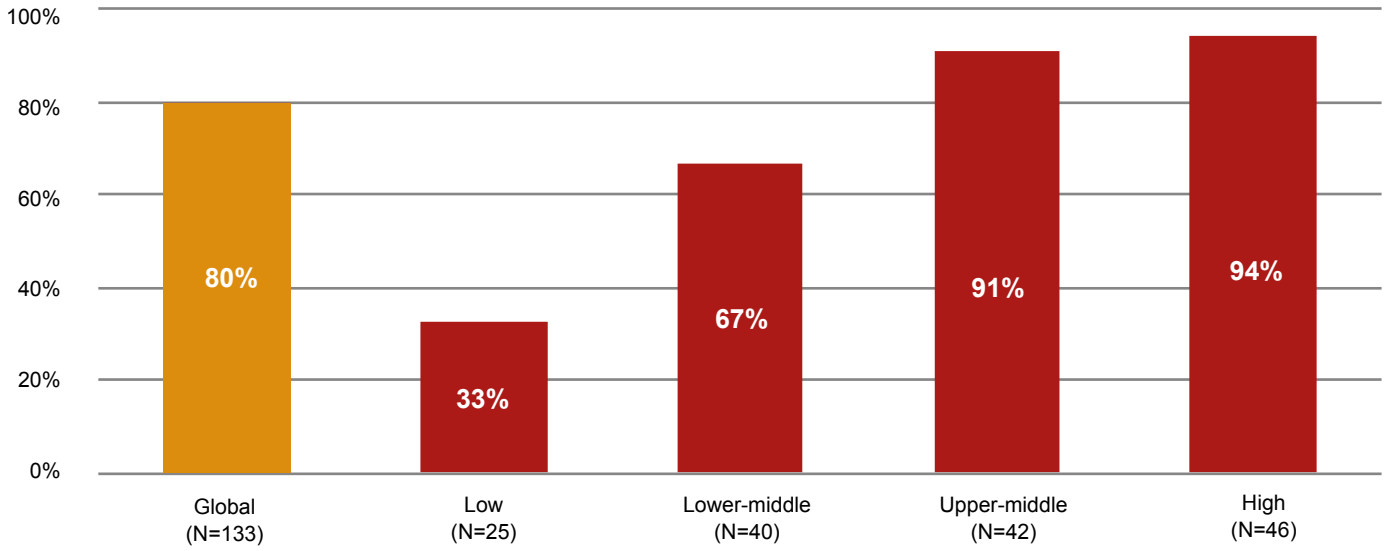
3.2 NATIONAL INSURANCE FOR MENTAL HEALTH

Inclusion of mental health conditions in national insurance

Universal health coverage means that all people have access to the health services they need, when and where they need them, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. The Mental Health Atlas 2020 questionnaire included a specific question to assess whether the care and treatment of persons with specific mental health conditions (psychosis, bipolar disorder and depression) were included in national health insurance or reimbursement schemes. Of 133 countries that answered this question, 106 countries, corresponding to 80% of responding countries or 55% of WHO Member States, reported that care and treatment of persons with specifc mental health conditions of this nature were included in national health insurance or reimbursement schemes and in insurance coverage of inpatient/outpatient mental health services (Figure 3.2.1). The proportion of responding countries that reported the inclusion of care and treatment of persons with specific mental health conditions in their national health insurance or reimbursement schemes was high for most WHO regions (above 80%), with the exceptions of the Eastern Mediterranean Region and the African Regions, where the proportions were 62% and 52% of responding countries respectively (data not shown). Grouped by income level, the proportion of countries reporting that care and treatment of persons with specific mental health conditions were included in their national insurance or reimbursement schemes was 2–3 times higher in the high- and upper-middle-income groups than in the lower-middle- and low-income groups respectively.

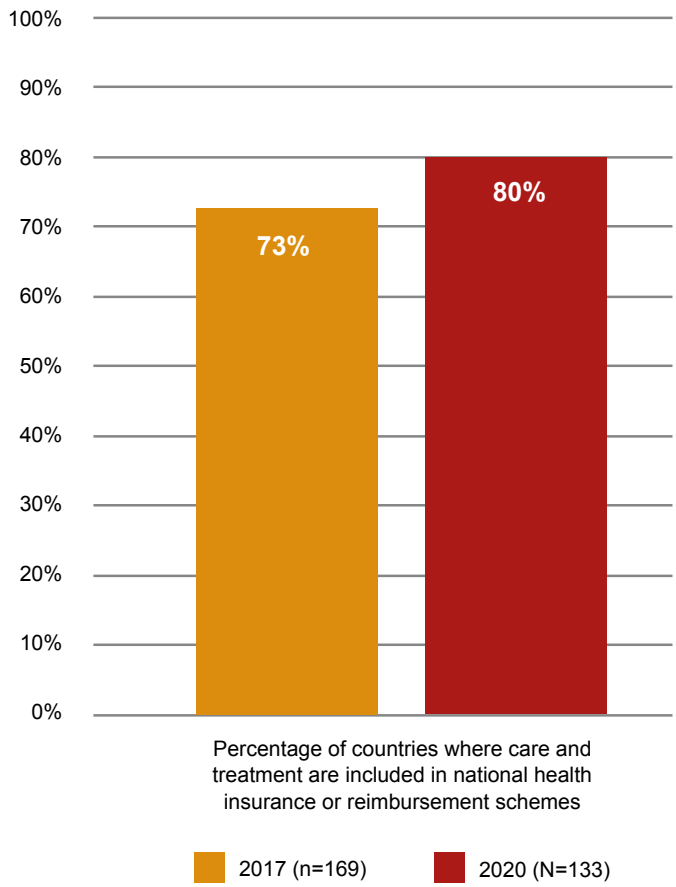
Of the 106 countries that responded in the affirmative to this question, 78 countries, representing 74% of responding countries, reported that such conditions were explicitly listed as conditions included in insurance schemes. On the other hand, 28 countries, corresponding to 26% of responding countries, reported that care and treatment were not included in national health insurance or reimbursement schemes; and of these, 11 countries, representing 44% of responding countries, reported that such conditions were explicitly listed as excluded conditions (data not shown).

FIGURE 3.2.1 Inclusion of care and treatment of persons with specific mental health conditions (e.g. psychosis, bipolar disorder, depression) in national health insurance or reimbursement schemes, by World Bank income group



There was a global increase in the percentage of responding countries reporting that care and treatment of persons with specific mental health conditions were included in national health insurance or reimbursement schemes from 2017 (from 73% of responding countries in 2017 to 80% in 2020) (Figure 3.2.2). However, it is important to note that the number of countries responding to this question was lower in 2020 (decreasing from 169 to 133 countries). Similarly, there was an increase in the percentage of responding countries reporting that these conditions were explicitly listed as included conditions (from 68% to 74% of responding countries). The percentage of countries reporting that care and treatment were not included declined (from 27% to 20% of responding countries) and there was a notable reduction in the percentage of countries reporting that conditions were explicitly listed as conditions excluded from national health insurance or reimbursement schemes (from 44% to 19% of responding countries). The global progress reported since 2017 points to advances in the inclusion of treatment of persons with mental health conditions in countries' financial reimbursement schemes (data not shown).

FIGURE 3.2.2 Inclusion of care and treatment of persons with specific mental health conditions in national health insurance or reimbursement schemes: global comparison, 2017 and 2020



Source of payment for mental health services and psychotropic medicines

To assess out-of-pocket payments for the management of specific mental health conditions, Member States were asked about the financial resources used by most persons with mental health conditions to pay for care. They were asked to specify if persons paid nothing at the point of service use (fully insured), if they paid mostly or entirely out of pocket for services and medicines, or if they paid at most 20% towards the cost of services and medicines. Fifteen per cent of responding countries (13% of all WHO Member States) reported that persons pay mostly or entirely out of pocket for mental health services, and 20% of responding countries (15% of WHO Member States) reported that persons pay mostly or entirely out of pocket for psychotropic medicines (Table 3.2.1).

TABLE 3.2.1 Source of payment for mental health services and psychotropic medicines, by WHO region and World Bank income group

	Source of payment for mental health services (percentage of responding countries) (N=168)		Source of payment for psychotropic medicines (percentage of responding countries) (N=160)	
	Persons pay nothing (fully insured) or at most 20% towards the cost	Persons pay mostly or entirely out of pocket	Persons pay nothing (fully insured) or at most 20% towards the cost	Persons pay mostly or entirely out of pocket
Global	**85% (n=142)**	**15% (n=26)**	**80% (n=128)**	**20% (n=32)**
WHO region				
AFR	59% (n=23)	41% (n=16)	51% (n=21)	49% (n=18)
AMR	88% (n=29)	12% (n=4)	88% (n=28)	12% (n=4)
EMR	80% (n=16)	20% (n=4)	70% (n=14)	30% (n=6)
EUR	100% (n=45)	0% (n=0)	98% (n=39)	2% (n=1)
SEAR	100% (n=8)	0% (n=0)	88% (n=7)	12% (n=1)
WPR	91% (n=21)	9% (n=2)	91% (n=21)	9% (n=2)
World Bank income group				
Low	44% (n=11)	56% (n=14)	29% (n=7)	71% (n=17)
Lower-middle	77% (n=31)	23% (n=9)	74% (n=29)	26% (n=10)
Upper-middle	94% (n=49)	6% (n=3)	92% (n=46)	8% (n=4)
High	100% (n=51)	0% (n=0)	98% (n=46)	2% (n=1)

Figures 3.2.3 and 3.2.4 illustrate the enormous gap between low- and high-income countries: 56% of responding countries in the low-income group reported that persons pay mostly or entirely out of pocket for mental health services, while no country in the high-income group reported that this was the case. Similarly, 71% of responding countries in the low-income group reported that persons pay mostly or entirely out of pocket for psychotropic medicines, compared with just 2% of responding countries in the high-income group.

Similar gaps exist between WHO regions: 41% of responding countries in the African Region reported that persons pay mostly or entirely out of pocket for mental health services, compared with no countries in the European or South-East Asia Regions (Figure 3.2.5). Similarly, 49% of responding countries in the African Region reported that persons pay mostly or entirely out of pocket for psychotropic medicines, compared with just 2% of responding countries in the European Region (Figure 3.2.6).

A global comparison shows that the percentage of responding countries reporting that persons pay mostly or entirely out of pocket for mental health services decreased slightly from 17% in 2017 to 15% in 2020, while the percentage of responding countries reporting that persons pay mostly or entirely out of pocket for psychotropic medicines increased slightly from 18% in 2017 to 20% in 2020 (Figure 3.2.7).

FIGURE 3.2.3 Source of payment for mental health services, by World Bank income group

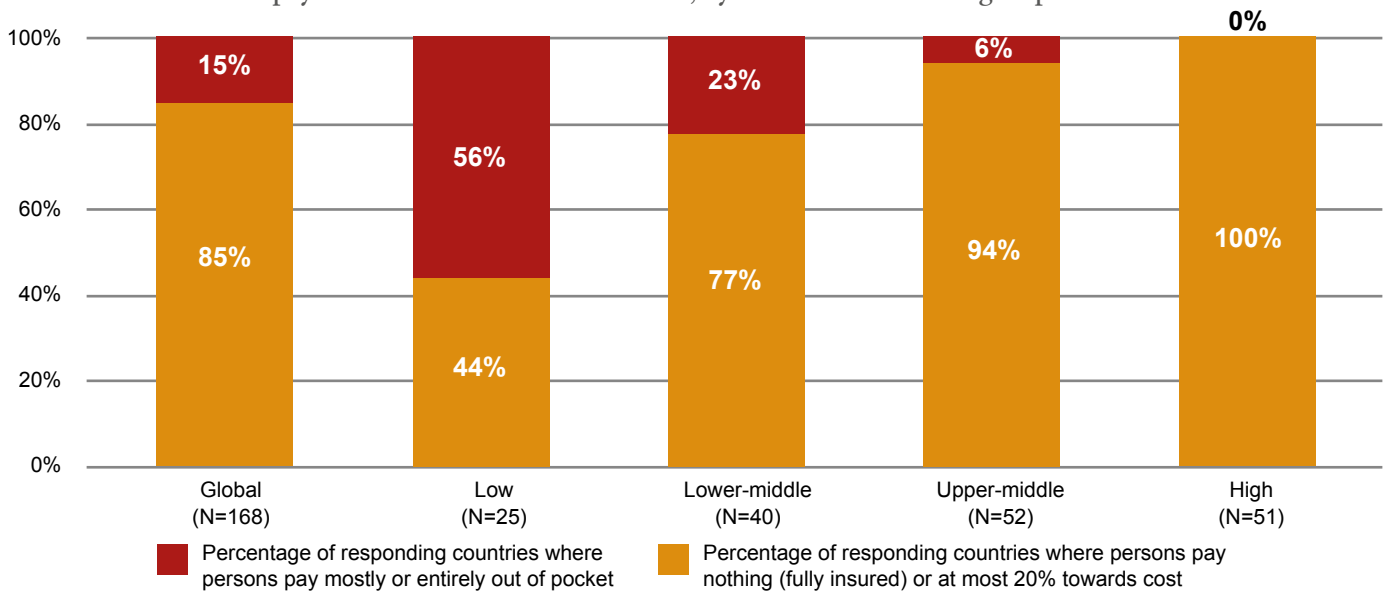


FIGURE 3.2.4 Source of payment for psychotropic medicines, by World Bank income group

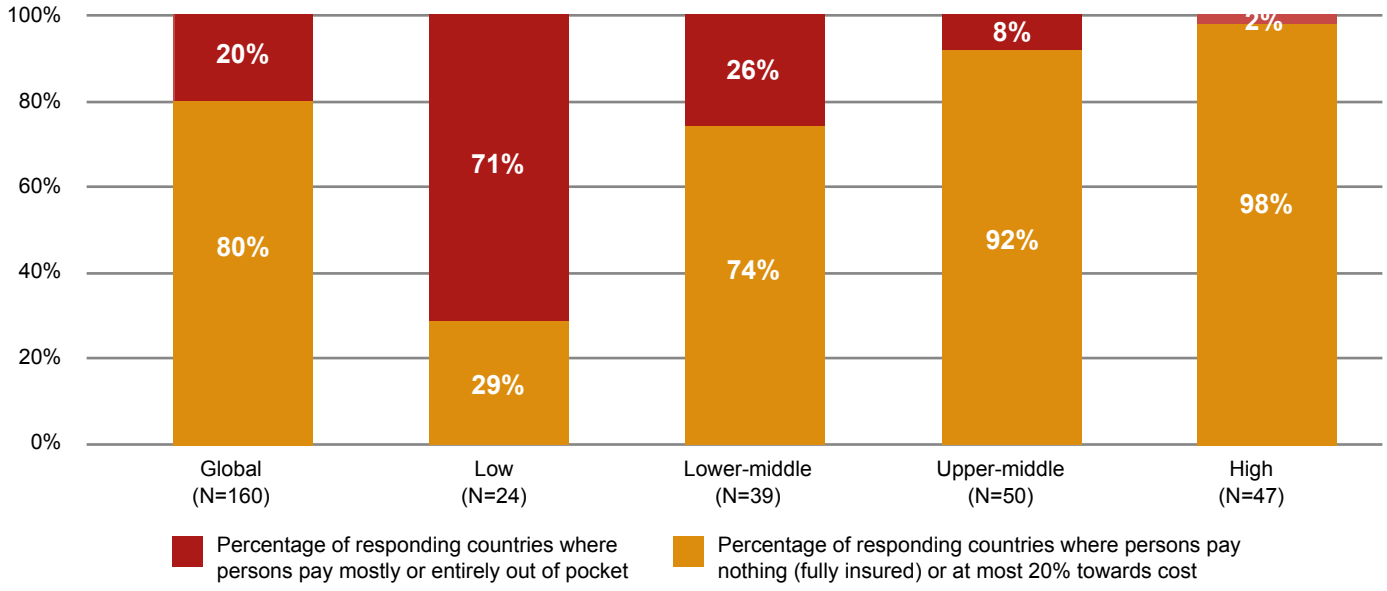


FIGURE 3.2.5 Source of payment for mental health services, by WHO region

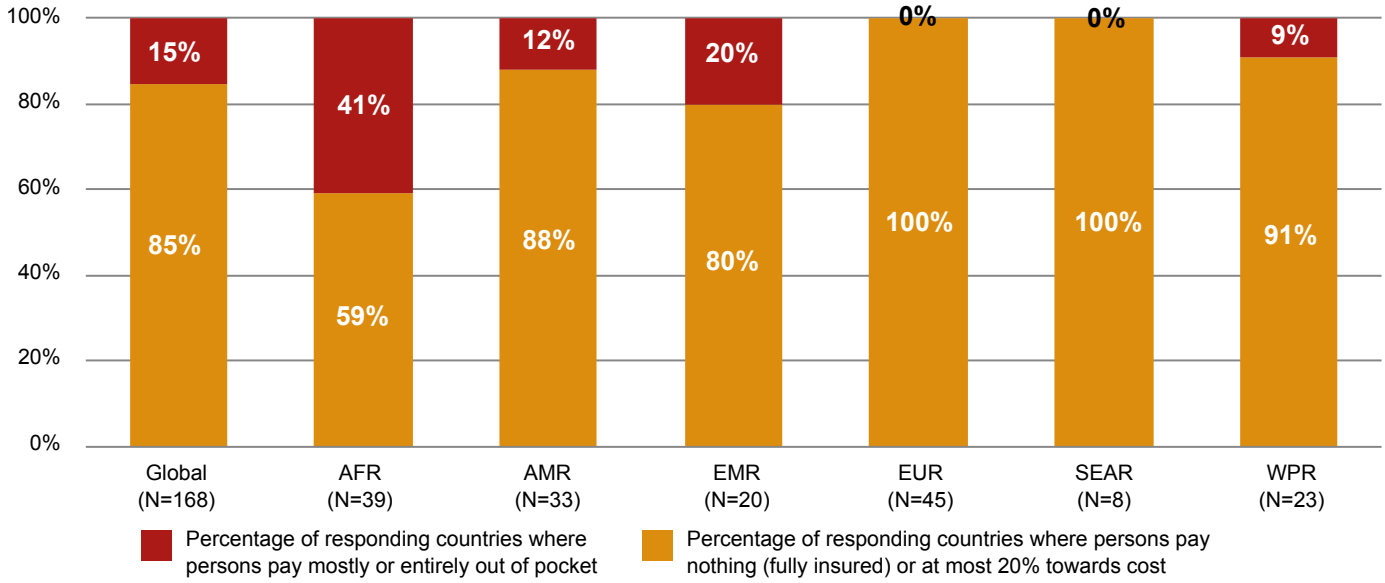


FIGURE 3.2.6 Source of payment for psychotropic medicines, by WHO region

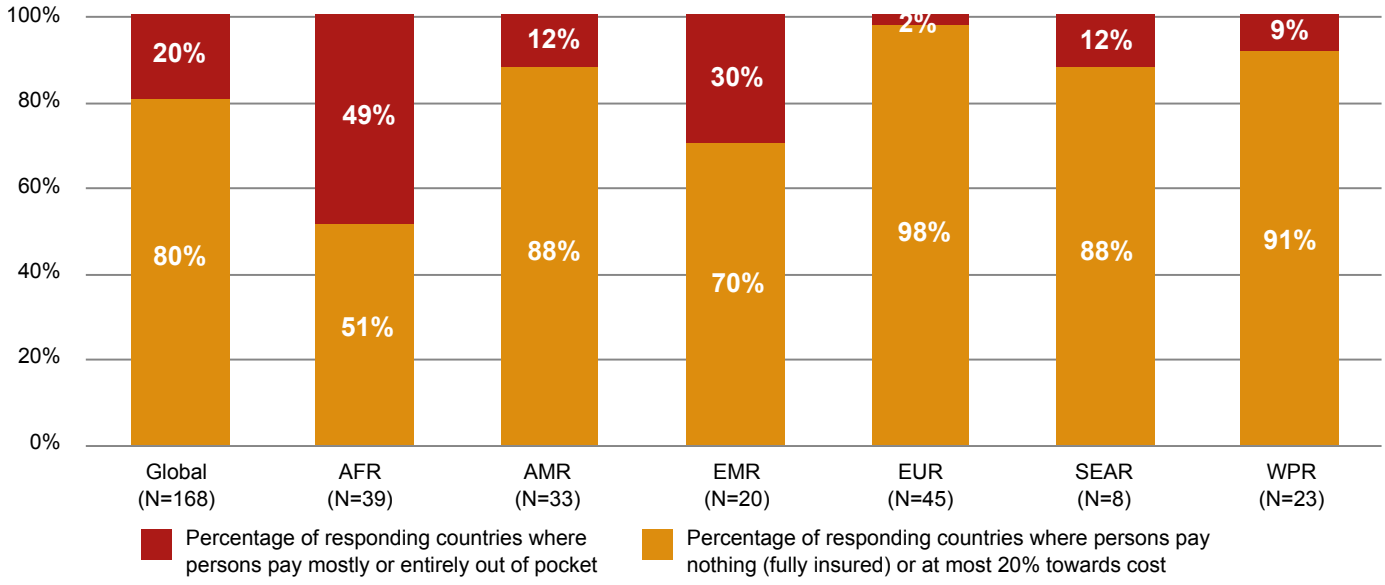
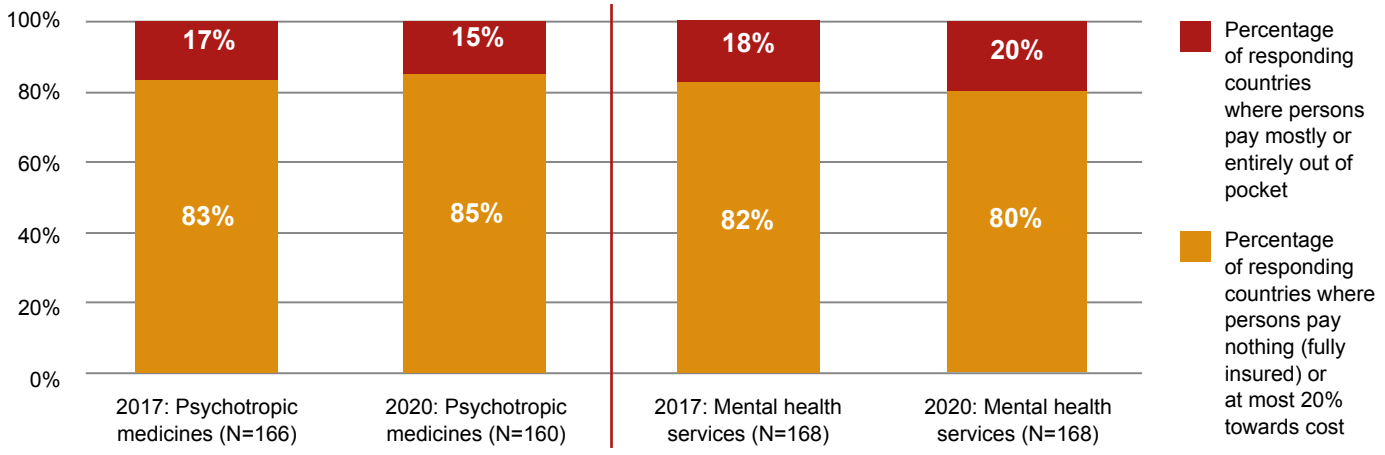


FIGURE 3.2.7 Source of payment for mental health services and psychotropic medicines: global comparison, 2017 and 2020



3.3 MENTAL HEALTH WORKFORCE

Human resources are the most valuable asset of any mental health service. Such services rely on the competence and motivation of their workforces to promote such, prevent mental health conditions and provide care for people with mental health conditions. As with earlier Mental Health Atlas surveys, Member States were asked to provide estimates of the total number of mental health workers in the country, broken down by specific cadres (including psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers in mental health). Mental health workers who had completed formal training in a recognized teaching institution were included in the professional categories. For the purposes of this report, a psychiatrist is defined as a medical doctor with at least two years of postgraduate training in psychiatry, which may include any subspecialty of psychiatry (see Appendix B). A total of 158 countries, corresponding to just over 80% of WHO Member States, were able to provide some estimation of their mental health workforce. This reflects a steady improvement in the completion rate for this question, compared with 130 countries in 2014 and 149 countries in 2017.

Figures 3.3.1 and 3.3.2 show the median numbers of mental health workers per 100 000 population for the different WHO regions and World Bank income groups. In the 2020 Atlas, the global median number of mental health workers per 100 000 population was 13. Access to a mental health worker varies globally. For example, the median number of mental health workers was 40 times higher in the European Region (44.8 mental health workers per 100 000 population) than in the African Region (1.6 mental health workers per 100 000 population) and 20 times higher than in the South-East Asia Region (2.8 mental health workers per 100 000 population). The gap was even more evident between countries in different income groups, ranging from fewer than 1.4 mental health workers per 100 000 population in low-income countries to over 62 workers per 100 000 population in high-income countries.

FIGURE 3.3.1 Mental health workers (median number per 100 000 population), by WHO region

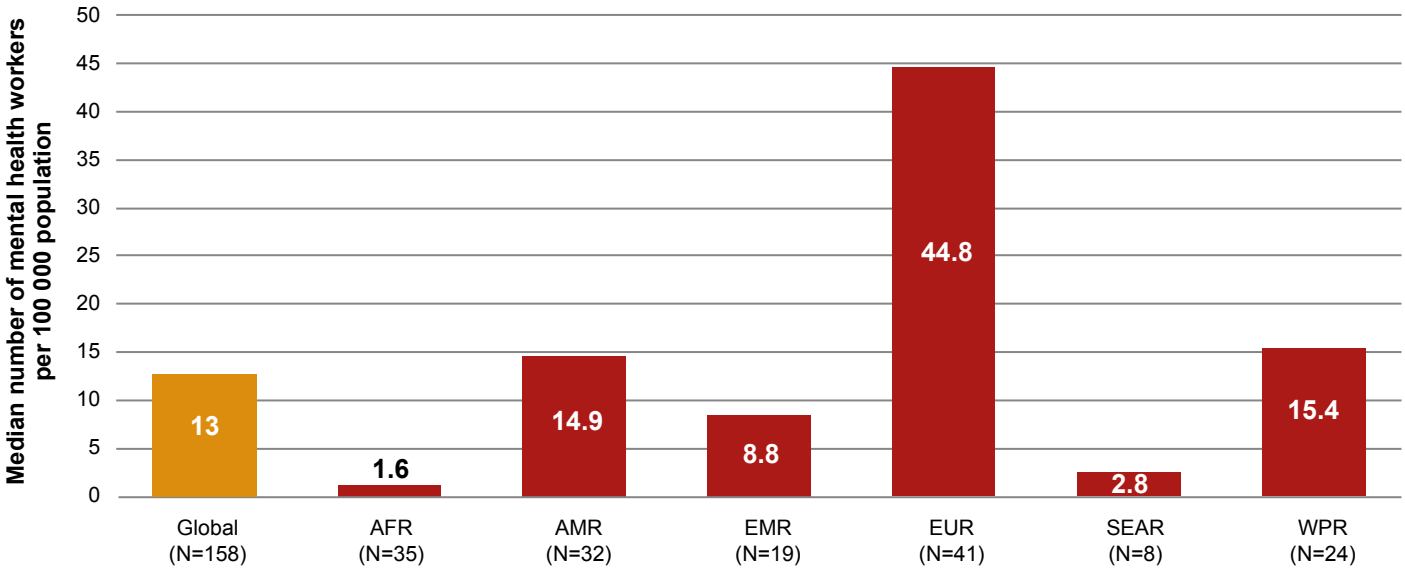
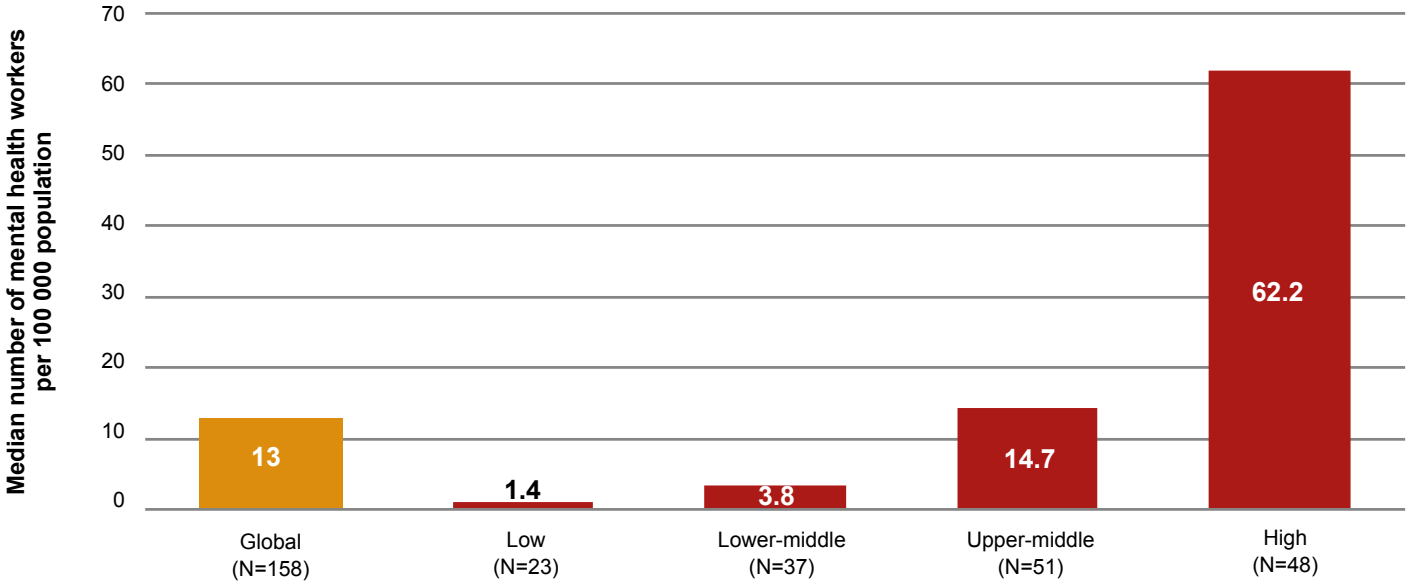


FIGURE 3.3.2 Mental health workers (median number per 100 000 population), by World Bank income group



The global median number of mental health workers per 100 000 population has changed from nine workers in 2014 to 13 workers per 100 000 population in 2020. The most notable change was reported in the Western Pacific Region, where the number of mental health workers in 2020 (15.4 per 100 000 population) was almost twice as high as in 2014 (8.7 per 100 000 population). In addition to an actual increase in the total number of mental health workers in some responding countries in the Western Pacific Region, this change can be further explained by the fact that a higher number of countries provided data on the number of mental health workers (19 responding countries in 2014 compared with 24 countries in 2020). In the Region of the Americas and the South-East Asia Region, the median number of workers reported fell, respectively, from 16.2 to 15 workers per 100 000 population and from 4.8 to 2.8 workers per 100 000 population from 2014 (Figure 3.3.3).

Changes in values across years can also be explained by improvements in data quality reported over time. In 2020, some Member States with large populations did not report data, which affected the median value, and in addition data collection took place against the backdrop of the COVID-19 pandemic, which may have resulted in incomplete data collection in some countries. In 2014 and 2017, Member States were also requested to report separately on more specific cadres of mental health workers (i.e. occupational therapists, speech therapists), while in 2020 these categories were simplified and the cadres grouped into one category of "Other specialized mental health workers".

By income level, comparisons with previous years clearly show fluctuations across time for all income groups, with an initial increase from 2014 to 2017 offset by a slight decrease from 2017 to 2020. Countries in the lower-middle-income group reported the most substantial decrease, with the number of mental health workers per 100 000 population almost halving between 2017 and 2020, from 6.2 to 3.8 workers per 100 000 population (Figure 3.3.4).

FIGURE 3.3.3 Mental health workers (median number per 100 000 population), by WHO region (2014, 2017 and 2020)

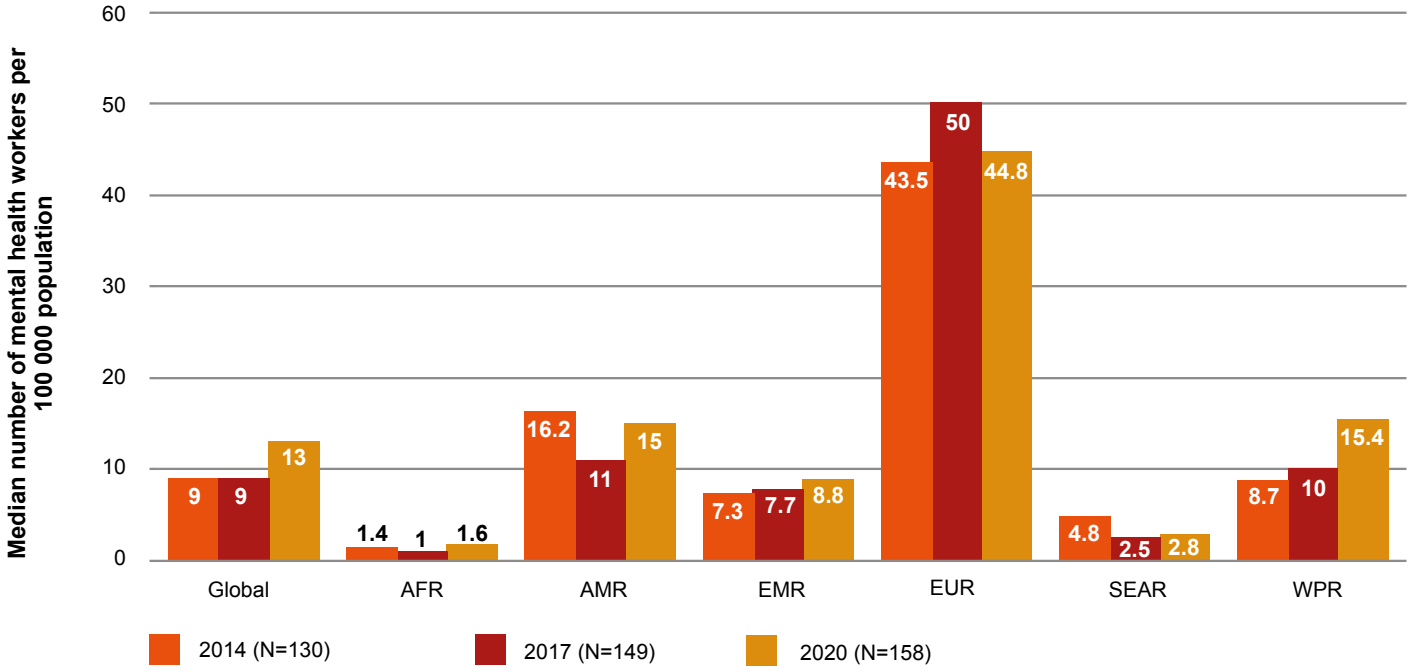
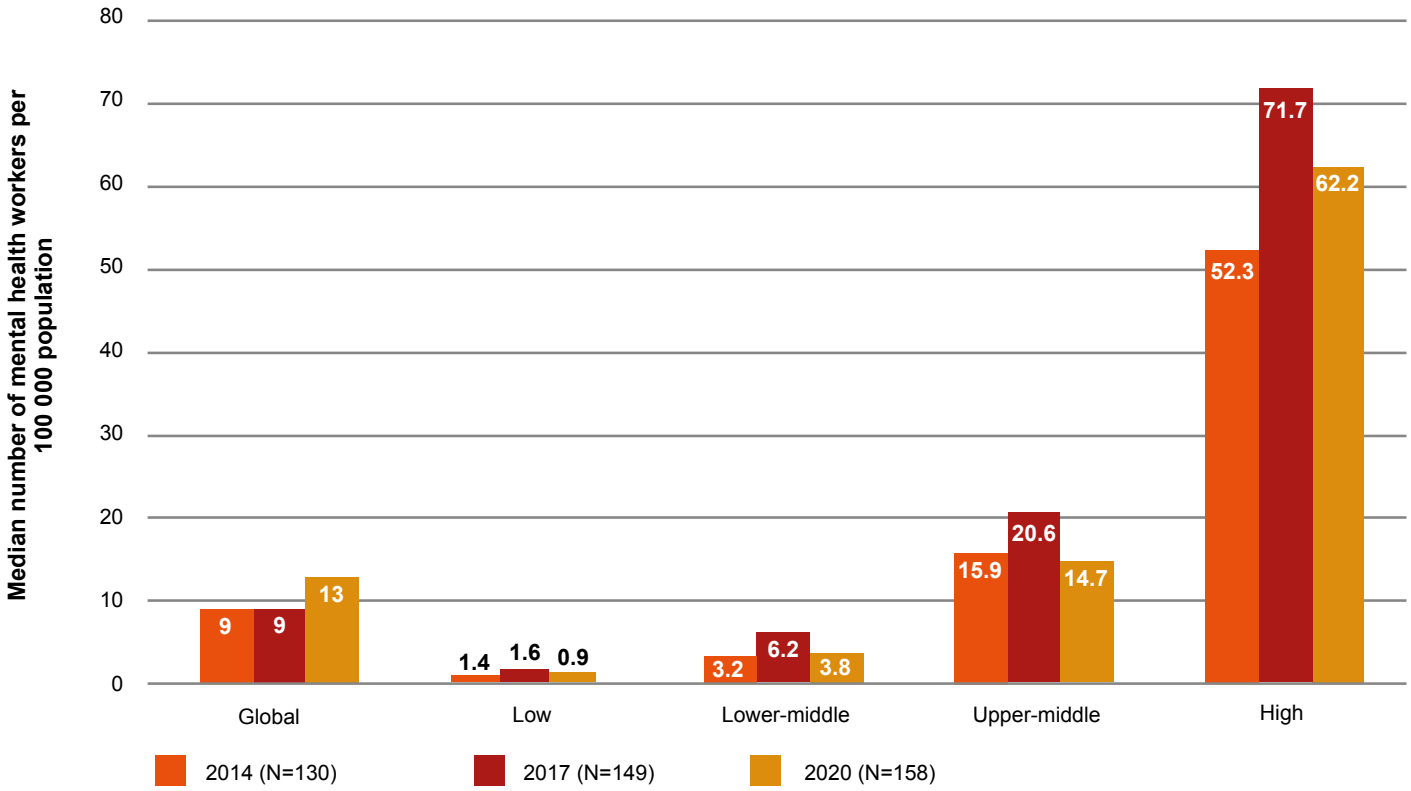


FIGURE 3.3.4 Mental health workers (median number per 100 000 population), by World Bank income group



Composition of mental health workforce

Figures 3.3.5 and 3.3.6 provide a breakdown of the mental health workforce by cadre, by WHO region and by World Bank income group. In general, the distribution of different workforce categories was consistent across regions and income groups: mental health nurses represented the single largest group, followed by psychiatrists and psychologists. Globally, nurses represent 44% of the mental health workforce, though in some regions, such as the Western Pacific, they represent up to 68% of the workforce. Exceptionally, the proportion of psychologists was reported to be higher than those of nurses and psychiatrists in the Americas region (4.6 psychologists per 100 000 population compared with 3.6 nurses and 1.9 psychiatrists per 100 000 population). Similar to the 2014 and 2017 editions of the Atlas, there were notable differences between WHO regions and income groups. For example, in 2020 there were 0.1 psychiatrists and 0.9 nurses per 100 000 population in the African Region, compared with 9.7 psychiatrists and 25.2 nurses per 100 000 population in the European Region.

Similarly, there were 0.1 psychiatrists and 0.4 nurses per 100 000 population in low-income countries compared with more than eight psychiatrists and 29 nurses per 100 000 population in high-income countries. Numbers of social workers and other specialized mental health workers (e.g. occupational therapists and speech therapists) were very low across all income groups, with the highest numbers reported by high-income countries (2.9 social workers per 100 000 population and 4.1 other specialized mental health workers per 100 000 population). It is also important to highlight that the questionnaire completion rate for mental health workforce disaggregation by cadre increased from under 60% of WHO Member States providing data for this question in 2017 (115 countries) to 65% in 2020 (127 countries), which perhaps indicates an improvement in the availability of data on the mental health workforce in different countries.

FIGURE 3.3.5 Breakdown of mental health workforce (median number per 100 000 population), by WHO region

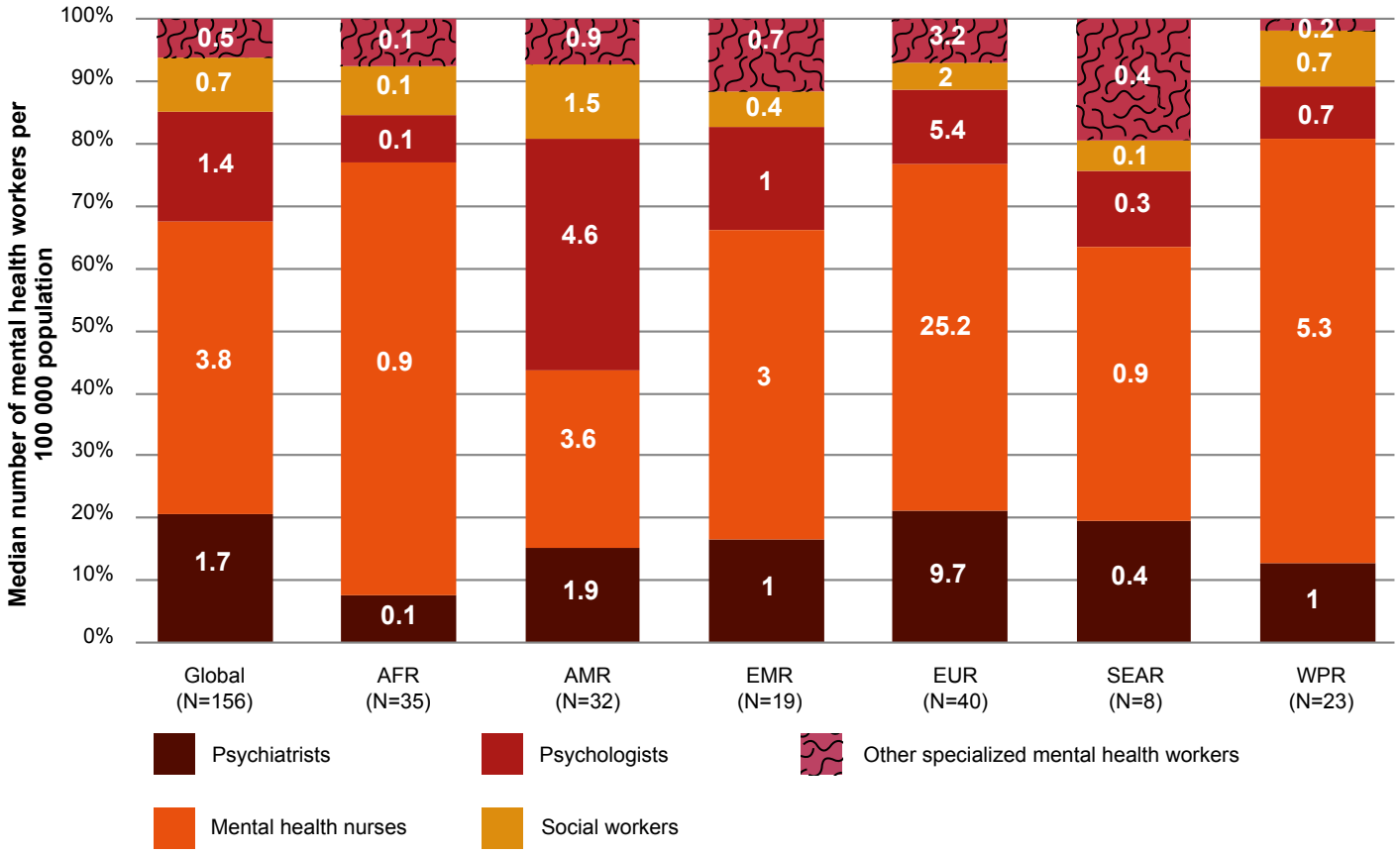
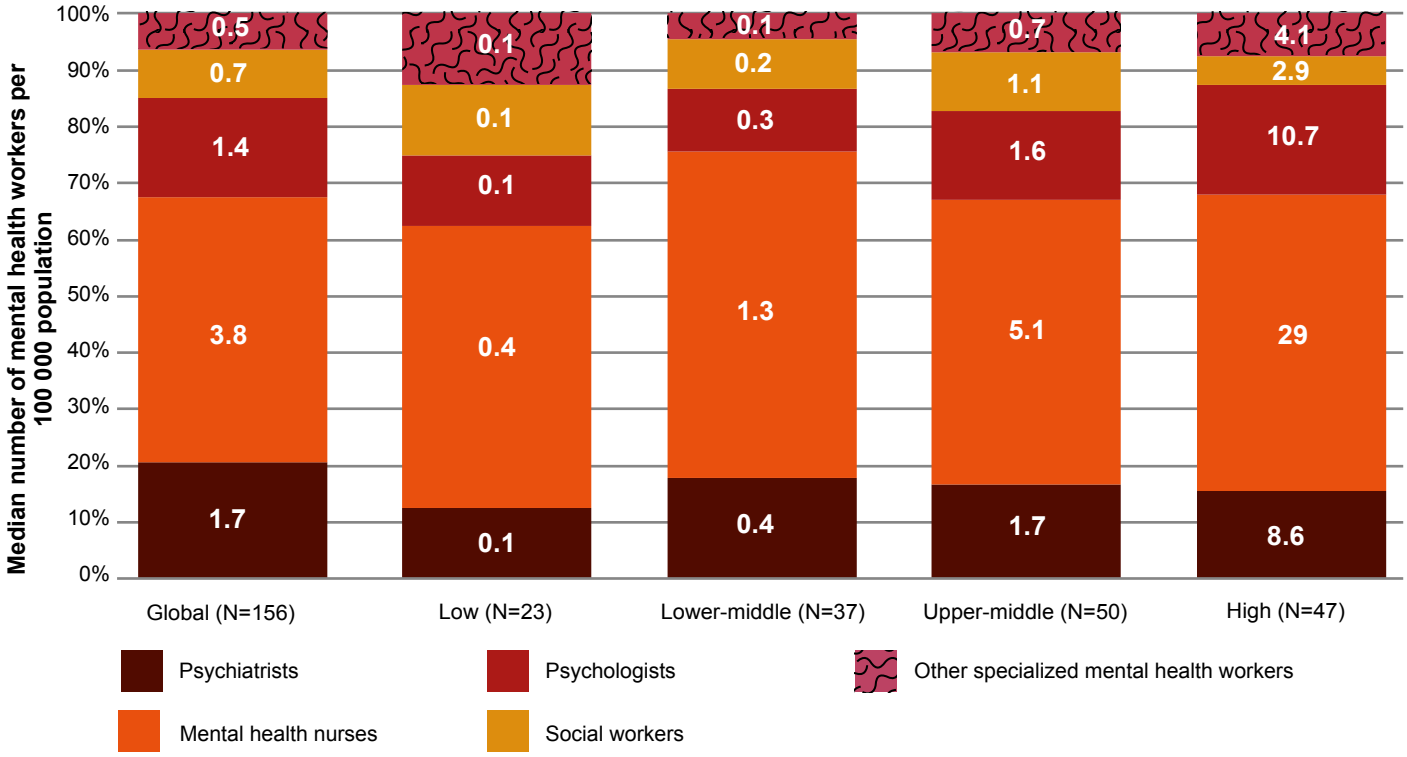
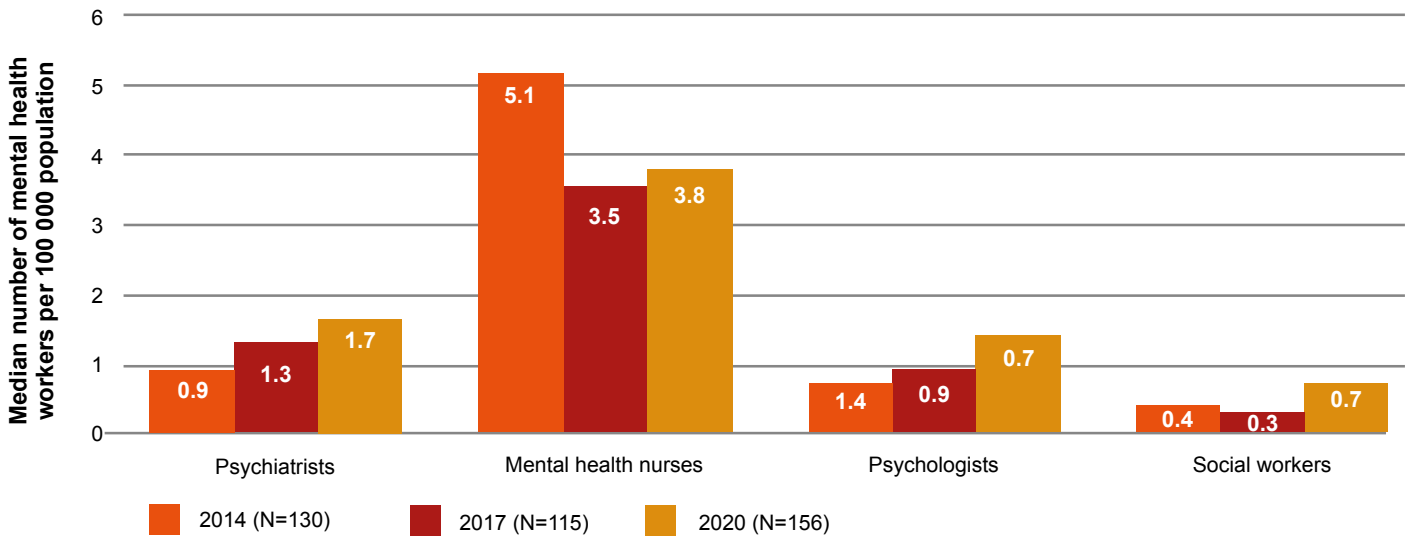


FIGURE 3.3.6 Breakdown of mental health workforce (median number per 100 000 population), by World Bank income group



As shown in Figure 3.3.7, the number of psychiatrists and psychologists per 100 000 population has increased steadily since 2014. This consistent increase might reflect an actual increase in the human resources available or it might indicate an improvement in reported and available information on the mental health workforce. The number of mental health nurses per 100 000 population increased slightly from 2017 to 2020 (from 3.5 nurses per 100 000 population in 2017 to 3.8 in 2020), but this followed a decrease from 5.1 nurses per 100 000 population in 2014. The number of social workers per 100 000 population increased from 0.4 in 2014 and 0.3 in 2017 to 0.7 in 2020.

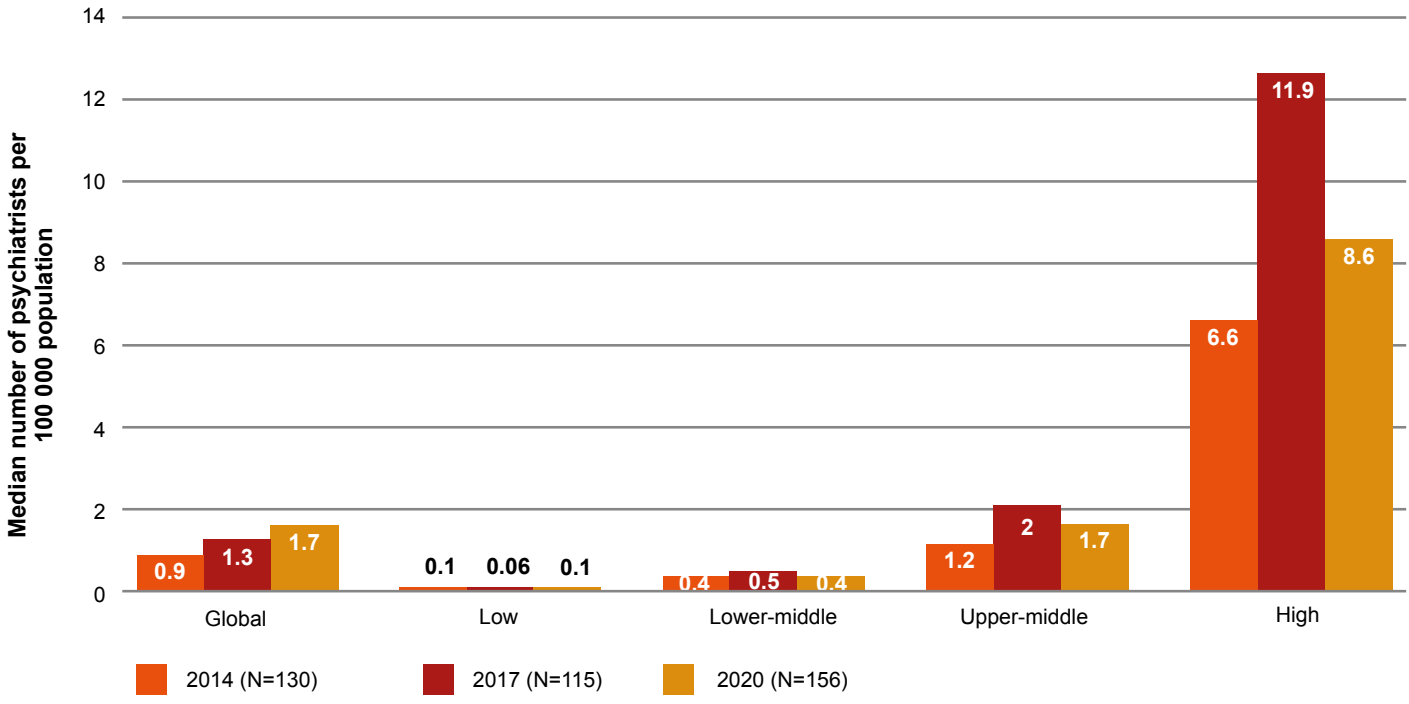
FIGURE 3.3.7 Global mental health workers: breakdown (median number per 100 000 population), (2014, 2017 and 2020)



Since 2014, the number of psychiatrists per 100 000 population has fluctuated across income groups (Figure 3.3.8). While it has barely changed in low- and lower-middle-income countries, the number of psychiatrists per 100 000 population in upper-middle- and high-income countries increased from 2014 to 2017, and then decreased slightly from 2017 to 2020. Although the number of psychiatrists per 100 000 population in 2020 was still higher than in 2014, the decrease between 2017 and 2020 was noticeable, with numbers falling from two in 2017 to 1.7 in 2020 in upper-middle-income countries, and from 11.9 in 2017 to 8.6 in 2020 in high-income countries. These fluctuations may also be explained by differences in the sets of countries reporting data across the years as well as by a greater number of countries reporting such data in 2020.

A breakdown by care settings shows that, globally, 94% of reported mental health staff work in government mental health settings (data not shown). This might reflect a lack of access to data about the private sector, leading to underreporting of the mental health workforce in the private sector and overestimation of the number of staff working in government mental hospitals, particularly given that the reporting of data for the Mental Health Atlas relies on data available to and reported by government sources.

FIGURE 3.3.8 Psychiatrists (median number per 100 000 population) (2014, 2017 and 2020), by World Bank income group



BOX 2: HEALTH WORKERS IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Median numbers of mental health workers in child and adolescent mental health services per 100 000 population for the different WHO regions and World Bank income groups are provided in Table 3.3.1. Globally, 3.4 mental health workers for children and adolescents per 100 000 population were reported in the Mental Health Atlas 2020. As with the mental health workforce for all populations, there were significant differences across countries and income groups. The median number of mental health workers for children and adolescents per 100 000 population ranged between 0.2 workers and one worker in all regions apart from the Region of the Americas (8.6 mental health workers per 100 000 population) and the European Region (12.5 mental health workers per 100 000 population). By income group, it varied from 0.01 mental health workers for children and adolescents per 100 000 population in low-income countries to nearly 20 mental health workers per 100 000 population in high-income countries. Please note that the population considered for analysis in 2020 was different from that in 2017, with the denominator limited to children and adolescents between zero and 19 years of age, instead of the whole population.

TABLE 3.3.1 Median number of health workers in child and adolescent mental health services per 100 000 population (0–19 years old)

	Median number of health workers in child and adolescent mental health services per 100 000 population	
	Number of responding countries	Median number of health workers
Global	**122**	**3.4**
WHO region		
AFR	26	0.2
AMR	22	8.6
EMR	14	1.0
EUR	35	12.5
SEAR	8	0.9
WPR	17	0.8
World Bank income group		
Low	18	0.01
Lower-middle	29	0.4
Upper-middle	41	4.1
High	34	19.9

Mental health workforce in child and adolescent mental health services per 100 000 population

Table 3.3.2 provides a breakdown of the composition of the mental health workforce for children and adolescents disaggregated by cadre, by WHO region and by World Bank income group. The mental health workforce for children and adolescents across different cadres, as reported by WHO Member States, was scarce or non-existent for some categories such as speech therapists, occupational therapists and other specialized mental health workers.

Comparisons between countries by income level showed significant differences, with high-income countries reporting the highest median number of child and adolescent mental health workers across all categories, and low- and lower-middle-income countries largely reporting that the mental health workforce for children and adolescents was non-existent across all categories.

TABLE 3.3.2 Mental health workforce in child and adolescent services: breakdown per 100 000 population, by WHO region and World Bank income group

	Mental health workforce in child and adolescent services, by cadre: breakdown per 100 000 population						
	Psychiatrists	Mental health nurses	Psychologists	Social workers	Speech therapists	Occupational therapists	Other specialized mental health workers
Global	**0.3 (N=121)**	**0.2 (N=99)**	**0.1 (N=104)**	**0.1 (N=94)**	**0.01 (N=96)**	**0.02 (N=95)**	**0.005 (N=74)**
WHO region							
AFR	0.1 (N=26)	0.003 (N=24)	0.004* (N=24)	0.003* (N=22)	0.001* (N=22)	0.004* (N=24)	0.007* (N=17)
AMR	0.7 (N=22)	0.3 (N=20)	3.8 (N=21)	0.6 (N=19)	0.02 (N=17)	0.1 (N=18)	0.3 (N=13)
EMR	0.1 (N=13)	0.1 (N=13)	0.1 (N=12)	0.04 (N=12)	0.02 (N=13)	0.1 (N=12)	0.005* (N=9)
EUR	3.4 (N=35)	5.3 (N=20)	6.3 (N=23)	1.1 (N=18)	1.1 (N=21)	3.0 (N=18)	3.9 (N=14)
SEAR	0.1 (N=8)	0.8 (N=6)	0.04 (N=8)	0.002 (N=8)	0.04 (N=8)	0.1 (N=8)	0.1 (N=6)
WPR	0.1 (N=17)	0.1 (N=16)	0.02* (N=16)	0.04* (N=15)	0.008* (N=15)	0.008* (N=15)	0.03* (N=15)
World Bank income group							
Low	0.003 (N=18)	0.003* (N=18)	0.01* (N=17)	0.002* (N=15)	0.001* (N=17)	0.01* (N=16)	0.005* (N=15)
Lower-middle	0.6 (N=29)	0.1 (N=23)	0.03 (N=25)	0.02 (N=22)	0.009 (N=25)	0.007 (N=23)	0.007 (N=20)
Upper-middle	0.5 (N=40)	0.5 (N=32)	0.8 (N=33)	0.2 (N=32)	0.02 (N=30)	0.07 (N=31)	0.03 (N=22)
High	5.5 (N=34)	3.0 (N=26)	4.3 (N=29)	1.2 (N=25)	0.6 (N=24)	0.7 (N=25)	4.4 (N=17)

* The median value was estimated as zero, therefore the nearest non-zero median was calculated and is reported.

MENTAL HEALTH ATLAS 2020

4 MENTAL HEALTH SERVICE AVAILABILITY AND UPTAKE

4.1 INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE

The integration of mental health into primary health care was highlighted as part of the Alma-Ata Declaration in 1978 and the Astana Declaration in 2018. There is a need to prioritize investment in strong primary health care, including mental health prevention, promotion, treatment and rehabilitation, to improve the efficiency of health management and to achieve universal health coverage. For this purpose, WHO has developed the Mental Health Gap Action Programme (mhGAP), which aims to scale up services for MNS conditions, especially for countries with low and middle levels of income. Different tools have been developed, among which the WHO mhGAP Intervention Guide (mhGAP-IG) is a vital resource, containing evidence-based interventions to be used by non-specialized general health-care workers to scale up management of priority MNS conditions.

In increasing access to mental health care and improving the quality of mental health services, the Comprehensive Mental Health Action Plan emphasizes the systematic decentralization of the focus of care and treatment from long-stay mental hospitals to primary care settings. The Action Plan emphasizes the increased use of evidence-based interventions and principles of stepped care that offers a holistic approach combining mental and physical health care. This integrated and responsive form of care requires the training and monitoring of non-specialized health workers to identify people with mental health conditions, deliver appropriate treatment and support and refer them, when needed, to other levels of care. Objective 2 of the Comprehensive Mental Health Action Plan concerns the provision of comprehensive, integrated and responsive mental health and social care services in community-based settings, including primary health care settings, as a priority. Global target 2.3 of the Action Plan is for 80% of countries to have integrated mental health into primary health care by 2030.

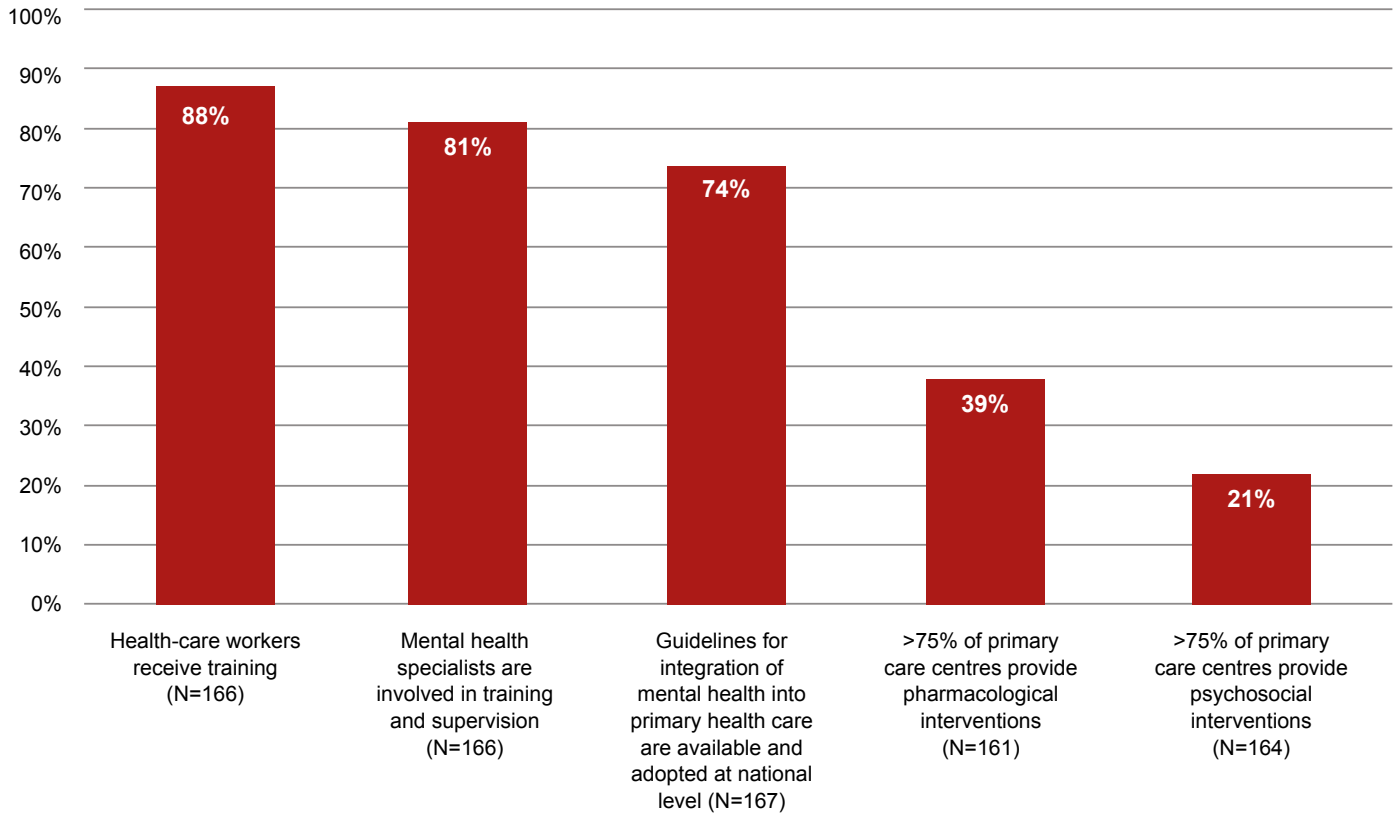
In the Mental Health Atlas 2020, “primary health care” refers to the provision of mental health care through non-specialized services and workers, including health-care services provided by governments and NGOs and private (for-profit) health facilities and services. The integration of mental health into primary health care is considered to be functional only if at least four of the following five criteria are fulfilled: 1) guidelines for mental health integration into primary health care are available and adopted at the national level; 2) pharmacological interventions for mental health conditions are available and provided at the primary care level; 3) psychosocial interventions for mental health conditions are available and provided at the primary care level; 4) health workers at primary care level receive training on the management of mental health conditions; 5) mental health specialists are involved in the training and supervision of primary care professionals.

Of the 160 responding countries, only 15% met all the criteria for functional integration of mental health into primary care. Nevertheless, the majority of countries met at least three of the five criteria (Table 4.1.1). The criterion most frequently fulfilled was the availability of training for health-care workers (88% of responding countries); however, countries were not asked about the specificities of training such as its type, duration, coverage, etc. The criterion least frequently fulfilled was the provision of psychosocial interventions by at least 75% of primary care centres (21% of responding countries) (Figure 4.1.1).

TABLE 4.1.1 Functional integration of mental health into primary care: fulfilment of criteria

	Countries' fulfilment of criteria for functional integration into primary care (N=160)		
	Number of countries	Percentage of responding countries	Percentage of WHO Member States
Fulfilled no criteria	9	6%	5%
Fulfilled 1/5 criteria	11	7%	6%
Fulfilled 2/5 criteria	22	14%	11%
Fulfilled 3/5 criteria	69	43%	36%
Fulfilled 4/5 criteria	25	16%	13%
Fulfilled 5/5 criteria	24	15%	12%

FIGURE 4.1.1 Percentage of responding countries that responded "Yes" to criteria



Guidelines for integration of mental health into primary health care

Of the 168 Member States that answered this question, 74% of responding countries, corresponding to 64% of WHO Member States, reported that guidelines for the integration of mental health into primary health care were available and had been adopted at the national level. However, as with mental health training, limited information was available on the content, quality and extent of implementation of these guidelines.

Disaggregated by region, more than two-thirds of responding countries in the different WHO regions stated that guidelines for the integration of mental health into primary health care were available and had been adopted at the national level, with the highest percentage in the Eastern Mediterranean Region (90% of responding countries) and the lowest in the African Region (66% of responding countries) (Table 4.1.2). There were slight variations between the different World Bank income categories, but more than two thirds of responding countries across all income groups reported that such guidelines were available and had been adopted at the national level.

TABLE 4.1.2 Guidelines for integration of mental health into primary health care available and adopted at national level, by WHO region and World Bank income group

	Countries reporting that guidelines are available and adopted at national level (N=168)	
	Number of countries	Percentage of responding countries
Global	**125**	**74%**
WHO region		
AFR	25	66%
AMR	24	75%
EMR	18	90%
EUR	34	74%
SEAR	6	75%
WPR	18	75%
World Bank income group		
Low	17	71%
Lower-middle	27	69%
Upper-middle	40	77%
High	41	77%

Pharmacological and psychosocial interventions in primary health care

To assess the provision of mental health services at the primary health care level, countries were asked to estimate the percentage of primary care facilities that typically have available pharmacological and psychosocial interventions for mental health conditions (Table 4.1.3). Eighteen per cent of responding countries reported having both pharmacological and psychosocial interventions available and provided in more than 75% of primary care centres.

Pharmacological interventions were more widely available and more widely provided at the level of primary care centres than psychosocial interventions. The gap between pharmacological and psychosocial interventions was particularly evident in high-income countries, where the availability and provision of pharmacological treatment at the primary care level were remarkably high (71% of responding high-income countries reported pharmacological interventions available at more than 75% of primary care centres). In comparison, the availability and provision of psychosocial interventions were low in high-income countries (34% of responding countries), reflecting the limited provision of such interventions at the primary health care level globally.

Overall, 39% of responding countries reported that pharmacological interventions for mental health conditions were available in more than 75% of primary care centres and that guidelines for the integration of mental health were available and had been adopted at the national level. Meanwhile, 21% of responding countries reported that psychosocial interventions for mental health conditions were available in more than 75% of primary care centres and that guidelines for the integration of mental health were available and had been adopted at the national level (data not shown). This reflects a critical gap between the existence and adoption of guidelines for the integration of mental health into primary health care and the limited integration of interventions for service delivery, such as pharmacological and psychosocial interventions for mental health conditions.

TABLE 4.1.3 Percentage of responding countries with availability and provision of pharmacological and psychosocial interventions in >75% of primary care centres, by WHO region and World Bank income group

	Percentage of countries with pharmacological and psychosocial interventions in >75% of primary care centres	
	Pharmacological interventions (N=161)	Psychosocial interventions (N=164)
Global	**39% (n=62)**	**21% (n=35)**
WHO region		
AFR	16% (n=6)	11% (n=4)
AMR	36% (n=11)	31% (n=10)
EMR	25% (n=5)	10% (n=2)
EUR	71% (n=31)	30% (n=13)
SEAR	13% (n=1)	13% (n=1)
WPR	41% (n=9)	21% (n=5)
World Bank income group		
Low	9% (n=2)	8% (n=2)
Lower-middle	13% (n=5)	8% (n=3)
Upper-middle	41% (n=21)	25% (n=13)
High	71% (n=35)	34% (n=17)

Training

Since primary care centres are a common setting for the provision of initial care for people with mental health conditions, primary care workers must be trained to diagnose and treat such conditions. In the Mental Health Atlas 2020 questionnaire, Member States were asked about the proportion of primary health-care workers receiving training on the management of mental health conditions.

Globally, the percentage of health workers at the primary care level receiving training on the management of mental health conditions was high, 88% of responding countries (Table 4.1.4). The highest percentages were reported by the Western Pacific Region (100% of responding countries) and the Region of the Americas (91% of responding countries). In comparison, the lowest percentages were reported by the African Region (82% of responding countries) and the Eastern Mediterranean Region (85% of responding countries). In the different World Bank income groups, at least 79% of responding countries in each group stated that mental health training of health workers was provided at the primary health care level.

TABLE 4.1.4 Health workers at primary care level receiving training on the management of mental health conditions, by WHO region and World Bank income group

	Countries reporting that health-care workers at primary care level receive training on the management of mental health conditions (N=166)	
	Number of countries	Percentage of responding countries
Global	**146**	**88%**
WHO region		
AFR	31	82%
AMR	29	91%
EMR	17	85%
EUR	40	87%
SEAR	7	88%
WPR	2	100%
World Bank income group		
Low	19	79%
Lower-middle	36	92%
Upper-middle	44	85%
High	48	92%

Supervision

WHO mhGAP recommends the engagement of mental health specialists in capacity-building and on-the-job supervision and support of the primary care workforce. Of the 166 countries that responded to this question, 81% reported that mental health specialists were involved in the training and supervision of primary care professionals (Table 4.1.5). At least 70% of responding countries across all regions reported the involvement of mental health specialists in the training and supervision of primary care workers, with the highest percentage reported by the South-East Asia Region (100% of responding countries) and the lowest by the African Region (74% of responding countries). At the income group level, at least 67% of responding countries in each group reported the involvement of mental health specialists in the training and supervision of primary care workers. However, more information is needed from countries about the specificities of this supervision, such as its duration, quantity, quality, etc., to be able to adequately evaluate its consistency and efficacy.

In total 132 countries, corresponding to 80% of responding countries, reported that health workers at the primary care level were receiving training on the management of mental health conditions and that mental health professionals were involved in their training and supervision (data not shown).

TABLE 4.1.5 Percentage of countries reporting the involvement of mental health specialists in the training and supervision of primary care professionals, by WHO region and World Bank income group

	Percentage of countries reporting the involvement of mental health specialists in the training and supervision of primary care professionals (N=166)	
	Number of countries	Percentage of responding countries
Global	**135**	**81%**
WHO region		
AFR	28	74%
AMR	28	88%
EMR	14	70%
EUR	37	80%
SEAR	8	100%
WPR	21	91%
World Bank income group		
Low	16	67%
Lower-middle	35	90%
Upper-middle	42	81%
High	43	83%

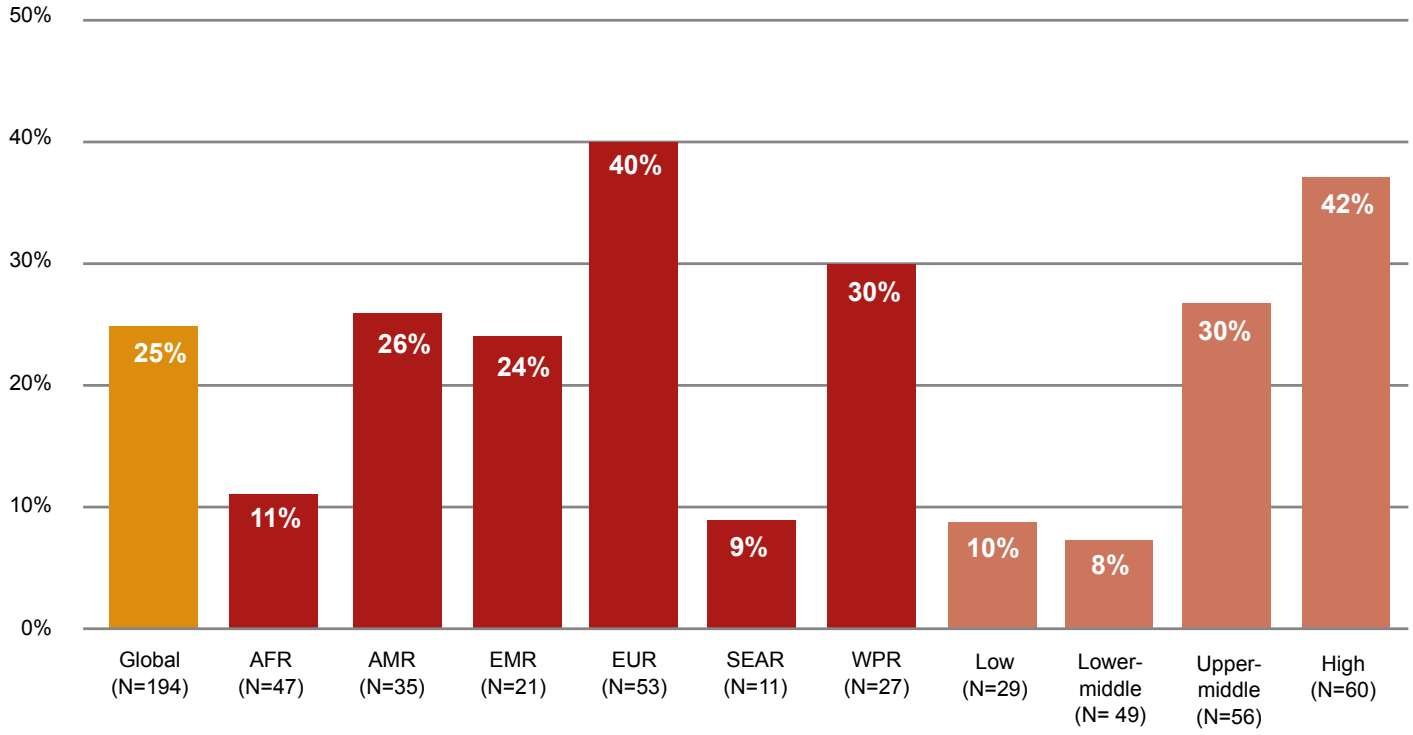
Functionality of the integration of mental health into primary care

In total, 49 out of 194 WHO Member States fulfilled at least four of the five indicators detailed above (see page 70). This corresponds to only 31% of responding countries and 25% of all Member States with functional integration of mental health into primary care (Table 4.1.6), and, is less than one third of the way to the 2030 global target of 80%. Variations were observed across WHO regions, with remarkably low percentages of countries fulfilling four or more indicators in the African Region (13% of responding countries, 11% of WHO Member States) and the South-East Asia Region (12% of responding countries, 9% of WHO Member States). Similarly, the integration of mental health into primary care was strongly influenced by countries' level of income. There were 3–4 times more countries with functional integration of mental health into primary health care in the upper-middle- and high-income groups than in the lower-middle- and low-income groups, where respectively just 10% and 13% of responding countries, corresponding to 8% and 10% of all Member States, fulfilled at least four of the five indicators (Figure 4.1.2).

TABLE 4.1.6 Functionality of the integration of mental health into primary care: number and proportion of Member States scoring at least 4/5 on the checklist, by WHO region and World Bank income group

	Countries meeting at least 4/5 criteria on functionality of the integration of mental health into primary care (N=160)		
	Number of countries	Percentage of responding countries	Percentage of WHO Member States that fulfilled at least 4/5 criteria
Global	**49**	**31%**	**25%**
WHO region			
AFR	5	13%	11%
AMR	9	29%	26%
EMR	5	25%	24%
EUR	21	50%	40%
SEAR	1	12%	9%
WPR	8	36%	30%
World Bank income group			
Low	3	13%	10%
Lower-middle	4	10%	8%
Upper-middle	17	33%	30%
High	25	53%	42%

FIGURE 4.1.2 Functional integration of mental health into primary care: percentage of Member States fulfilling at least 4/5 indicators, by WHO and World Bank income group



4.2 INPATIENT AND RESIDENTIAL CARE

Inpatient and residential care comprises public and/or private, profit and non-profit, mental hospitals, psychiatric wards in general hospitals, community residential facilities and mental health inpatient facilities for children and adolescents (in both mental and general hospitals). Definitions of these facilities are provided in the Glossary of Terms (Appendix B). The Comprehensive Mental Health Action Plan emphasizes the development of interdisciplinary community-based mental health services for people across the life course, for instance through outreach services, home care and support, primary health care, emergency care, community-based rehabilitation and supported housing, and supporting the establishment and implementation of community mental health services run by NGOs, faith-based organizations and other community groups, including self-help and family support groups, which protect, respect and promote human rights and are subject to monitoring by government agencies.

The Mental Health Atlas 2020 questionnaire asked WHO Member States separately about the level of availability of mental health inpatient services for adults and children, and whether the data collected were disaggregated by sex. It is important to note that significant discrepancies were noted between data reported in 2017 and in 2020 during the analysis and interpretation of availability of inpatient and residential care services. Consequently, some country data were excluded from the analysis of inpatient care indicators, as a result of the following revision process: data were checked against 2017 country profiles and reports from the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS)[8] and with WHO Regional and Country Offices to clarify the reasons for the discrepancies, before a decision was made to discard either the 2017 or 2020 data, to discard both the 2017 and 2020 data or to keep the data. For this reason, data reported here for 2017 may not reflect data contained in the Mental Health Atlas 2017 match. Data for 2014 were not included in the revision process or the comparisons due to limited completion and data quality. Table 4.2.1 summarizes overall adult inpatient care

[8] WHO MiNDbank: More Inclusiveness Needed in Disability and Development. WHO-AIMS Country Reports. https://www.mindbank.info/collection/type/whoaims_country_reports/all?page=all

for mental health services (including mental hospitals, psychiatric units in general hospitals, and residential facilities) by WHO region and World Bank income group for both 2017 and 2020 data.

According to data collected for the Mental Health Atlas 2020, the median number of inpatient facilities globally was 0.25 facilities per 100 000 population. There were 14.5 beds per 100 000 population, distributed unequally across regions (62.7 beds per 100 000 population in the European Region, compared with just under three beds per 100 000 population in the African Region and three beds in the South-East Asia Region) and across income groups (51.0 beds per 100 000 population in high-income countries compared with only 1.8 beds per 100 000 population in low-income countries). Similarly, the median admission rate per 100 000 population to inpatient facilities varied widely, from 17.6 in low-income countries to 318.4 in high-income countries. Although the data show that the number of reported inpatient beds has decreased since 2017, the admission rate has increased, though this might indicate shorter stays at inpatient facilities. The decrease in the number of beds may be due to reporting limitations, including varying definitions of types of facility across countries, or it could perhaps reflect an actual reduction in bed numbers.

The number of countries reporting the availability of sex-disaggregated data on mental health inpatient care was lower (Table 4.2.2). When the data on total inpatient care admissions were disaggregated by sex, they showed a higher proportion of males (58%) versus females (42%) globally, as well as across all WHO regions and different income groups.

TABLE 4.2.1 Median levels of total inpatient care (mental hospital, psychiatric unit, community residential facility) per 100 000 population (2017 and 2020), by WHO region and World Bank income group (N=number of responding countries)

	Median rate of total inpatient care per 100 000 population					
	Facilities		**Beds**		**Admissions**	
	2017	**2020**	**2017**	**2020**	**2017**	**2020**
Global	**0.24 (N=157)**	**0.25 (N=158)**	**16.25 (N=156)**	**14.5 (N=156)**	**91.7 (N=137)**	**125.6 (N=131)**
WHO region						
AFR	0.07 (N=40)	0.05 (N=37)	2.4 (N=40)	2.6 (N=34)	18.3 (N=30)	34.3 (N=27)
AMR	0.29 (N=30)	0.37 (N=32)	19.4 (N=29)	13.6 (N=31)	83.9 (N=27)	59.4 (N=23)
EMR	0.07 (N=17)	0.06 (N=20)	6.2 (N=15)	5.2 (N=18)	27.1 (N=13)	44.0 (N=16)
EUR	0.64 (N=42)	0.79 (N=42)	50.8 (N=45)	62.7 (N=44)	456.7 (N=42)	486.1 (N=42)
SEAR	0.12 (N=10)	0.16 (N=8)	3.2 (N=9)	3.0 (N=8)	35.7 (N=8)	76.3 (N=7)
WPR	0.68 (N=18)	0.65 (N=19)	18.4 (N=18)	17.2 *(N=21)*	114.3 (N=17)	101.2 (N=16)
World Bank income group						
Low	0.04 (N=26)	0.05 (N=24)	1.4 (N=26)	1.8 (N=24)	14.8 (N=20)	17.6 (N=19)
Lower-middle	0.12 (N=40)	0.09 (N=38)	6.3 (N=38)	4.4 (N=34)	44.2 (N=31)	59.8 (N=27)
Upper-middle	0.26 (N=47)	0.30 (N=49)	20.9 (N=46)	19.2 (N=48)	103.0 (N=42)	125.6 (N=42)
High	1.19 (N=44)	0.95 (N=47)	45.5 (N=46)	51.0 (N=50)	332.1 (N=44)	318.4 (N=43)

TABLE 4.2.2 Median percentages of total inpatient care admissions, by WHO region and World Bank income group and disaggregated by sex (mental hospital, psychiatric unit, community residential facility)

	Total inpatient care admissions, by sex (N=91)		
	Number of countries	Female (percentage)	Male (percentage)
Global	**91**	**42%**	**58%**
WHO region			
AFR	15	39%	61%
AMR	21	39%	61%
EMR	13	32%	68%
EUR	23	45%	55%
SEAR	5	35%	65%
WPR	14	43%	57%
World Bank income group			
Low	8	44%	59%
Lower-middle	21	36%	62%
Upper-middle	30	42%	58%
High	32	44%	56%

Globally, 10% of the total number of admissions to inpatient facilities were involuntary admissions, with the highest proportion of involuntary admissions being to mental hospitals (15%). Lower proportions of involuntary admissions were reported to psychiatric units in general hospitals (2% of admissions) and to mental health community residential facilities (1% of admissions). This indicator suffered from limited data availability and incomplete inputs, making the data non-computable at regional and income group levels. The small percentage of involuntary admissions in some regions, such as the South-East Asia and the African Regions, does not necessarily indicate that all admissions were voluntary but might instead reflect the way that involuntary admissions are documented across all regions and income groups and specifically in regions and income groups with very low reporting percentages.

Mental hospitals

Mental hospitals are specialized facilities that provide inpatient care and long-stay residential services for people with mental health conditions, mainly those with severe conditions such as major depressive disorders, schizophrenia or bipolar disorders. They are usually independent and stand-alone, although they may have some links with the rest of the health-care system. In many countries, they remain the main type of inpatient mental health-care facility. Table 4.2.3 provides a summary of numbers of facilities, beds and admissions in mental hospitals by WHO region, World Bank income group and sex of people admitted.

Based on reported data, there were 10.8 mental hospital beds and 71.8 admissions per 100 000 population globally in 2020. Although the median number of mental hospital beds decreased from 12.5 beds per 100 000 population in 2017 to 10.8 beds per 100 000 population in 2020, the median number of admissions increased slightly, from 62.4 to 71.8 admissions per 100 000 population. This could indicate shorter stays in mental hospitals and more effective utilization of available beds, and would be in line with Member States' ongoing efforts to gradually shift care towards psychiatric wards in general hospitals and to provide community-based facilities that enable rapid reintegration of persons with mental health conditions into society. However, high-income countries still reported a far greater number of mental hospital beds (28.6 beds per 100 000 population) and much higher admission rates (150.7 admissions per 100 000 population) than low-income countries (1.9 mental hospital beds per 100 000 population and 14.3 admissions per 100 000 population). This was true particularly for countries in the European Region, which collectively reported 35 beds per 100 000 population compared with fewer than five beds per 100 000

TABLE 4.2.3 Median numbers of mental hospital facilities, beds and admissions per 100 000 population, by WHO region and World Bank income group and disaggregated by sex (median percentages) (N=number of responding countries)

	Median number of mental hospital facilities, beds and admissions per 100 000 population			Median percentage of admissions, by sex	
	Facilities	Beds	Admissions	Female	Male
Global	**0.05 (N=130)**	**10.8 (N=125)**	**71.8 (N=100)**	**40% (N=72)**	**60% (N=72)**
WHO region					
AFR	0.16 (N=27)	3.7 (N=23)	27.8 (N=15)	39% (N=9)	61% (N=9)
AMR	0.04 (N=29)	6.7 (N=27)	41.8 (N=20)	36% (N=19)	64% (N=19)
EMR	0.02 (N=19)	4.4 (N=17)	32.2 (N=16)	31% (N=13)	69% (N=13)
EUR	0.14 (N=37)	35.0 (N=39)	275.0 (N=35)	44% (N=20)	56% (N=20)
SEAR	0.01 (N=6)	3.6 (N=6)	34.5 (N=5)	32% (N=4)	68% (N=4)
WPR	0.56 (N=12)	11.2 (N=13)	94.2 (N=9)	44% (N=7)	56% (N=7)
World Bank income group					
Low	0.02 (N=16)	1.9 (N=15)	14.3 (N=10)	39% (N=4)	61% (N=4)
Lower-middle	0.02 (N=33)	3.8 (N=29)	34.5 (N=23)	40% (N=17)	60% (N=17)
Upper-middle	0.07 (N=42)	17.7 (N=43)	91.2 (N=35)	36% (N=26)	64% (N=26)
High	0.08 (N=39)	28.6 (N=41)	150.7 (N=32)	42% (N=25)	58% (N=25)

population in the Eastern Mediterranean, the South-East Asia and the African Regions, the overall picture being very similar to that of 2017.

Regarding the duration of stay in mental hospitals, the proportion of inpatients staying for less than one year increased slightly, from 82% in 2017 to 87% in 2020. There were significant increases in the proportion of inpatients staying less than one year in the African Region (from 80% in 2017 to 94% in 2020), South-East Asia Region (from 89% to 97%), the Western Pacific Region (from 69% to 91%) and the European Region (from 85% to 88%) (data not shown). However, in certain regions, including the Region of the Americas and the Eastern Mediterranean Region, there were still significant proportions (more than 25%) of mental hospital residents whose length of stay was more than one year or even as long as five years (Figures 4.2.1 and 4.2.2). Similar to the situation in 2017, in low-income countries more than 90% of inpatient service users had a stay of less than one year, which may reflect the continuation of a notable trend in the 2017 edition of the Mental Health Atlas of effective utilization of the limited resources available. As shown in Tables 4.2.3 and 4.2.4, there was an overall predominance of male inpatients over female inpatients, independent of duration of stay. This applied to all WHO regions and World Bank income groups.

FIGURE 4.2.1 Median percentages of duration of stay in mental hospitals, by WHO region

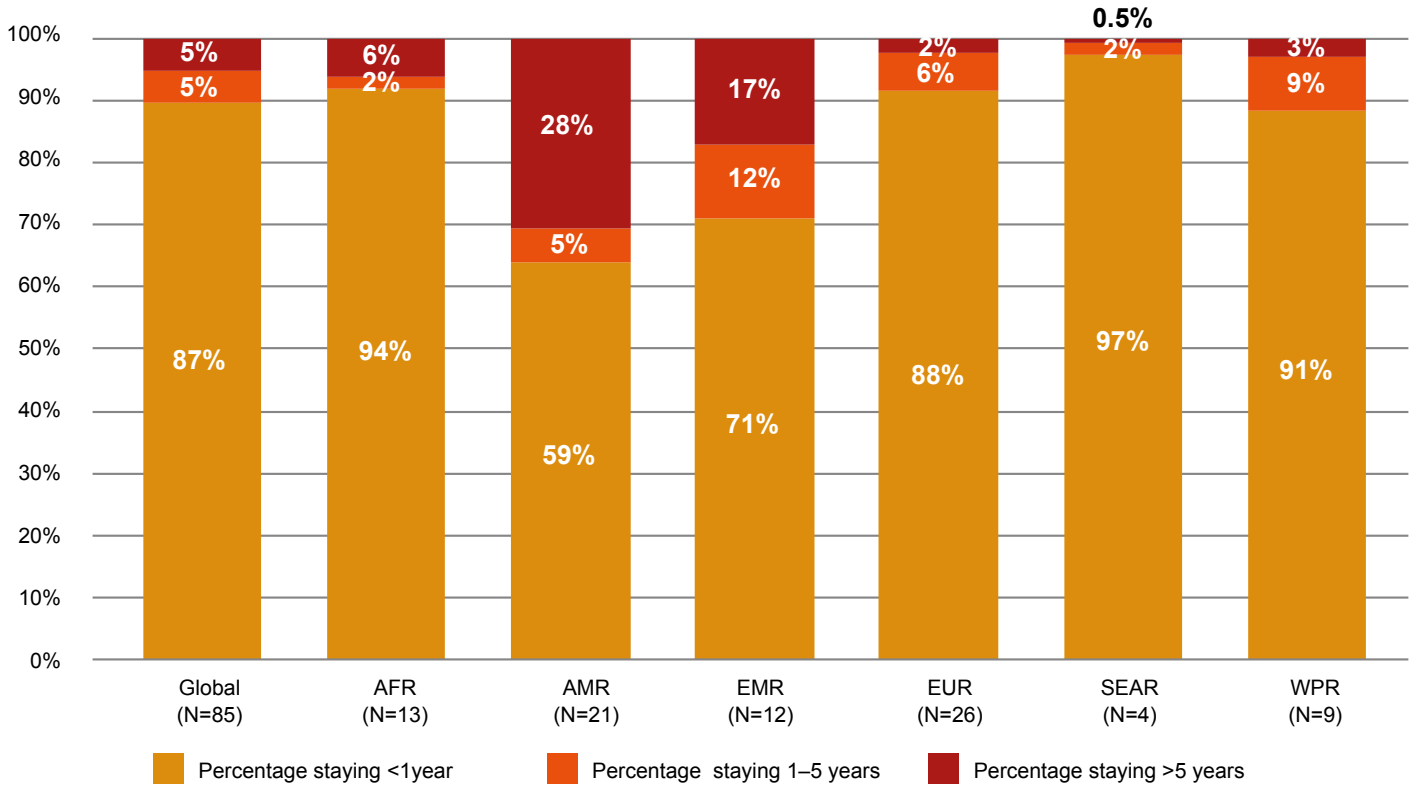
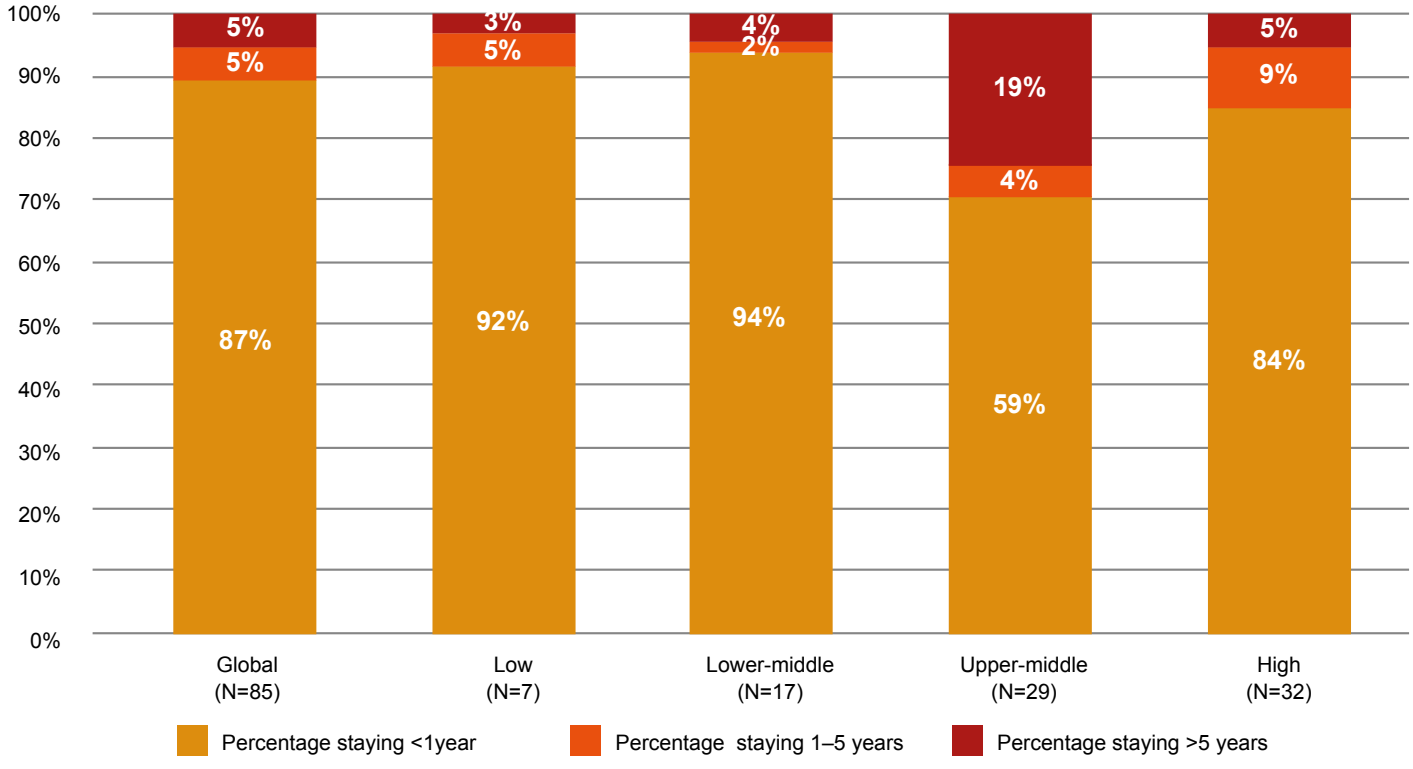


FIGURE 4.2.2 Median percentages of duration of stay in mental hospitals, by World Bank income group



* Note: values may not add up to 100% due to the use of median percentages.

TABLE 4.2.4 Median duration of stay in mental hospitals, disaggregated by sex, by WHO region and World Bank income group (median percentages) (N=number of responding countries)

	Median duration of stay in mental hospitals, disaggregated by sex (N=85)					
	<1 year		1–5 years		>5 years	
	Female	Male	Female	Male	Female	Male
Global	**43% (N=63)**	**57% (N=63)**	**28% (N=57)**	**72% (N=57)**	**35% (N=52)**	**64% (N=52)**
WHO region						
AFR	35% (N=9)	65% (N=9)	15% (N=8)	85% (N =8)	19% (N=7)	81% (N=7)
AMR	45% (N=18)	55% (N=18)	27% (N=16)	73% (N=16)	42% (N=17)	58% (N=17)
EMR	30% (N=9)	70% (N=9)	30% (N=8)	70% (N=8)	24% (N=6)	76% (N=6)
EUR	46% (N=20)	54% (N=20)	28% (N=20)	72% (N=20)	21% (N=19)	75% (N=19)
SEAR	35% (N=3)	65% (N=3)	36% (N=2)	64% (N=2)	0% (N=1)	100% (N=1)
WPR	43% (N=4)	57% (N=4)	33% (N=3)	67% (N=3)	32% (N=2)	68% (N=3)
World Bank income group						
Low	29% (N=4)	71% (N=4)	19% (N=2)	81% (N=2)	38% (N=1)	63% (N=1)
Lower-middle	43% (N=7)	57% (N=7)	8% (N=5)	92% (N=5)	19% (N=6)	81% (N=6)
Upper-middle	45% (N=26)	56% (N=26)	33% (N=25)	68% (N=25)	38% (N=22)	61% (N=23)
High	44% (N=26)	56% (N=26)	28% (N=25)	72% (N=25)	25% (N=23)	70% (N=23)

* Note: values may not add up to 100% due to the use of median percentages.

Mental health inpatient care in general hospitals

Psychiatric wards in general hospitals are psychiatric units that provide inpatient care within community-based hospital facilities. These units provide care to persons with acute mental health conditions, and the period of stay is usually relatively short (weeks to months).

Based on the reported data, there were over three times as many beds in mental hospitals as in general hospitals'. As shown in Table 4.2.5, there were 2.5 psychiatric beds in general hospitals per 100 000 population, a slight increase from 2017 (2.0 psychiatric beds per 100 000 population). As with reported data in 2014 and 2017, there were substantial differences between regions and country income groups. For example, there were more than 12 psychiatric beds per 100 000 population in the European Region compared with fewer than two psychiatric beds per 100 000 population in the Eastern Mediterranean Region, the Region of the Americas and the South-East Asia Region, and fewer than one psychiatric bed per 100 000 population in the African Region. More than 15 psychiatric beds per 100 000 population were reported in high-income countries compared with fewer than 0.4 psychiatric beds per 100 000 population in low-income countries.

TABLE 4.2.5 Median number of psychiatric units in general hospital facilities, beds and admissions per 100 000 population, by WHO region and World Bank income group and disaggregated by sex (median percentages) (N=number of responding countries)

	Median numbers of psychiatric units in general hospital facilities, beds and admissions per 100 000 population			Median percentages of admissions, by sex	
	Facilities	**Beds**	**Admissions**	**Female**	**Male**
Global	**0.17 (N=125)**	**2.5 (N=116)**	**43.0 (N=93)**	**45% (N=63)**	**55% (N=64)**
WHO region					
AFR	0.05 (N=27)	0.7 (N=25)	6.7 (N=19)	41% (N=9)	59% (N=9)
AMR	0.18 (N=24)	1.4 (N=22)	31.3 (N=15)	52% (N=13)	48% (N=13)
EMR	0.05 (N=15)	1.2 (N=11)	15.3 (N=10)	44% (N=7)	56% (N=7)
EUR	0.32 (N=36)	12.3 (N=35)	220.6 (N=32)	49% (N=21)	51% (N=21)
SEAR	0.13 (N=7)	1.3 (N=7)	30.1 (N=5)	37% (N=4)	63% (N=4)
WPR	0.48 (N=16)	4.6 (N=16)	41.6 (N=12)	39% (N=9)	61% (N=10)
World Bank income group					
Low	0.03 (N=19)	0.4 (N=17)	6.7 (N=15)	43% (N=7)	57% (N=7)
Lower-middle	0.06 (N=32)	0.8 (N=27)	7.1 (N=18)	38% (N=12)	64% (N=13)
Upper-middle	0.19 (N=35)	3.3 (N=34)	30.7 (N=28)	45% (N=21)	55% (N=21)
High	0.37 (N=39)	15.2 (N=38)	271.3 (N=32)	49% (N=23)	51% (N=23)

As shown in Figures 4.2.3 and 4.2.4 and in Table 4.2.6, comparisons between data for the 2014, 2017 and 2020 editions of the Mental Health Atlas show that the global number of beds per 100 000 population in mental hospitals almost doubled from 2014 to 2017 but then decreased again after 2017. Meanwhile, the number of psychiatric beds per 100 000 population in general hospitals remained almost the same, with a marginal decrease from 2014 to 2017 but a slight increase since 2017. The exception was the low-income country group, where there was a decrease followed by a rise in the number of mental hospital beds (from 1.6 beds per 100 000 population in 2014 to 1.5 beds in 2017, and then to 1.9 beds in 2020), and a decrease in the number of psychiatric beds in general hospitals (from 0.5 beds per 100 000 population in 2014 to 0.4 beds in 2017 and 2020). By contrast, countries in the high-income group reported a steady decrease in the number of beds in mental hospitals but a steady increase in psychiatric beds in general hospitals since 2014. There could be a number of reasons to explain the observed fluctuations, which may include limitations to data collection, actual changes in services or changes in the definitions of this type of service in information systems. Fluctuations in numbers of psychiatric beds in general hospitals can also be explained by sensitivity to operational needs: numbers of functioning beds allocated within general hospitals may increase or decrease based on actual needs and changes in the prioritization of available resources.

Further information and analysis of available data are required to understand better the factors or reasons behind these trends across the different regions and income groups.

FIGURE 4.2.3 Mental hospital beds per 100 000 population (2014, 2017 and 2020), by World Bank income group

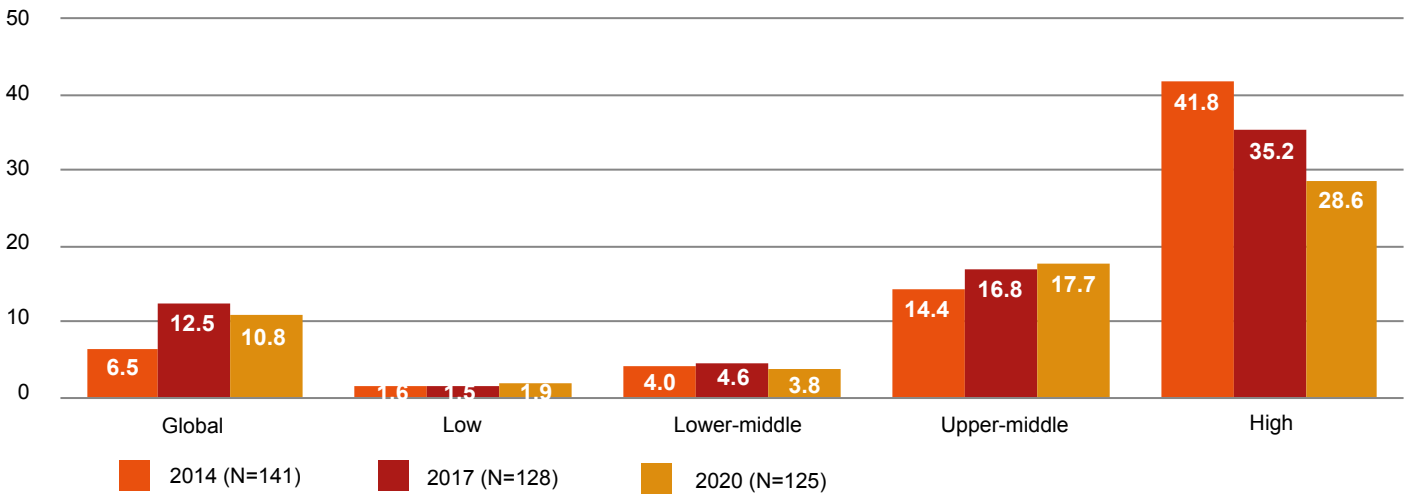


FIGURE 4.2.4 Psychiatric beds in general hospitals per 100 000 population (2014, 2017 and 2020), by World Bank income group

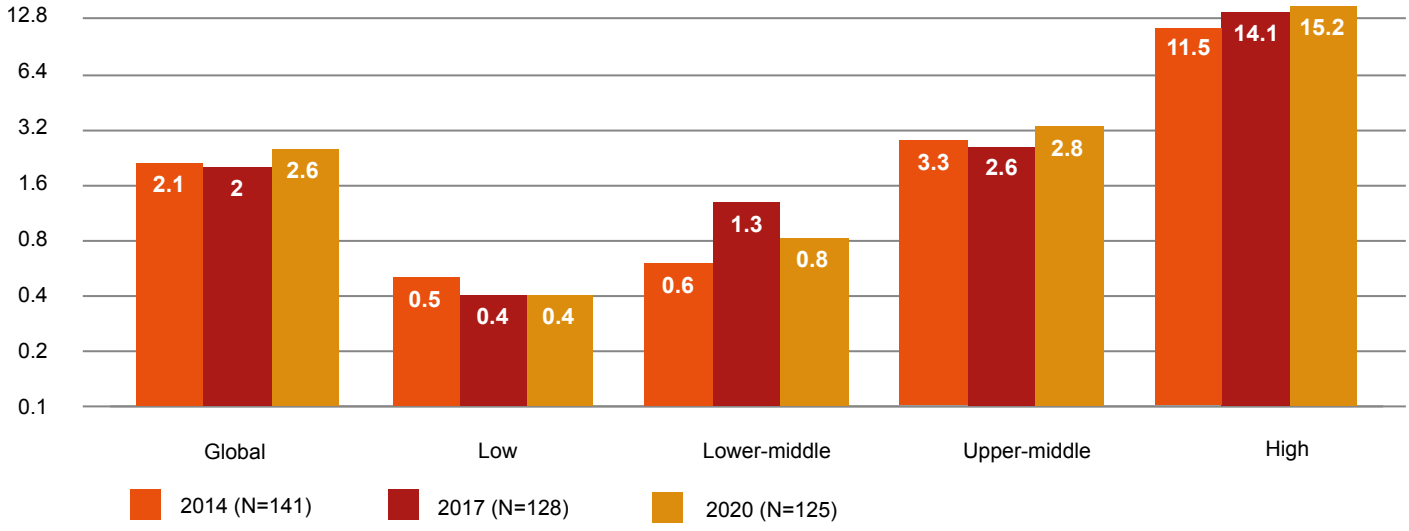


TABLE 4.2.6 Total numbers of mental health beds in inpatient facilities per 100 000 population, by WHO region and World Bank income group (2017 and 2020) (N=number of responding countries)

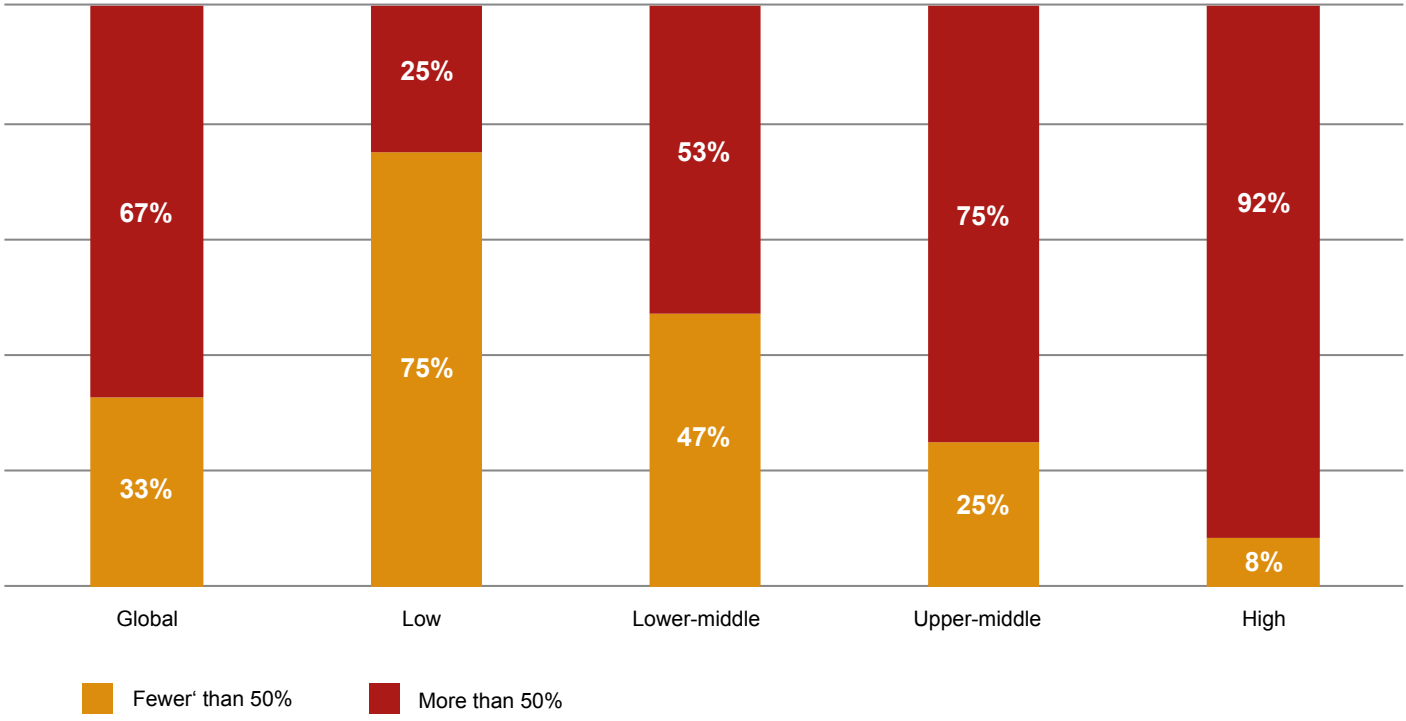
	Mental hospital beds		Psychiatric beds in general hospitals	
	2017	**2020**	**2017**	**2020**
Global	**12.54 (N=128)**	**10.8 (N=125)**	**2.0 (N=122)**	**2.5 (N=116)**
WHO region				
AFR	2.0 (N=27)	3.7 (N=23)	0.6 (N=30)	0.7 (N=25)
AMR	16.7 (N=27)	6.8 (N=27)	1.7 (N=21)	1.4 (N=22)
EMR	4.2 (N=15)	4.4 (N=17)	0.5 (N=11)	1.2 (N=11)
EUR	35.5 (N=41)	35.0 (N=39)	12.1 (N=38)	12.3 (N=35)
SEAR	2.1 (N=6)	3.6 (N=6)	0.8 (N=8)	1.3 (N=7)
WPR	14.8 (N=12)	11.2 (N=13)	4.2 (N=14)	4.6 (N=16)
World Bank income group				
Low	1.5 (N=18)	1.9 (N=15)	0.4 (N=20)	0.4 (N=17)
Lower-middle	4.6 (N=28)	3.8 (N=29)	1.3 (N=32)	0.8 (N=27)
Upper-middle	16.8 (N=41)	17.7 (N=40)	2.6 (N=36)	3.3 (N=34)
High	35.2 (N=41)	28.6 (N=41)	14.1 (N=34)	15.2 (N=38)

In the Mental Health Atlas 2020 questionnaire, Member States were asked for the first time to indicate the percentages of inpatients receiving timely diagnosis, treatment and follow-up for physical health conditions (e.g. cancer, tuberculosis, diabetes) in mental hospitals. Overall, 67% of responding countries confirmed that more than 50% of their inpatients benefited from such services, with high-income countries reporting a larger percentage than low-income countries. Of high-income countries that responded to this question, 92% reported that more than 50% of mental health inpatients received timely diagnosis, treatment and follow-up for physical health conditions. In comparison, just 25% of low-income countries reported that more than 50% of inpatients received timely diagnosis, treatment and follow-up (Table 4.2.7 and Figure 4.2.5).

TABLE 4.2.7 Physical care: percentage of mental health inpatients who receive timely diagnosis, treatment and follow-up for physical health conditions, by WHO region and World Bank income group (N=number of responding countries)

	Percentage of mental health inpatients who receive timely diagnosis, treatment and follow-up for physical health conditions (N=132)			
	<25%	**26%–50%**	**51%–75%**	**>75%**
Global	**43% (N=63)**	**57% (N=63)**	**28% (N=57)**	**72% (N=57)**
WHO region				
AFR	33% (N=10)	20% (N=6)	17% (N=5)	30% (N=9)
AMR	15% (N=4)	8% (N=2)	19% (N=5)	58% (N=15)
EMR	33% (N=6)	17% (N=3)	17% (N=3)	33% (N=6)
EUR	14% (N=5)	6% (N=2)	26% (N=9)	54% (N=19)
SEAR	29% (N=2)	0% (N=0)	43% (N=3)	29% (N=2)
WPR	13% (N=2)	13% (N=2)	13% (N=2)	63% (N=10)
World Bank income group				
Low	50% (N=10)	25% (N=5)	10% (N=2)	15% (N=3)
Lower-middle	28% (N=9)	19% (N=6)	31% (N=10)	22% (N=7)
Upper-middle	18% (N=8)	7% (N=3)	25% (N=11)	50% (N=22)
High	5% (N=2)	3% (N=1)	11% (N=4)	81% (N=29)

FIGURE 4.2.5 Percentage of mental health inpatients receiving timely diagnosis, treatment and follow-up for physical health conditions, by World Bank income group



Mental health inpatient care in community residential facilities

Community-based residential care facilities are non-hospital facilities providing overnight residence for persons with mental health conditions (e.g. staffed or unstaffed group homes or hostels, halfway houses, therapeutic communities). As shown in Table 4.2.8, such facilities scarcely exist in countries in the low- and lower-middle-income groups, where the number of facilities reported was less than 0.05 per 100 000 population. In high-income countries, on the other hand, the number of facilities was 1.90 per 100 000, and the number of beds was also greater than 25 per 100 000 population. This represented an increase from 2017 (20.4 beds per 100 000 population in high-income countries). The European Region had the highest number of facilities (2.8 facilities per 100 000 population), and the number of beds per 100 000 population in this region rose from 42.3 beds in 2017 to 53.3 in 2020. When data were disaggregated by sex, there was a remarkable dominance of this service by males in some regions, particularly in the Eastern Mediterranean and the South-East Asia Regions, which might potentially be attributable to cultural variation. In the high-, upper-middle- and lower-middle-income country groups, and in the European and Western Pacific Regions, there was a nearly equal sex distribution for utilization of this type of service.

TABLE 4.2.8 Median number of mental health community residential facilities, beds and admissions per 100 000 population, by WHO region and World Bank income group and disaggregated by sex (N=number of responding countries)

	Median number of community residential facilities, beds and admissions per 100 000 population			Median percentage of admissions, by sex	
	Facilities	**Beds**	**Admissions**	**Female**	**Male**
Global	**0.2 (N=61)**	**5.1 (N=57)**	**4.0 (N=33)**	**44% (N=22)**	**56% (N=22)**
WHO region					
AFR	0.03 (N=10)	0.6 (N=10)	4.0 (N=5)	39% (N=4)	61% (N=4)
AMR	0.2 (N=14)	1.1 (N=13)	0.4 (N=9)	41% (N=6)	59% (N=6)
EMR	0.7 (N=8)	1.5 (N=7)	1.4 (N=3)	18% (N=2)	82% (N=2)
EUR	2.8 (N=21)	53.3 (N=20)	22.3 (N=11)	48% (N=6)	52% (N=6)
SEAR	0.1 (N=3)	1.7 (N=3)	3.7 (N=2)	24% (N=1)	76% (N=1)
WPR	0.1 (N=5)	8.7 (N=4)	30.6 (N=3)	44% (N=3)	56% (N=3)
World Bank income group					
Low	0.02 (N=9)	1.0 (N=9)	1.2 (N=6)	36% (N=4)	64% (N=4)
Lower-middle	0.05 (N=11)	1.5 (N=10)	2.3 (N=5)	45% (N=4)	55% (N=4)
Upper-middle	0.3 (N=17)	1.7 (N=15)	2.2 (N=8)	55% (N=5)	45% (N=5)
High	1.9 (N=24)	25.4 (N=23)	26.4 (N=14)	44% (N=9)	56% (N=9)

BOX 3: INPATIENT CARE FOR CHILDREN AND ADOLESCENTS

Member States were also asked to report on the availability and provision of inpatient care services for children and adolescents. Sixty per cent of responding countries (51% of WHO Member States) reported the availability and provision of mental health inpatient services specifically for children and adolescents in mental hospitals and/or general hospitals, and 27% of responding countries (22% of WHO Member States) reported the availability and provision of mental health inpatient services in community residential facilities specifically for children and adolescents (e.g. group housing for young people with psychosis or developmental disabilities) (data not shown).

Based on the reported data for 2020, the provision of mental health facilities for children and adolescents is meagre (0.2 facilities per 100 000 population globally). There were 3.3 beds per 100 000 population and 34.2 admissions per 100 000 population. Although there were twice as many mental health beds in residential community facilities as in psychiatric hospitals (7.4 beds per 100 000 population compared with three beds per 100 000 population), the rate of admissions to psychiatric hospitals was more than three times greater than the number of admissions to community residential facilities (34.7 admissions per 100 000 population compared with 11.3 admissions per 100 000 population) (data not shown).

4.3 OUTPATIENT CARE

Outpatient care consists of both public and private and non-profit and for-profit facilities, including hospital-based outpatient facilities (e.g. outpatient departments and/or clinics located in mental and/or general hospitals, including those for specific mental health conditions, treatments or user groups), community-based mental health outpatient facilities (e.g. community mental health centres) and other outpatient facilities (e.g. residential facilities for specific mental health conditions). Definitions for these types of facility are provided in Appendix B. Outpatient care serves persons with both chronic and acute, and mild and severe, mental health conditions. It focuses on the management of mental health conditions using a bio-psychosocial approach.

It is important to note that large discrepancies were noted between data reported in 2017 and 2020 during the analysis and interpretation of data in this section on the availability of outpatient care services. Consequently, some country data were excluded from the analysis of outpatient care indicators, following a revision process in which data were checked against 2017 country profiles and WHO-AIMS[9] reports and with WHO Regional and Country Offices to clarify the reasons for discrepancies before a decision was made to discard either the 2017 or 2020 data, to discard both the 2017 and 2020 data or to keep the data. For this reason, data reported here for 2017 may not match data contained in the Mental Health Atlas 2017 report. Data for 2014 were not included in the revision process or the comparisons due to limited completion and data quality.

Proportionally, of the the 194 WHO Member States, 79% reported availability of hospital-based mental health outpatient facilities, 59% reported availability of community-based mental health outpatient facilities, and a little under 50% reported availability of other mental health outpatient facilities.

Table 4.3.1 summarizes overall adult mental health outpatient care services (including mental hospitals, community-based facilities and other outpatient facilities), by WHO region and World Bank income group for 2014, 2017 and 2020. According to data provided for 2020, the median number of outpatient facilities globally was 0.83 per 100 000 population, which represented a slight increase from 2017 (0.75 facilities per 100 000 population). The number of visits has increased steadily, from 1051 visits in 2014 to 1508.2 visits in 2017 and 2000.8 visits per 100 000 population in 2020.

As in the 2017 Mental Health Atlas report, there were significant differences between numbers of outpatient facilities and visits in different WHO regions and in countries at different income levels. For example, numbers of facilities in the European Region (two per 100 000 population) were 28 times greater than in the African Region (0.07 facilities per 100 000 population), while the number of visits was 78 times greater (7404.9 visits per 100 000 population compared with 94.4 visits per 100 000 population). In 2020, the total numbers of outpatient facilities per 100 000 population in high-income countries (2.28 facilities per 100 000 population) was 38 times greater than the number in low-income countries (0.06 facilities per 100 000 population), and the total number of outpatient visits (5849.6 visits per 100 000 population) was almost 60 times greater than in low-income countries (100.1 visits per 100 000 population). Numbers of outpatient visits decreased between 2017 and 2020 in the African Region, the Region of the Americas and the South-East Asia Region, but since 2014 numbers of visits have increased in all regions except the South-East Asia and Western Pacific Regions. Numbers of outpatient visits per 100 000 population have also increased since 2014 for the low- and high-income country groups, while they declined in countries in the lower-middle- and upper-middle-income groups.

[9] WHO MiNDbank: More Inclusiveness Needed in Disability and Development. WHO-AIMS Country Reports. https://www.mindbank.info/collection/type/whoaims_country_reports/all?page=all

TABLE 4.3.1 Total outpatient facilities and visits (hospital-based, community-based, other outpatient facilities): median rate per 100 000 population (2014, 2017 and 2020), by WHO region and World Bank income group (N=number of responding countries)

	Median numbers of outpatient facilities and visits, per 100 000 population				
	Facilities		Visits		
	2017	2020	2014	2017	2020
Global	**0.75 (N=136)**	**0.83 (N=136)**	**1051 (N=89)**	**1508.2 (N=109)**	**2000.8 (N=115)**
WHO region					
AFR	0.08 (N=29)	0.07 (N=25)	14 (N=17)	519.4 (N=22)	94.4 (N=18)
AMR	1.38 (N=30)	1.10 (N=28)	1165 (N=19)	3222.1 (N=22)	2936.1 (N=19)
EMR	0.48 (N=14)	0.52 (N=19)	990 (N=11)	605.8 (N=11)	1207.6 (N=16)
EUR	1.12 (N=36)	2.00 (N=37)	6688 (N=26)	4963.4 (N=32)	7404.9 (N=37)
SEAR	1.21 (N=9)	0.21 (N=8)	320 (N=7)	436.6 (N=5)	277.4 (N=6)
WPR	2.08 (N=18)	0.85 (N=19)	2321 (N=9)	692.7 (N=17)	2002.1 (N=19)
World Bank income group					
Low	0.06 (N=18)	0.06 (N=18)	83.8 (N=14)	83.8 (N=14)	100.1 (N=12)
Lower-middle	0.51 (N=37)	0.18 (N=32)	588.4 (N=24)	588.4 (N=24)	475.5 (N=24)
Upper-middle	1.08 (N=42)	0.87 (N=44)	2011.7 (N=36)	2011.7 (N=36)	1802.6 (N=39)
High	2.12 (N=39)	2.28 (N=42)	4968.5 (N=35)	4968.5 (N=35)	5849.6 (N=40)

* No comparable data for facilities were reported in 2014: data were available only for total population per facility per millions and converted per 100 000.

Globally, as shown in Table 4.3.2, there was slightly more utilization of outpatient services by males (52% of total visits) than females. This finding applies for all regions and income groups, except for the European Region and the Region of the Americas, where more female visits were reported (56% and 54% of total visits respectively). The trend was also reversed in high-income countries, where slightly more females using outpatient care services were reported (51% of total visits).

TABLE 4.3.2 Median percentage of total visits to outpatient services (hospital-based, community-based, other outpatient facilities), by WHO region and World Bank income group and disaggregated by sex (N=number of responding countries)

	Median percentage of visits to outpatient services, by sex	
	Female	**Male**
Global	**48% (N=76)**	**52% (N=75)**
WHO region		
AFR	45% (N=8)	55% (N=8)
AMR	56% (N=15)	44% (N=15)
EMR	43% (N=12)	57% (N=12)
EUR	54% (N=21)	46% (N=21)
SEAR	47% (N=5)	53% (N=5)
WPR	49% (N=15)	53% (N=14)
World Bank income group		
Low	47% (N=6)	53% (N=6)
Lower-middle	46% (N=20)	54% (N=20)
Upper-middle	46% (N=23)	54% (N=22)
High	51% (N=27)	49% (N=27)

* Note: values may not add up to 100% due to the use of median percentages

Hospital-based outpatient mental health services

According to responses from WHO Member States, there were on average 0.26 hospital-based outpatient mental health facilities per 100 000 population in 2020, and 1102.7 visits per 100 000 population were made to these facilities. While the number of hospital-based outpatient facilities has remained the same since 2017 (0.28 facilities per 100 000 population), there has been a slight increase in hospital-based outpatient visits (from 984 visits per 100 000 population in 2017 to 1102.7 in 2020). The average number of outpatient facilities per 100 000 population in high-income countries was more than six times higher than in low-income countries (0.51 facilities compared with 0.08 facilities). The number of visits to hospital-based outpatient services increased in line with countries' income levels. It was 36 times greater in high-income countries (3142.8 visits per 100 000 population) than in low-income countries (86.5 visits per 100 000 population) (Table 4.3.3).

TABLE 4.3.3 Median numbers of hospital-based mental health outpatient facilities and visits per 100 000 population, disaggregated by sex (median percentage), by WHO region and World Bank income group (N=number of responding countries)

	Median numbers of hospital-based mental health outpatient facilities and visits, per 100 000 population		Median percentage of visits, by sex	
	Facilities	**Visits**	**Female**	**Male**
Global	**0.26 (N=117)**	**1102.7 (N=102)**	**49% (N=65)**	**51% (N=64)**
WHO region				
AFR	0.06 (N=20)	78.5 (N=13)	49% (N=7)	51% (N=7)
AMR	0.32 (N=25)	914.9 (N=18)	57% (N=12)	43% (N=12)
EMR	0.1 (N=19)	586.9 (N=16)	40% (N=11)	60% (N=11)
EUR	0.5 (N=32)	3220.9 (N=34)	56% (N=17)	44% (N=17)
SEAR	0.1 (N=6)	403.8 (N=5)	46% (N=5)	54% (N=5)
WPR	0.85 (N=15)	1525.8 (N=16)	49% (N=13)	53% (N=13)
World Bank income group				
Low	0.08 (N=15)	86.5 (N=11)	53% (N=5)	47% (N=5)
Lower-middle	0.08 (N=26)	375.1 (N=18)	45% (N=18)	55% (N=18)
Upper-middle	0.32 (N=39)	1177.2 (N=35)	47% (N=20)	54% (N=19)
High	0.51 (N=37)	3142.8 (N=38)	53% (N=22)	47% (N=22)

* Note: values may not add up to 100% due to the use of median percentages.

Hospital-based outpatient facilities were used mainly by males, except in the Region of the Americas and the European Region, where male patients accounted for fewer than 45% of outpatient visits. Analysed by income level, low-income and high-income countries reported less utilization of outpatient mental hospital services by males (47% of total visits for both groups). Comparisons with 2017 show that numbers of visits increased in lower- and upper-middle-income countries, while decreasing in low- and high-income countries (data not shown).

Community-based outpatient mental health services

Globally, as shown in Table 4.3.4, community-based outpatient mental health facilities (0.55 facilities per 100 000 population) were more widely available than hospital-based outpatient mental health facilities (0.26 facilities per 100 000 population). However, such facilities (1085.80 visits per 100 000 population) were utilized less frequently than hospital-based outpatient facilities (1102.74 visits per 100 000 population). This applied to all WHO regions apart from the Region of the Americas and the European Region, where numbers of community-based outpatient visits were higher. This might reflect the centralization of care in hospital-based settings, and in South-East Asia Region might also be explained by the small number of countries reporting (N=2 to 5), which can potentially be attributed to the limitations of data collection at the time of the COVID-19 pandemic. Similarly, there were fewer community-based outpatient visits than hospital visits in all income groups. A slightly larger proportion of females (54% of total visits) used community-based outpatient services than males, with the biggest proportion reported in high-income countries (59% of total visits).

Numbers of community-based outpatient mental health facilities and also visits have decreased since 2017, from 0.81 facilities per 100 000 population in 2017 to 0.55 in 2020, and from 1244.01 visits per 100 000 population in 2017 to 1085.8 in 2020 (data not shown). Numbers of community-based outpatient facilities and visits have decreased across all WHO regions and income groups, except for the Eastern Mediterranean and the Western Pacific Regions. This decrease might reflect actual changes in the utilization of such services, or it could potentially be attributed to limitations in data collection imposed by the COVID-19 pandemic. More information and further analysis of available data are required to better understand the factors or reasons behind these trends across regions and income groups.

TABLE 4.3.4 Median numbers of community-based mental health outpatient facilities and visits per 100 000 population, by WHO region and World Bank income group and disaggregated by sex (N=number of responding countries)

	Median numbers of community-based mental health outpatient facilities and visits per 100 000 population		Median percentage of visits, by sex	
	Facilities	**Visits**	**Female**	**Male**
Global	**0.55 (N=81)**	**1085.8 (N=60)**	**54% (N=43)**	**46% (N=43)**
WHO region				
AFR	0.14 (N=12)	17.6 (N=8)	48% (N=5)	52% (N=5)
AMR	1.57 (N=19)	1559.1 (N=14)	59% (N=11)	41% (N=11)
EMR	0.29 (N=11)	498.0 (N= 9)	54% (N=8)	46% (N=8)
EUR	0.80 (N=26)	3331.2 (N=22)	55% (N=12)	45% (N=12)
SEAR	1.03 (N=5)	15.8 (N=2)	56% (N=3)	44% (N=3)
WPR	1.25 (N=8)	183.3 (N=5)	40% (N=4)	60% (N=4)
World Bank income group				
Low	0.12 (N=9)	30.1 (N= 5)	43% (N=4)	57% (N=4)
Lower-middle	0.18 (N=17)	188.9 (N=12)	48% (N=11)	52% (N=11)
Upper-middle	0.92 (N=25)	437.9 (N=19)	44% (N= 12)	56% (N=12)
High	1.92 (N=30)	3137.7 (N=19)	59% (N=16)	41% (N=16)

Other mental health services

Various other kinds of mental health service exist across countries, depending on available resources and defined needs. Examples include day treatment centres, residential facilities for persons with specific mental health conditions (e.g. people with intellectual disabilities, autism spectrum disorders, disorders due to substance use or dementia) and specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. services for survivors of gender-based violence or homeless people). Globally, however, response rates on the availability and utilization of such centres were low.

Where reported, the availability and utilization of these different mental health services were also low (0.19 facilities and 158.2 visits per 100 000 population). They were available mainly in high-income countries, particularly in the European Region, where 1.04 facilities and 592.0 visits per 100 000 population were reported in 2020, compared with 0.01 facilities and 3.4 visits in the African Region (Table 4.3.5).

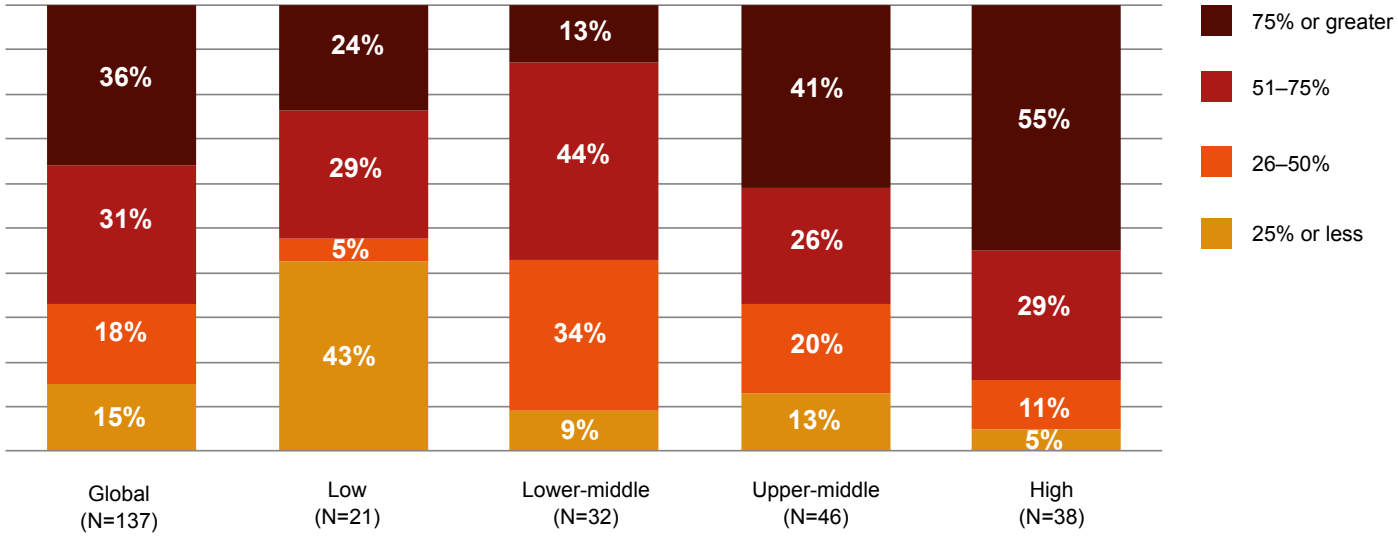
TABLE 4.3.5 Median numbers of other mental health outpatient facilities and visits per 100 000 population, by WHO region and World Bank income group and disaggregated by sex (N=number of responding countries)

	Median numbers of other mental health outpatient facilities and visits per 100 000 population		Median percentages of visits, by sex	
	Facilities	**Visits**	**Female**	**Male**
Global	**0.19 (N=55)**	**158.2 (N=38)**	**43% (N=26)**	**57% (N=26)**
WHO region				
AFR	0.01 (N=4)	3.4 (N=2)	40% (N=1)	60% (N=1)
AMR	0.14 (N=9)	104.9 (N=6)	62% (N=5)	38% (N=5)
EMR	0.07 (N=11)	468.3 (N=6)	46% (N=5)	54% (N=5)
EUR	1.04 (N=18)	592.0 (N=15)	48% (N=8)	52% (N=8)
SEAR	0.11 (N=5)	23.8 (N=2)	33% (N=1)	67% (N=1)
WPR	0.48 (N=8)	124.4 (N=7)	38% (N=6)	62% (N=6)
World Bank income group				
Low	0.00 (N=4)	5.1 (N=3)	32% (N=2)	68% (N=2)
Lower-middle	0.03 (N=9)	47.2 (N=5)	50% (N=3)	50% (N=3)
Upper-middle	0.12 (N=20)	170.6 (N=12)	36% (N=10)	64% (N=10)
High	1.04 (N=22)	705.5 (N=18)	46% (N=11)	54% (N=11)

Continuity of care

To assess continuity of care, as a proxy marker for the quality of the mental health care system, Member States were asked about the proportion of mental health inpatients discharged from hospitals who are followed up within one month. As shown in Figure 4.3.1, reported rates on this indicator (from 137 countries) were generally high, with over 67% of responding countries stating that more than 50% of discharged persons were seen within a month. Globally, the proportion of cases where fewer than 50% of discharged persons were seen within a month decreased from 37% in 2017 to 33% in 2020, reflecting an improvement in the continuity of care. It also fell across the different income groups, except for low-income countries, where the number of cases where fewer than 50% of discharged persons were seen within a month increased from 40% in 2017 to 48% in 2020 (data not shown).

FIGURE 4.3.1 Continuity of care: percentage of discharged persons seen within a month, by World Bank income group



BOX 4: OUTPATIENT CARE INDICATORS SPECIFICALLY FOR CHILDREN AND ADOLESCENTS, PER 100 000 POPULATION

Member States were also asked to report on the availability and provision of outpatient care services for children and adolescents. Of responding countries, 70% (60% of WHO Member States) reported the availability and provision of mental health outpatient services specifically for children and adolescents in hospital-based mental health outpatient facilities, 46% of responding countries (38% of WHO Member States) in community-based mental health outpatient facilities, 41% of responding countries (34% of WHO Member States) in school-based mental health centres and 46% of responding countries (37% of WHO Member States) in other outpatient services (data not shown).

According to the data reported for 2020, the total number of outpatient mental health facilities for children and adolescents was low, at 1.1 facilities per 100 000 population and with 1096.1 visits per 100 000 population. There were six times more community-based outpatient facilities than hospital-based outpatient facilities (1.2 compared with 0.2 facilities per 100 000 population) and twice as many visits to community-based outpatient facilities as to hospital-based outpatient facilities (1096.1 visits compared with 429.6 visits per 100 000 population). While the number of school-based outpatient facilities was highest (7.2 facilities per 100 000 population), the number of visits to these centres was the lowest for any kind of outpatient facility (50.5 visits per 100 000 population) (data not shown).

Community-based mental health services

One of the key objectives of the Comprehensive Mental Health Action Plan 2013–2030 is to provide comprehensive, integrated and responsive mental health and social care services in community-based settings. Global target 2.2 is for 80% of countries to have doubled their number of community-based mental health facilities by the year 2030. This is a new indicator in the Comprehensive Mental Health Action Plan and the data collected in 2020 will provide a baseline to for comparison in future Atlas reports.

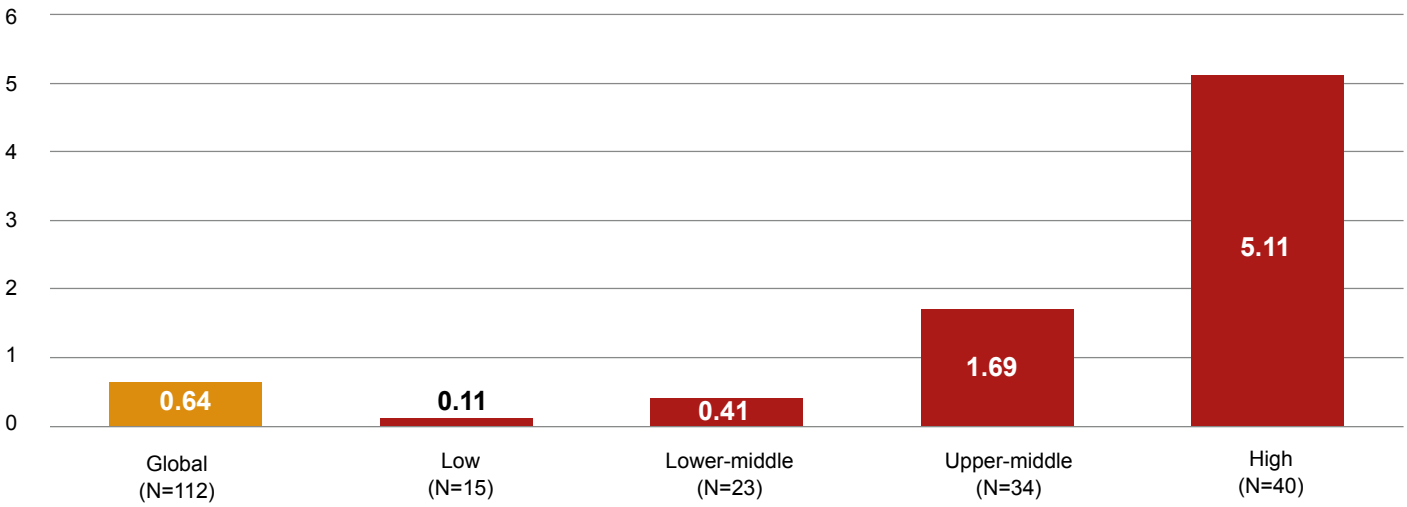
Community-based mental health services are defined as services that are provided in the community, outside a hospital setting. Data for this indicator include countries' reported number of community-based outpatient facilities (e.g. community mental health centres), other outpatient services (e.g. day treatment facilities) and mental health community residential facilities for adults.

TABLE 4.3.6 Median number of adult community-based mental health facilities per 100 000 population, by WHO region

	Number of countries	Median number of facilities per 100 000 population
Global	**112**	**0.64**
WHO region		
AFR	18	0.03
AMR	23	1.57
EMR	17	0.48
EUR	34	2.60
SEAR	6	0.99
WPR	14	0.46

As shown in Table 4.3.6, 112 responding countries reported that on average 0.64 community-based mental health facilities existed per 100 000 population. There was wide variation across WHO regions, from 0.03 community-based mental health facilities in the African Region to 2.60 facilities per 100 000 population in the European Region. Likewise, there was variation across World Bank income groups, with 0.11 community-based mental health facilities in the low-income group compared with 5.11 in the high-income group (Figure 4.3.2).

FIGURE 4.3.2 Median number of community-based mental health facilities per 100 000 population, by World Bank income group



4.4 TREATED PREVALENCE

Achieving universal health coverage, including for persons with mental health conditions, is the cornerstone of WHO's Thirteenth General Programme of Work (GPW) Impact Framework. Increased service coverage for persons with severe mental health conditions is one of the core targets of the WHO Comprehensive Mental Health Action Plan 2013–2030. This is defined as the proportion of persons with a mental health condition contacting a mental health service out of those estimated to have the condition over a period of 12 months. It reflects the actual contact between persons with mental health conditions and mental health services and also the quality of health information systems reporting on the utilization of mental health specialist services.

The 2014 and 2017 editions of the Mental Health Atlas showed that service utilization for persons with depression and bipolar disorders was extremely limited in most countries. For the 2020 edition, Member States were asked to report on service utilization for persons with psychosis, according to ICD-10 case definitions, as a proxy indicator of service coverage for severe mental health conditions. Data were gathered from specialist mental health facilities, run by government and non-government (for-profit or not-for-profit) providers. Service utilization, which refers to the number of people per 100 000 population who have received care from inpatient or outpatient mental health facilities over the previous year, served as a proxy for treated prevalence in specialist mental health services.

BOX 5: METHODOLOGY FOR ESTIMATION OF SERVICE COVERAGE IN THE MENTAL HEALTH ATLAS 2020

- Service coverage for psychosis was estimated, globally and regionally, using data collected for the Mental Health Atlas 2017 and 2020 following a methodology developed by Jaeschke et al.[10]

- Service coverage was defined as the proportion of persons with a mental health condition contacting a mental health service out of those estimated to have the condition during a 12-month period. This drew upon 12-month service utilization data collected for the Mental Health Atlas 2017 and 2020, according to the following formula:

  Total service coverage = total treated cases/expected cases.

- **Treated cases of psychosis** were estimated using 12-month service utilization data from specialist inpatient and outpatient) mental health facilities (section 8 of the Mental Health Atlas questionnaire). Data were excluded if: 1) they did not include service utilization for both inpatient and outpatient services, 2) their representativeness of the population was not reported, 3) the number of visits per individual case was less than 1.

  Total treated cases were calculated as follows:
  Total treated cases = inpatient cases + outpatient cases:
  Total treated cases per 100 000 population = 100 000 x (total treated cases/total population).

- **Expected cases of psychosis** were estimated using schizophrenia prevalence estimates from the Global Burden of Disease study (GBD) and total population sizes.

  Expected cases = prevalence rate x total population.[11]

[10] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19

[11] Vos T et al. (2017). Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990--2016: a systematic analysis for the Global Burden of Disease Study 2016. The Lancet, 390(10100):1211–1259. doi:10.1016/S0140-6736(17)32154-2

Prevalence rates for schizophrenia were adjusted to prevalence rates for non-affective psychosis based on a 0.49 ratio derived from the literature[12]. UN population estimates were used wherever a country did not report its population size, or its reported population size was notaby different from UN population estimates.

- **Case definitions:** GBD prevalence estimates and Mental Health Atlas service utilization data adhere to ICD-10 case definitions (schizophrenia F20, adjusted to non-affective psychosis F20–29).

- **Adjustment of service utilization data:** Countries were categorized as being either inpatient- or outpatient-prioritized based on reported data. To prevent double-counting of individuals, it was assumed in the data that all individuals utilizing inpatient facilities also used outpatient facilities in outpatient-prioritized countries. Total unique case adjustment was based on the reported rates of discharged inpatients making a follow-up outpatient visit within one month. This ranged from 1 (25% or less) to 4 (more than 75%). Adjusted outpatient utilization estimates were calculated by averaging the follow-up range, multiplying this by the number of inpatient cases and subtracting from the reported outpatient utilization value, as follows:

  Total unique treated cases = (outpatient cases) – (follow-up rate x inpatient cases) + inpatient cases.

  Adjusted total treated cases per 100 000 population = (unique cases/total population)/100 000.

- **Service coverage thresholds:** A validity check was designed to determine whether countries reported cases or visits by applying service coverage thresholds derived from published literature. The lower threshold for psychosis was based on the World Mental Health Survey[13] country with the lowest service estimate for severe conditions. No upper threshold was set, to acknowledge that there is potential for service coverage in specialist mental health services to be high.

- **Calculation of uncertainty and meta-analysis:** Standard errors around the service estimates of each country were calculated, and country-level data were aggregated by World Bank income group, WHO region and GBD super-region using random-effects meta-analyses.

[12] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19
[13] Harvard University. The World Mental Health Survey Initative. 2005. https://www.hcp.med.harvard.edu/wmh/participating_collaborators.php

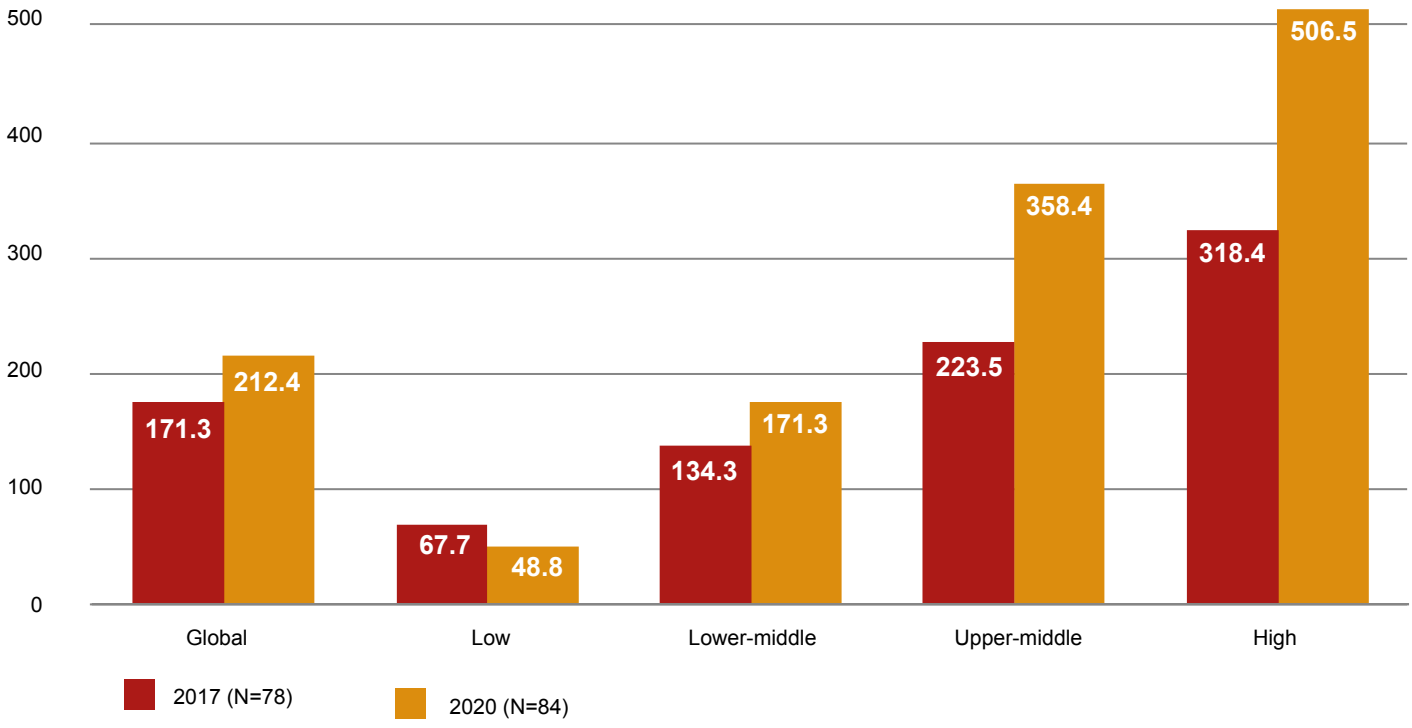
Service utilization

The service utilization rate for persons with psychosis was calculated based on the total number of persons admitted to inpatient facilities and treated in outpatient mental health centres per 100 000 population. According to the data reported by Member States, the rate was estimated to be 212.4 per 100 000 population in 2020, with large variations across World Bank income groups (Figure 4.4.1). The service utilization rate for persons with psychosis increased with countries' income levels, with rates in high-income and upper-middle-income countries (506.5 and 358.4 persons per 100 000 population respectively) more than seven times higher than rates in low-income countries (48.8 persons per 100 000 population). Since 2017, service utilization for persons with psychosis globally has increased from 171.3 to 212.4 persons per 100 000 population. It has also increased in every World Bank income group except for the low-income group, where service utilization has decreased from 67.7 persons per 100 000 population to 48.8 persons per 100 000 population. This indicates limited access to specialized mental health services in lower-income countries.

Member States were also asked whether data collected on service utilization were disaggregated by sex. According to their responses, 45% of persons with psychosis served by the mental health system were female and 55% were male (data not shown).

Of the countries responding to this section, 78% (53% of WHO Member States) reported using national-level data. In comparison, 36% of responding countries (22% of WHO Member States) reported using data that represented part of the country only. Ninety-one per cent of responding countries (59% of Member States) included data from government services, while only 25% of responding countries (15% of Member States) included data from non-government/NGOs. Finally, 47% of responding countries (28% of Member States) reported that data represented cases and not individual visits (data not shown).

FIGURE 4.4.1 Total service utilization rate for psychosis per 100 000 population, by World Bank income group (2017 and 2020)



Service coverage

Target 2.1 of the Comprehensive Mental Health Action Plan is, by 2030, to increase service coverage for mental health conditions at least by half. Indicator 2.1.1 measures the proportion of persons with psychosis who have used mental health services over the past 12 months.

Service coverage for psychosis was globally low in 2020 (29%). It is noteworthy that this is likely to be underestimation of the initial indicator since it assesses the proportion of persons with psychosis who have used only mental health services over the past 12 months, excluding primary health care services. As shown in Table 4.4.1 and Figures 4.4.2 and 4.4.3, fewer than 30% of persons with psychosis were served by mental health systems in 2020, except in the European Region and in high-income countries, where over 70% of persons with psychosis were served. There continues to be a wide gap between service coverage for persons with psychosis in low-income and high-income countries, with mental health systems serving only 12% of persons with psychosis in low-income countries compared with 70% in high-income countries. Comparisons with 2017 should be made with caution since response rates for both editions of the Mental Health Atlas were and extremely low in some WHO regions, such as the South-East Asia Region (N=2 in 2017, N=4 in 2020).

TABLE 4.4.1 Mean service coverage for psychosis (proportion of people with psychosis served by mental health systems), by WHO region and World Bank income group, 2017 and 2020

	Mean service coverage for psychosis			
	2017		2020	
	Number of countries	Percentage of people with psychosis served by mental health systems	Number of countries	Percentage of people with psychosis served by mental health systems
Global	**49**	**30%**	**47**	**29%**
WHO region				
AFR	8	12%	10	13%
AMR	11	18%	6	18%
EMR	7	18%	6	19%
EUR	15	63%	13	76%
SEAR	2	25%	4	16%
WPR	6	28%	8	29%
World Bank income group				
Low	6	9%	7	12%
Lower-middle	13	28%	11	29%
Upper-middle	14	28%	15	19%
High	16	67%	14	70%

FIGURE 4.4.2 Service coverage for psychosis, by WHO region

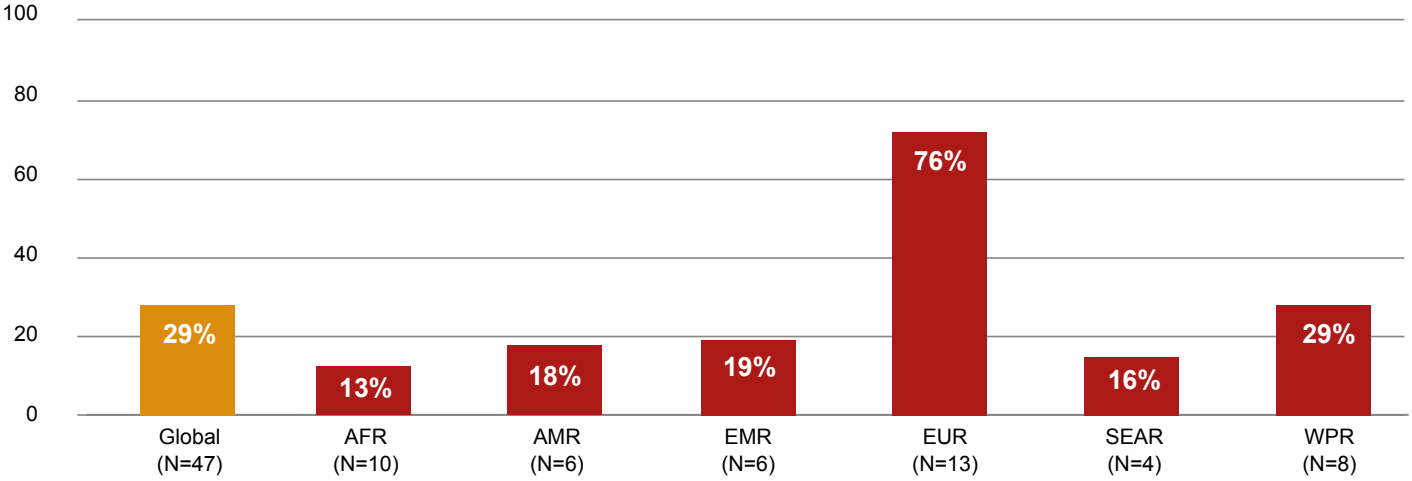
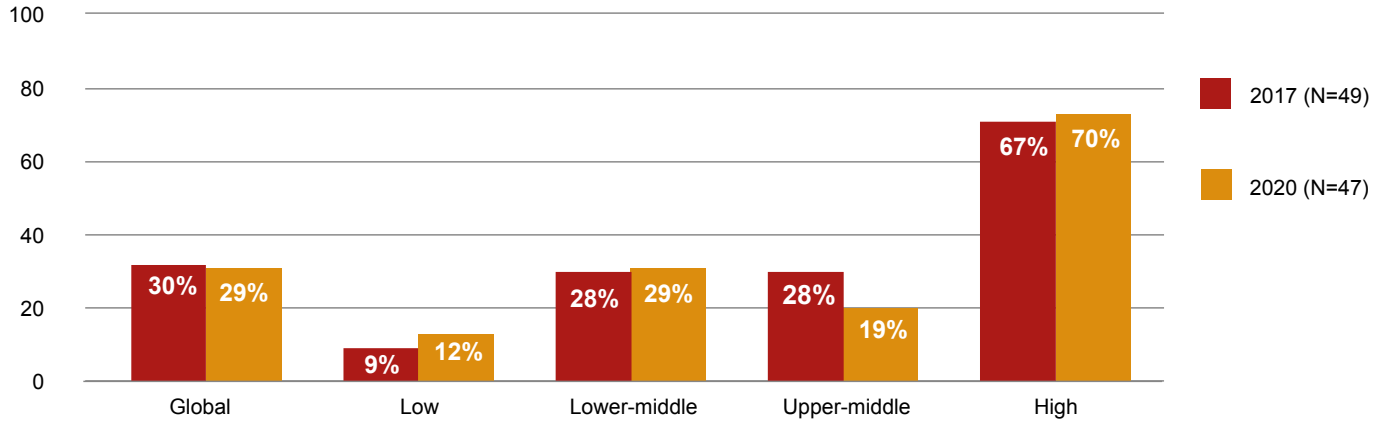


FIGURE 4.4.3 Service coverage for psychosis: comparison across World Bank income groups (2017 and 2020)



The Mental Health Atlas appears not to be the ideal method for estimating service coverage for depression.[14] This is not unexpected given that people living with depression tend to seek help first from general physicians or other primary health care facilities.[15] There is also a relative lack of help-seeking behaviour by people with depression compared with those suffering from psychosis. Based on Atlas data, mental health information services are less able to report complete data on outpatient services, which are the most appropriate facilities for managing depression.

At the time of writing, the most comprehensive and comparable estimates of service coverage for depression come from the World Mental Health Surveys, administered to 51,547 respondents in 21 countries.[16] These surveys estimate service coverage for depression of 18.2% in lower-middle-income countries, 31.1% in upper-middle-income countries, 50.6% in high-income countries and 40.3% overall.[17] Furthermore, among people with major depressive disorder, only 16.5% received minimally adequate treatment (22.4%, 11.4% and 3.7%, respectively, in high-, upper-middle-, and low-/lower-middle-income countries)[18].

While this method of data collection produces robust estimates of service coverage, it is immensely resource-intensive, and it is simply not feasible to conduct repeat cross-sectional surveys to measure trends over time. Other methods need to be explored. Data collection from sentinel primary care settings or facility-based surveys may be important to estimate service coverage for mental health conditions such as depression.

[14, 17] Jaeschke K, Hanna F, Ali S, Chowdhary N, Dua T, Charlson F. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017. Global Mental Health. 2021;8. doi:10.1017/gmh.2021.19

[15] Bifftu BB, Takele WW, Guracho YD and Yehualashet FA. Depression and Its Help Seeking Behaviors: A Systematic Review and Meta-Analysis of Community Survey in Ethiopia. Depression Research and Treatment, 2018; 1592596. https://doi.org/10.1155/2018/1592596

[16, 18] Thornicroft G et al. Undertreatment of people with major depressive disorder in 21 countries. The British Journal of Psychiatry, 2017; 210(2):119–124. doi:10.1192/bjp.bp.116.188078

4.5 SOCIAL SUPPORT

Social support refers to monetary or non-monetary welfare benefits from public funds that may be provided, as part of a legal right, to persons with health conditions that reduce their ability to function. For the Mental Health Atlas 2020, Member States were asked to report on the availability of government social support for persons with mental health conditions and to include specifically persons with mental health conditions who are officially recorded/recognized as receiving government support (e.g. disability payments or income support), but to to exclude persons with a mental health condition who receive monetary/non-monetary support from family members or from local charities or other NGOs. Social support can be provided in the form of income, housing, employment, education, social care or legal support.

Existence of government social support for persons with mental health conditions

The reported existence of government social support for persons with mental health conditions was high globally (over 85% of responding countries). However, it varied widely between regions and was strongly influenced by income level (Table 4.5.1). Across the different regions, more than 85% of countries reported that persons with mental health conditions benefited, to some extent, from social support; the African Region was an exception (56% of responding countries). All responding countries in the upper-middle- and high-income groups reported that persons with mental health conditions benefited from social support, compared with 39% of responding countries in the low-income group (Figure 4.5.1). A clear gap in support was evident in countries in the low-income group, with 61% reporting that no persons with severe mental health conditions received social support, and no countries reporting that a majority of persons with mental health conditions received such support.

FIGURE 4.5.1 Percentage of countries according to the number of persons with mental health conditions receiving government social support, by World Bank income group (N=164)

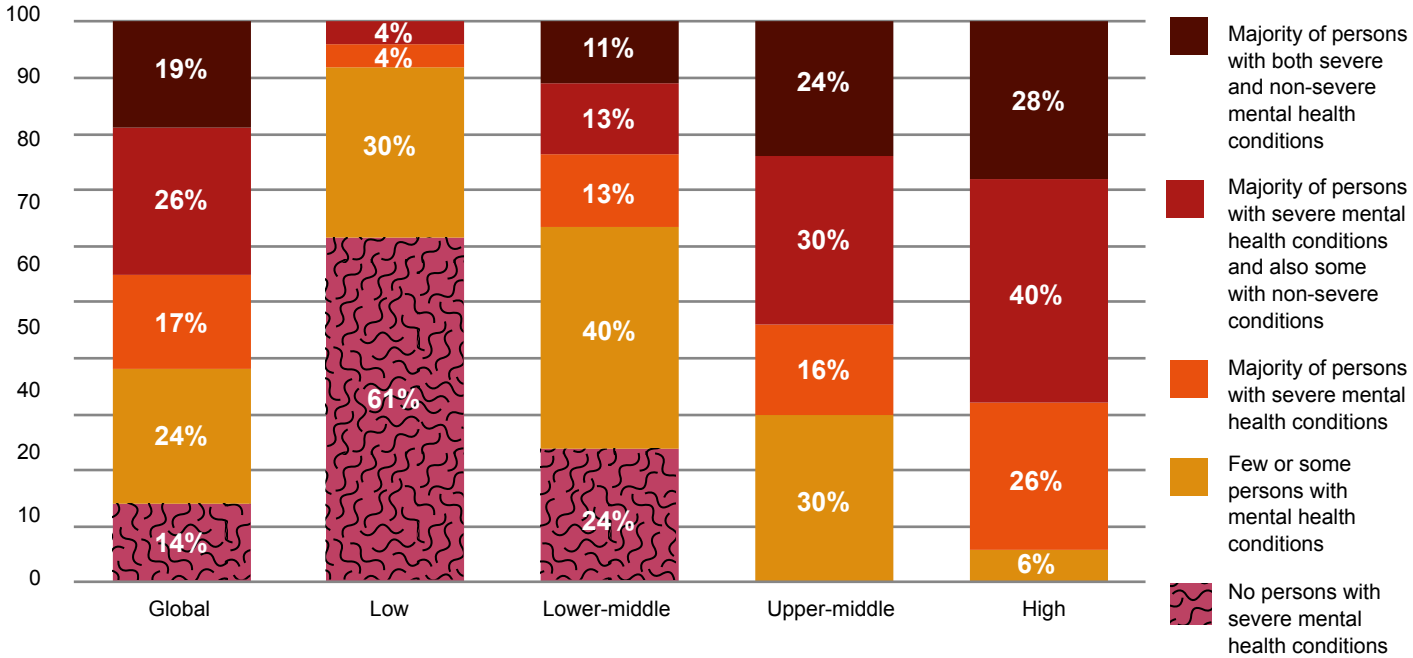


TABLE 4.5.1 Persons with mental health conditions receiving government social support, by WHO region and World Bank income group

	Percentage of countries according to the number of persons with mental health conditions receiving government social support (N=164)				
	No persons with severe mental health conditions	Few or some persons with severe mental health conditions	Majority of persons with severe mental health conditions	Majority of persons with severe mental health conditions and also some with non-severe conditions	Majority of persons with both severe and non-severe mental health conditions
Global	**14% (N=23)**	**24% (N=40)**	**17% (N=28)**	**26% (N=42)**	**19% (N=31)**
WHO region					
AFR	44% (N=16)	36% (N=13)	6% (N=2)	6% (N=2)	8% (N=3)
AMR	6% (N=2)	36% (N=12)	18% (N=6)	21% (N=7)	18% (N=6)
EMR	10% (N=2)	45% (N=9)	10% (N=2)	15% (N=3)	20% (N=4)
EUR	0% (N=8)	2% (N=1)	30% (N=13)	50% (N=22)	18% (N=8)
SEAR	0% (N=0)	50% (N=4)	0% (N=0)	25% (N=2)	25% (N=2)
WPR	13% (N=3)	4% (N=1)	22% (N=5)	26% (N=6)	35% (N=8)
World Bank income group					
Low	61% (N=14)	30% (N=7)	4% (N=1)	4% (N=1)	0% (N=0)
Lower-middle	24% (N=9)	40% (N=15)	13% (N=5)	13% (N=5)	11% (N=4)
Upper-middle	0% (N=0)	30% (N=15)	16% (N=8)	30% (N=15)	24% (N=12)
High	0% (N=0)	6% (N=3)	26% (N=14)	40% (N=21)	28% (N=15)

* Note: values may not add up to 100% due to the use of median percentages.

There has been a slight increase (5%) in the reported availability of social support for persons with mental health conditions since 2017, with the proportion of responding countries with such support available increasing from 81% (68% of WHO Member States) in 2017 to 86% (73% of WHO Member States) in 2020. While the proportion of countries reporting the availability of social support has increased in the lower-, upper-middle- and high-income groups since 2017, the proportion of countries in the low-income group reporting that social support is available has declined, from 71% of responding countries in 2017 to 39% of responding countries in 2020 (data not shown). This reported decline may be due either to a real decline of available social support in the low-income group or to methodological limitations of self-reported data; this needs better monitoring in the future. Although the utilization of Mental Health Atlas datasets at successive time points can provide important information and insights into emerging trends in mental health social support, such comparisons of data over time are heavily constrained by the fact that country data are not always available at all relevant time points.

Main forms of social support provided for persons with mental health conditions

Mental health focal points were also asked about the main forms of social support provided by their country's government to persons with mental health conditions. Similar to data reported in 2017, the main types of government social support were social care support (73%) and income support (67%), while housing, employment, education and legal support were reported in fewer than 45% of responses. It is notable that only 24% of the 168 responding countries provided all six forms of social support, corresponding to just 19% of WHO Member States. On a positive note, there has been an overall increase in all forms of social support since 2017 (Figure 4.5.2). However, large discrepancies persist across income groups (Table 4.5.2): for example, 96% of responding countries in the high-income group reported that income support and social care were provided, compared with 21% of responding countries in the low-income group for income support and 38% for social care support. Differences were even more significant for housing and employment support, which were provided by 76% of responding countries in the high-income group but by just 4% of those in the low-income group. Housing was the least reported form of social support globally, while social care support was the most frequently reported type of social support.

FIGURE 4.5.2 Percentage of responding countries according to the main forms of social support provided for persons with mental health conditions: global percentages and comparison across years (2017 and 2020)

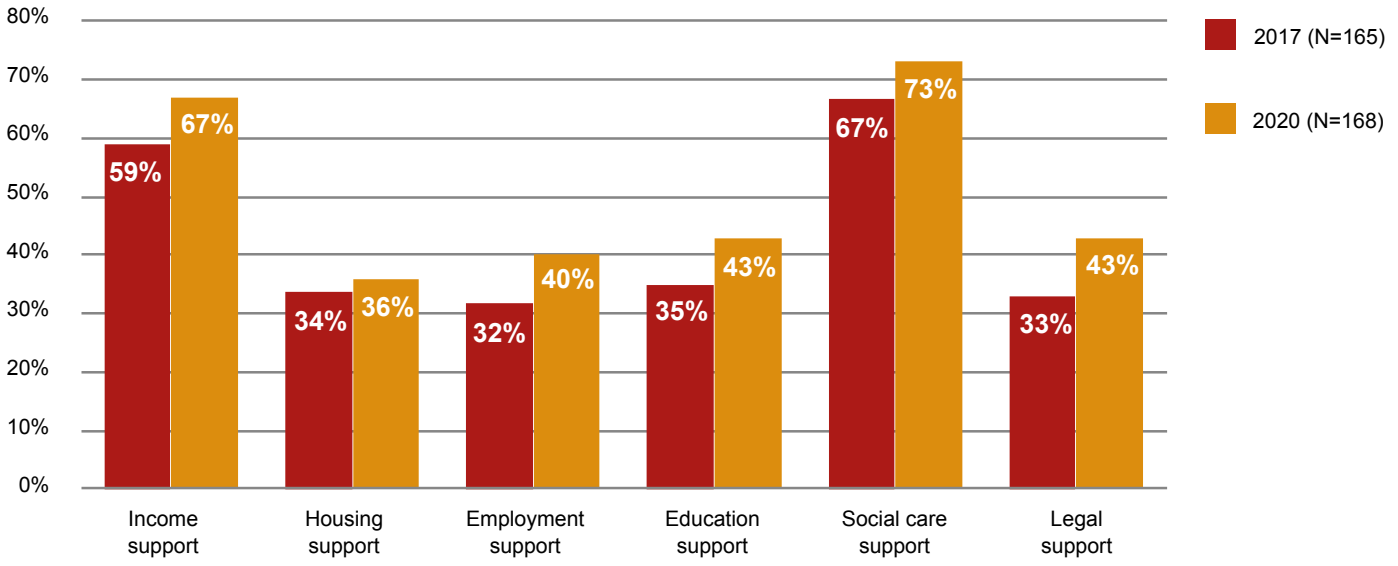


TABLE 4.5.2 Percentage of countries according to the main forms of social support provided for persons with mental health conditions, by WHO region and World Bank income group

	Percentage of responding countries according to the main forms of social support provided for persons with mental health conditions					
	Income support (N=168)	Housing support (N=168)	Employment support (N=168)	Education support (N=168)	Social care support (N=168)	Legal support (N=168)
Global	**67% (n=112)**	**36% (n=61)**	**40% (n=67)**	**43% (n=72)**	**73% (n=123)**	**43% (n=72)**
WHO region						
AFR	24% (n=9)	8% (n=3)	5% (n=2)	11% (n=4)	53% (n=20)	18% (n=7)
AMR	76% (n=25)	46% (n=15)	42% (n=14)	39% (n=13)	79% (n=26)	46% (n=15)
EMR	65% (n=13)	25% (n=5)	25% (n=5)	35% (n=7)	70% (n=14)	35% (n=7)
EUR	96% (n=43)	67% (n=30)	71% (n=32)	69% (n=31)	96% (n=43)	60% (n=27)
SEAR	63% (n=5)	0% (n=0)	38% (n=3)	63% (n=5)	50% (n=4)	75% (n=6)
WPR	71% (n=17)	33% (n=8)	46% (n=11)	50% (n=12)	67% (n=16)	42% (n=10)
World Bank income group						
Low	21% (n=5)	4% (n=1)	4% (n=1)	4% (n=1)	38% (n=9)	17% (n=4)
Lower-middle	33% (n=13)	8% (n=3)	13% (n=5)	28% (n=11)	56% (n=22)	33% (n=13)
Upper-middle	83% (n=43)	33% (n=17)	40% (n=21)	48% (n=25)	79% (n=41)	48% (n=25)
High	96% (n=51)	76% (n=40)	76% (n=40)	66% (n=35)	96% (n=51)	57% (n=30)

Social care for people with mental health conditions requires a comprehensive and multidisciplinary approach. Only 24% of responding countries reported covering all six of the categories of social support included in the questionnaire (Table 4.5.3). No countries in the South-East Asia Region reported covering all six types of social support. The limited availability of a comprehensive approach to social support for people with mental health conditions reflects gaps in the essential services required by such people for daily living and for integration into their communities.

TABLE 4.5.3 Total forms of social support for persons with mental health conditions: number and proportion of countries covering all six types of social support, by WHO region and World Bank income group

	Countries covering all six types of social support (N=168)	
	Number of countries	Percentage of responding countries
Global	**36**	**24%**
WHO region		
AFR	2	5%
AMR	8	24%
EMR	2	10%
EUR	17	38%
SEAR	0	0%
WPR	7	29%
World Bank income group		
Low	15	0.11
Lower-middle	23	0.41
Upper-middle	34	1.69
High	40	5.11

MENTAL HEALTH ATLAS 2020

5 MENTAL HEALTH PROMOTION AND PREVENTION

5.1 MENTAL HEALTH PROMOTION AND PREVENTION PROGRAMMES

National health authorities have a major role to play in the treatment and promotion of mental health and the prevention of mental health conditions in all sectors and across the life course. The WHO Comprehensive Mental Health Action Plan recommends that Member States lead and coordinate universal and targeted interventions from the early stages of life and across the life span to prevent mental health conditions and to reduce stigmatization, discrimination and human rights violations. It emphasizes the importance of integrating such interventions into national health promotion strategies and also the responsiveness of such strategies to core individual attributes in the different formative stages of life and adaptation to the needs of specific vulnerable groups.

The promotion of mental health and the prevention of mental health conditions was highlighted in the Sustainable Development Agenda adopted at the United Nations General Assembly in September 2015. SDG 3 aims to ensure healthy lives and, among other targets, to promote mental health and well-being. SDG Target 3.4 is, by 2030, to reduce by one third premature mortality from non-communicable diseases (NCDs) through prevention and treatment and promotion of mental health and well-being, the suicide rate being an indicator (3.4.2) for this target. This is matched by Objective 3 of the Comprehensive Mental Health Action Plan, which focuses on developing and implementing strategies for promotion and prevention in mental health, including prevention of suicide and self-harm as a priority. Global target 3.1 of the Action Plan is for 80% of countries to have at least two functioning national, multisectoral prevention and promotion programmes in place by 2030.

Similar to previous versions of the Mental Health Atlas, in the 2020 edition a mental health promotion and prevention programme is considered to be "functional" only if at least two of the following three characteristics are fulfilled: 1) dedicated financial and human resources; 2) a defined plan of implementation; and 3) evidence of progress and/or impact. Programmes that did not meet this threshold or were obviously associated with treatment or care were excluded from the analysis.

In all, 167 countries reported a total of 572 programmes. Of these programmes, 176 (31% of total reported programmes) did not have dedicated human and financial resources, 154 (27% of total reported programmes) did not have a defined plan, and 223 (39% of total reported programmes) did not have documented evidence of progress and/or impact.

Functioning mental health promotion and prevention programmes

In total, 101 countries, corresponding to 68% of responding countries and 52% of WHO Member States, reported having at least two functioning mental health promotion and prevention programmes in place, which represents an increase since 2017 (45% of WHO Member States) and a step forward on the way to the 2030 global target of 80% (Table 5.1.1). Based on the responses, over 60% of WHO Member States in the Western Pacific Regions reported having at least two functioning programmes, compared with fewer than 30% of WHO Member States in the African Region.

The percentage of WHO Member States with at least two functioning programmes has varied across regions since 2017. Rates in the Eastern Mediterranean Region have remained unchanged; they have decreased in the South-East Asia Region but have increased in the rest of the world. Countries in the Region of the Americas reported the most notable increase (from 40% to 57% of WHO Member States), followed by countries in the Western Pacific Region (from 52% to 63% of WHO Member States) (Table 5.1.1).

There was variation between income groups, with 50% of responding countries in low-income countries and 52% in lower-middle-income countries (35% of WHO Member

States) reporting at least two functioning promotion and prevention programmes, compared with 71% of responding countries (55% of WHO Member States) in upper-middle-income countries and 84% (72% of WHO Member States), in high-income countries (Figure 5.1.1).

As mentioned above, 572 promotion and prevention programmes in total were reported in 2020. Of these, only 420 qualified as "functional" (73% of the total), but this still marked a significant increase from the baselines in 2014 (80 functional programmes) and 2017 (356 functional programmes). It is important to note that both the 2014 and 2017 questionnaires allowed Member States to report a maximum of five programmes, while the 2020 questionnaire allowed for an unlimited number of programmes. While to a great extent the increase in numbers can be attributed to this methodological change in data collection, it might also be linked to improved reporting by Member States, increased completion rates for the Mental Health Atlas indicators and/or improved data checking processes. It is noteworthy that this indicator was included for the first time in the 2014 edition of the Atlas, allowing for time to improve the availability of data related to mental health promotion and prevention programmes. The overall increase might also reflect increased attention to and investment in promotion and prevention programmes since their inclusion in the SDG in 2015.

FIGURE 5.1.1 Mental health promotion and prevention programmes: proportion of countries with at least two functioning programmes, by World Bank income group

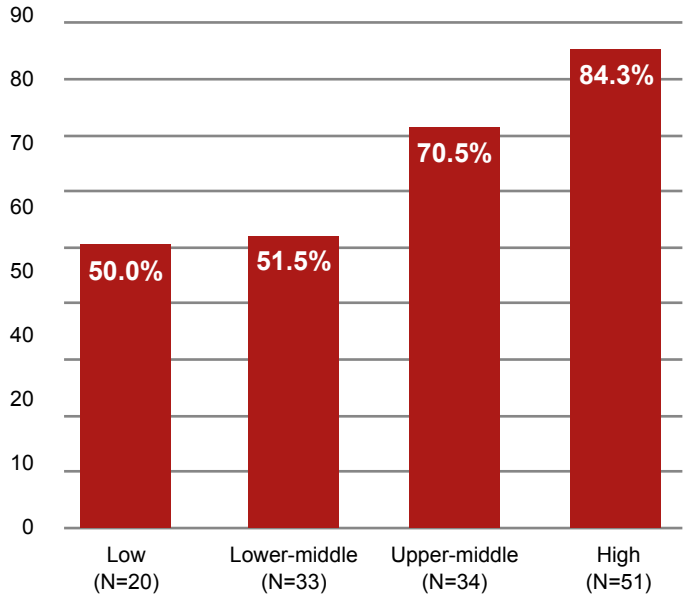


TABLE 5.1.1 Mental health promotion and prevention programmes: percentage of countries with at least two functioning programmes, by WHO region (2017 and 2020)

	Percentage of countries with at least two functioning mental health promotion and prevention programmes			
	Percentage of responding countries		Percentage of WHO Member States	
	2017 (N=123)	2020 (N=148)	2017	2020
Global	**71% (n=87)**	**68% (n=101)**	**45%**	**52%**
AFR	48% (n=12)	41% (n=13)	25%	28%
AMR	78% (n=14)	69% (n=20)	40%	57%
EMR	80% (n=12)	79% (n=15)	57%	58%
EUR	78% (n=29)	80% (n=31)	54%	59%
SEAR	75% (n=6)	71% (n=5)	54%	45%
WPR	70% (n=14)	77% (n=17)	52%	63%

In addition to the regional and thematic distribution of promotion and prevention programmes, programmes were categorized according to their geographical scope (national, regional, district) and ownership/management (government, NGO, private, jointly managed). According to the data reported, most functioning programmes are national programmes (over 80% globally).

The Mental Health Atlas 2020 questionnaire asked about countries' prevention and promotion programmes in the following specific thematic areas: suicide prevention, mental health awareness/anti-stigma, early childhood development, school-based mental health prevention and promotion, parental/maternal mental health promotion and prevention, work-related mental health prevention and promotion and mental health and psychosocial support (MHPSS) components of disaster preparedness and/or disaster risk reduction (DRR). As shown in Table 5.1.2, the most frequently reported functional programmes in 2020 were mental health awareness/anti-stigma programmes and school-based mental health promotion and prevention programmes (51% of responding countries), followed by early childhood development (45% of responding countries) and suicide prevention programmes (39% of responding countries). Work-related mental health and parental/maternal mental health promotion and prevention programmes were the least frequently reported by Member States (35% and 29% of responding countries respectively).

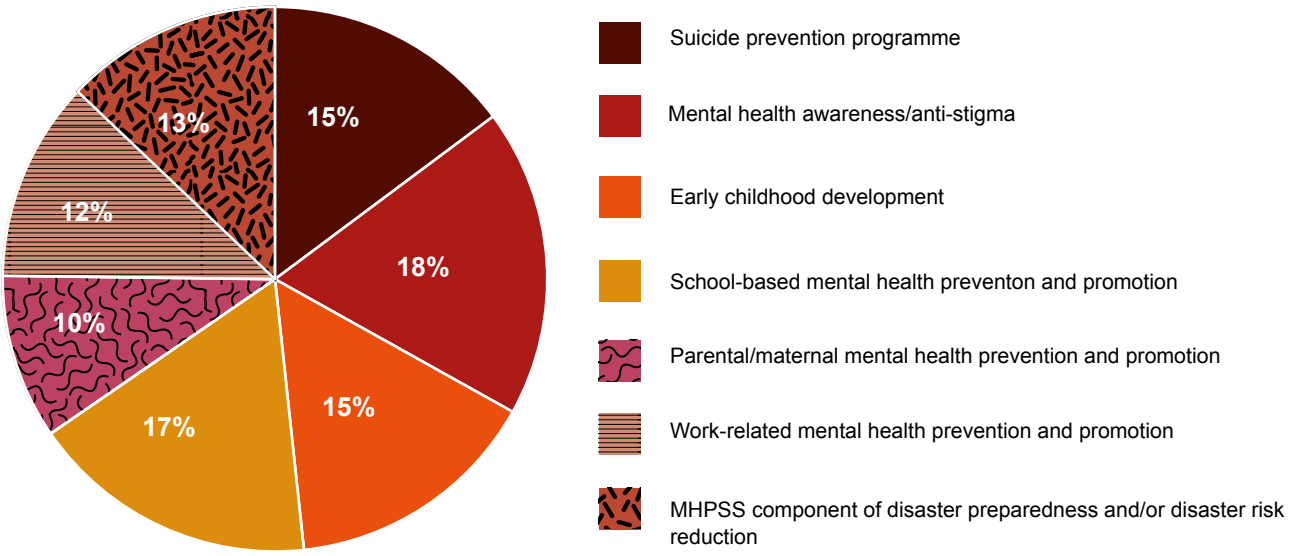
Looking at the types of programme reported, 18% of all functioning prevention and promotion programmes reported were described as mental health awareness and anti-stigma programmes (Figure 5.1.2). This is consistent with the 2017 edition of the Atlas, when mental health awareness represented the most common type of prevention and promotion programme reported (40% of all functioning programmes). However, more in-depth comparisons with the 2017 edition are limited by differences in the format of the question used in the 2020 round of the questionnaire.

Member States were able to report on different types of programme in 2017, while in 2020 categories were fixed according to seven specific thematic areas, in order to facilitate analysis based on prioritized thematic areas.

TABLE 5.1.2 Main types of functioning programme

	Main types of functioning programme in reporting countries	
	Number of countries	Percentage of countries
Mental health awareness/ anti-stigma (N=151)	77	51%
School-based mental health prevention and promotion (N=142)	72	51%
Early childhood development (N=142)	64	45%
Suicide prevention (N=161)	62	39%
Mental health and psychosocial support component of disaster preparedness and/or disaster risk reduction (N=139)	54	39%
Work-related mental health prevention and promotion (N=145)	50	35%
Parental/maternal mental health promotion and prevention (N=141)	41	29%

FIGURE 5.1.2 Promotion and prevention programmes (N=420): main types of functioning programme (percentage of total functioning programmes)



Existence of systems for mental health and psychosocial preparedness for emergencies/disasters

Reporting on systems in place for mental health and psychosocial preparedness for emergencies/disasters was recommended by the Seventy-fourth World Health Assembly and adopted in the updated Comprehensive Mental Health Action Plan 2013–2030, given the need to also support recovery from the COVID-19 pandemic. Objective 3 of the Action Plan includes strengthening preparedness, response capacity and resilience for future public health emergencies. Target 3.3 of the Action Plan is for 80% of countries to have a system for MHPSS in place by 2030.

The composite term MHPSS is used in the Inter-Agency Standing Committee (IASC) guidelines on mental health preparedness and social support in emergency settings to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder".[19] The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies such as the COVID-19 outbreak, including those working with biological approaches and sociocultural approaches in health, social, education and community settings, as well as to "underscore the need for diverse, complementary approaches in providing appropriate support".[20]

While traditionally MHPSS services have been focused primarily on the response and recovery phases of emergencies, research has suggested a clear need for the development of MHPSS with a DRR perspective, thus shifting paradigms towards "upstream" approaches targeting preparedness and prevention. This integrated approach focuses on capacity- and system-building; preparedness; policy development, consensus-building and awareness-raising; school- and child-focused initiatives; inclusive DRR; and resilience promotion as mandatory elements for the mainstreaming of MHPSS and DRR.

[19] IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007; p.1. https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

[20] IASC. Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak (circulated on 17 March 2020). https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing-note-addressing-mental-health-and-psychosocial-aspects-covid-19-outbreak

In the Mental Health Atlas 2020 questionnaire, countries were asked for the first time about the existence of functioning programmes on mental health and psychosocial preparedness with a designated component focused on DRR. Of the 139 countries that answered this question, 54 countries, corresponding to 39% of responding countries or 28% of WHO Member States, reported the existence of such programmes (Table 5.1.2). Such programmes represented 13% of total functioning promotion and prevention programmes reported overall (Figure 5.1.2).

5.2 SUICIDE PREVENTION

In 2019 suicide accounted for an estimated 703 000 deaths worldwide,[13] and it is therefore a prevention priority area in mental health. Suicide is the fourth most common cause of death among young people worldwide, and it affects in particular vulnerable and marginalized populations. People with mental health conditions experience disproportionately higher rates of disability and mortality than the general population, owing to physical health problems but also to suicide. Target 3.2 of the Comprehensive Mental Health Action Plan 2013–2020 called for a 10% reduction in the rate of suicide in countries by 2020, while SDG Target 3.4, addressing NCDs and mental health, includes an indicator for the reduction of mortality due to suicide by one third by 2030 (the only indicator for mental health). Following this lead, the extended Comprehensive Mental Health Action Plan 2013–2030 revised this target to also aim for a reduction of one third in the rate of suicide by 2030. As there are many risk factors associated with suicide beyond mental health conditions, such as chronic pain or acute emotional distress, or access to means of suicide, the Action Plan calls for comprehensive national suicide prevention strategies with collaboration not only by the health sector but also by other sectors simultaneously.

Data on age-standardized suicide rates per 100 000 population were taken from the WHO Global Health Observatory.[21] As shown in Table 5.2.1, the global age-standardized suicide rate in 2019 was estimated at 9.0 deaths per 100 000 population; this represents a 10% reduction in the rate of suicide since the 2013 baseline of 10.0 per 100 000 population.[22] Rates continue to be higher among males than females, at 12.6 and 5.4 per 100 000 respectively in 2019. While the majority of deaths by suicide occurred in low- and middle-income countries (77%), where most of the world's population live [22], the highest suicide rates are found in high-income countries (10.9 per 100 000 population in 2019), as shown in Table 5.2.1.

TABLE 5.2.1 Age-standardized suicide rates per 100 000 population in 2019, by WHO region and World Bank income group

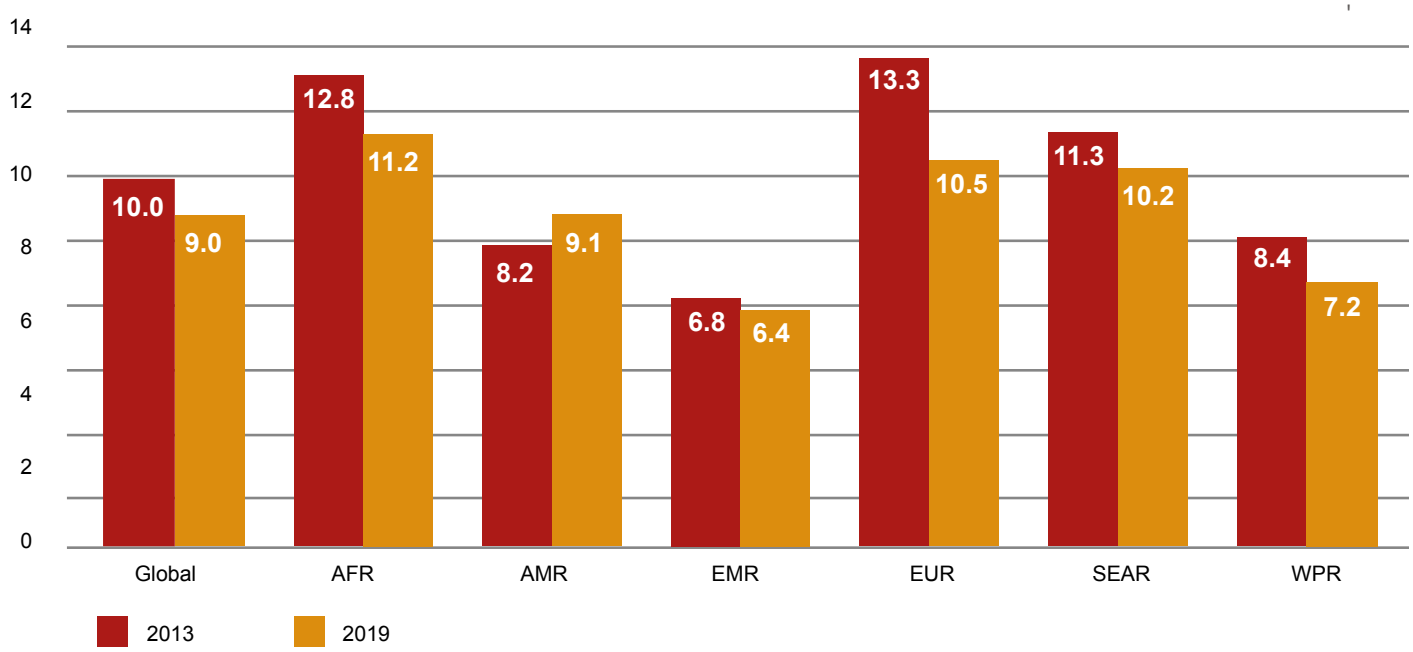
	Age-standardized suicide rate per 100 000 population, 2019		
	Male	Female	Both sexes
Global	**12.6**	**5.4**	**9.0**
WHO region			
AFR	18.0	5.2	11.2
AMR	14.2	4.1	9.0
EMR	9.1	3.5	6.4
EUR	17.1	4.3	10.5
SEAR	12.3	8.1	10.2
WPR	9.6	4.8	7.2
World Bank income group			
Low	15.2	5.3	9.9
Lower-middle	13.1	7.1	10.1
Upper-middle	10.7	4.1	7.3
High	16.5	5.4	10.9

Source: WHO, Global Health Estimates 2000–2019.

[21] World Health Organization. Global Health Observatory (GHO) data; 2019. http://www.who.int/gho/en/
[22] World Health Organization. Suicide in the World: Global Health Estimates. Geneva: WHO; 2019. https://apps.who.int/iris/bitstream/handle/10665/326948/WHO-MSD-MER-19.3-eng.pdf

Figure 5.2.1 provides age-standardized suicide rates per 100 000 population in different WHO regions in 2013 and 2019. Similar to reported figures in 2013, rates continue to be highest in the African, the European and the South-East Asia Regions, each of which has a suicide rate of over 10.0 per 100 000 population. By contrast, the Eastern Mediterranean (6.4 per 100 000 population) and the Western Pacific Regions (7.2 per 100 000) reported the lowest rates. Breaking down the figures by national income level, suicide rates per 100 000 varied from 7.3 in countries in the upper-middle-income group to 10.9 in the high-income group (Table 5.2.1). Since 2013, every income group has seen a decrease in the suicide rate per 100 000 population. Similarly, the suicide rate has decreased in every WHO region since 2013 except for the Region of the Americas, where it has increased from 8.2 to 9.0 per 100 000 population.

FIGURE 5.2.1 Age-standardized suicide rates per 100 000 population, by WHO region, 2013 and 2019 (both sexes)



Suicide prevention policies, strategies or plans

Member States were asked in the Mental Health Atlas 2020 questionnaire whether they had a stand-alone or integrated national suicide prevention strategy, policy or plan. In total, 35 countries (21% of responding countries, or 18% of WHO Member States), reported that they had a stand-alone prevention strategy, policy or plan (Table 5.2.2). Only one country, or 3% of responding countries, in the African Region reported having a stand-alone strategy, policy or plan for suicide prevention. In comparison, around one third of countries in the Region of the Americas (33% of responding countries) and the European Region (30% of responding countries) reported having such a strategy. Significant variations also existed across income groups, with just 4% of low-income countries reporting that they had a suicide prevention stand-alone strategy, policy or plan, compared with 37% of high-income countries.

Sixty-seven countries (40% of responding countries, or 35% of WHO Member States) reported that they had a stand-alone or integrated suicide prevention strategy, policy or plan. However, 60% of responding countries, or more than half of WHO Member States (52%), did not have such a plan, either stand-alone or integrated. Of those with a suicide prevention plan, 55% of responding countries reported that its most recent publication or revision had taken place after 2017, 32% between 2013 and 2016, and 13% before 2013.

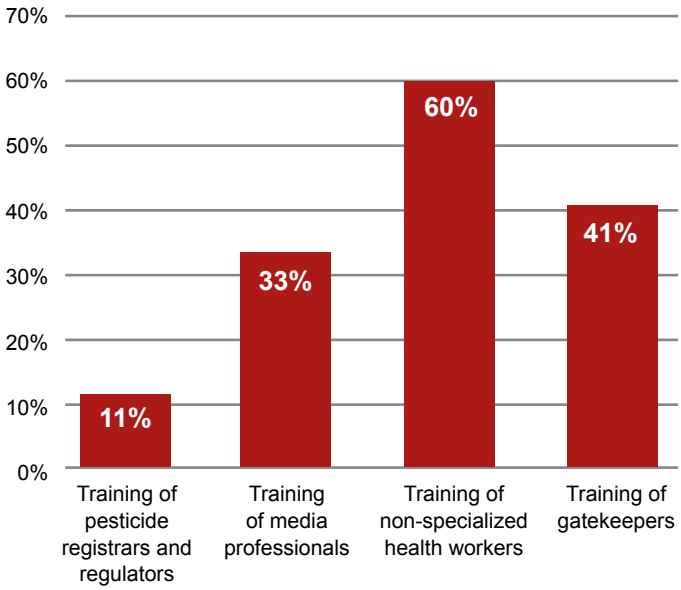
TABLE 5.2.2 Percentage of responding countries with a stand-alone or integrated suicide prevention strategy, policy or plan, by WHO region and World Bank income group

	Countries with a stand-alone or integrated suicide prevention strategy, policy or plan (N=168)					
	Stand-alone		Integrated		No strategy/policy/plan	
	Number of countries	Percentage of responding countries	Number of countries	Percentage of responding countries	Number of countries	Percentage of responding countries
Global	**35**	**21%**	**32**	**19%**	**101**	**60%**
WHO region						
AFR	1	3%	5	13%	32	84%
AMR	11	33%	5	15%	17	52%
EMR	2	10%	4	20%	14	70%
EUR	14	30%	9	20%	23	50%
SEAR	2	25%	3	38%	3	38%
WPR	5	22%	6	26%	12	52%
World Bank income group						
Low	1	4%	2	8%	21	88%
Lower-middle	4	11%	8	21%	26	68%
Upper-middle	10	19%	12	23%	30	58%
High	20	37%	10	19%	24	44%

Training on suicide prevention

The Mental Health Atlas 2020 questionnaire also asked countries to report on the different key groups targeted by their suicide prevention training programmes (Figure 5.2.2). Of the 163 countries that answered this question, 60% reported that suicide prevention training programmes existed in their country for non-specialized health workers, e.g. physicians, nurses and community health workers. Fewer countries reported that suicide prevention programmes existed in their country for gatekeepers, e.g. teachers, police, firefighters, other first responders and faith leaders (41% of responding countries), media professionals (33%) or pesticide registrars and regulators (11%).

FIGURE 5.2.2 Percentage of responding countries with training programmes focused on suicide prevention for key target groups (N=162)



Suicide prevention programmes

A suicide prevention programme was considered "functional" only if at least two of the following three characteristics were fulfilled: 1) dedicated financial and human resources; 2) a defined plan of implementation; 3) documented evidence of progress and/or impact.

Of 161 responding countries, 39% reported that they had a functioning suicide prevention programme (Table 5.2.3). Comparisons across regions show that fewer than 50% of responding countries in the African Region, the Region of the Americas and the Eastern Mediterranean Region reported the existence of a functioning suicide prevention programme. The lowest percentage was reported by the African Region (11% of responding countries) and the highest percentage was reported by the South-East Asia Region (63% of responding countries). Similarly, the existence of functioning programmes was low when data were analysed by income group, with percentages varying from 13% of responding countries in the low-income group to 52% of responding countries in the high-income group.

TABLE 5.2.3 Percentage of countries reporting the existence of functioning suicide prevention programmes, by WHO region and World Bank income group

	Percentage of countries reporting the existence of functioning suicide prevention programmes (N=161)	
	Number of countries	Percentage of responding countries
Global	**62**	**39%**
WHO region		
AFR	4	11%
AMR	12	38%
EMR	7	35%
EUR	22	51%
SEAR	5	63%
WPR	12	60%
World Bank income group		
Low	3	13%
Lower-middle	11	31%
Upper-middle	21	42%
High	27	52%

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APPENDIX A

PARTICIPATING COUNTRIES AND CONTRIBUTORS

WHO Member State	WHO region	World Bank income category (2019, published 2020)	Contributors to Atlas 2020
Afghanistan	EMR	Low	Bashir Ahmad Sarwari
Albania	EUR	Upper-middle	Emanuela Tollozhina
Algeria	AFR	Lower-middle	Mohamed Chakali
Andorra	EUR	High	Helena Mas Santuré
Antigua and Barbuda	AMR	High	Teri-Ann Joseph
Argentina	AMR	Upper-middle	Hugo Barrionuevo
Armenia	EUR	Upper-middle	Armine Aghajanyan
Australia	WPR	High	Leila Jordan
Austria	EUR	High	Christina Dietscher
Azerbaijan	EUR	Upper-middle	Musaev Tejmur Jusuf Oglu
Bahamas	AMR	High	Phillip Swann
Bahrain	EMR	High	Eman Ahmed Haji
Bangladesh	SEAR	Lower-middle	Helal Uddin Ahmed
Barbados	AMR	High	David Leacock
Belarus	EUR	Upper-middle	Korotkevich Tatiana Valerjevna
Belgium	EUR	High	Gerits Pol
Belize	AMR	Upper-middle	Iveth Quintanilla
Benin	AFR	Lower-middle	Yves Amonles
Bhutan	SEAR	Lower-middle	Mindu Dorji
Bolivia (Plurinational State of)	AMR	Lower-middle	Samadhi Fernando Salguedo Siles
Bosnia and Herzegovina	EUR	Upper-middle	Vedrana Janjetović-Čojo, Milan Latinović, Zlata Paprić and Iskra Vučina
Botswana	AFR	Upper-middle	Patrick Zibochwa
Brazil	AMR	Upper-middle	Maria Dilma Alves Teodoro
Brunei Darussalam	WPR	High	Nor Syahmun binti Matassan
Bulgaria	EUR	Upper-middle	Hristo Hinkov
Burkina Faso	AFR	Low	Marie Emmanuelle L. Zoure
Burundi	AFR	Low	Jérôme Ndaruhutse
Cabo Verde	AFR	Lower-middle	Aristides Delgado da Luz
Cambodia	WPR	Lower-middle	Chhit Sophal
Cameroon	AFR	Lower-middle	Justine Laure Menguene Mviena
Canada	AMR	High	Nicolas Palanque
Chad	AFR	Low	Attahir Sorto
Chile	AMR	High	Matías Irarrázaval
China	WPR	Upper-middle	Jun Fu

WHO Member State	WHO region	World Bank income category (2019, published 2020)	Contributors to Atlas 2020
Colombia	AMR	Upper-middle	Nubia Esperanza Bautista Bautista
Congo	AFR	Lower-middle	Emile Godefroy Ngakeni
Cook Islands	WPR	Upper-middle	Evangelene Wong
Costa Rica	AMR	Upper-middle	Karolina Ulloa Monge
Côte d'Ivoire	AFR	Lower-middle	Anna-Corinne Bissouma
Croatia	EUR	High	Maja Vajagic
Cuba	AMR	Upper-middle	Carmen Borrego Calzadilla
Cyprus	EUR	High	Anna Paradeisioti
Czechia	EUR	High	Petr Winkler
Democratic Republic of the Congo	AFR	Low	Abraham Kanyama and Nicolas Nkiere Masheni
Denmark	EUR	High	Carlo V. Andersen
Dominican Republic	AMR	Upper-middle	Angel V. Almánzar Valdez
Ecuador	AMR	Upper-middle	Ignacia Páez
Egypt	EMR	Lower-middle	Menan Abd Al Maksoud
El Salvador	AMR	Lower-middle	Magdalena Archila Lazo
Equatorial Guinea	AFR	Upper-middle	Raul Casto Esono Ada
Eritrea	AFR	Low	Ghidowon Yirgaw Nuguse
Estonia	EUR	High	Ingrid Ots-Vaik
Eswatini	AFR	Lower-middle	Violet Mwanjali
Ethiopia	AFR	Low	Dereje Assefa Zewude
Fiji	WPR	Upper-middle	Kiran Gaikwad
Finland	EUR	High	Helena Vorma
France	EUR	High	Simon Vasseur-Bacle and Patrick Risselin
Gabon	AFR	Upper-middle	Renée Enombo
Gambia	AFR	Low	Bakary Sonko
Germany	EUR	High	Robert Schlack
Ghana	AFR	Lower-middle	Akwasi Osei
Greece	EUR	High	Konstantinos Fountoulakis
Guatemala	AMR	Upper-middle	Fluvía Aracely Téllez Orellana
Guinea	AFR	Low	Kémo Soumaoro
Guinea-Bissau	AFR	Low	Agostinho M'Barco N'Dumba
Guyana	AMR	Upper-middle	Util Richmond-Thomas
Haiti	AMR	Low	Rene Domersant Jr
Honduras	AMR	Lower-middle	Carolina Padilla
Hungary	EUR	High	Zsofia Kimmel
Iceland	EUR	High	Nanna Briem

WHO Member State	WHO region	World Bank income category (2019, published 2020)	Contributors to Atlas 2020
Indonesia	SEAR	Upper-middle	Prianto Djatmiko
Iran (Islamic Republic of)	EMR	Upper-middle	Ahmad Hajebi
Iraq	EMR	Upper-middle	Emad Abdulrazaq Abdulghani
Ireland	EUR	High	Michael Murchan
Italy	EUR	High	Guiseppe Salamina
Jamaica	AMR	Upper-middle	Kevin Goulbourne
Japan	WPR	High	Kushima Takuro
Jordan	EMR	Upper-middle	Fateen Fakhri Janem
Kazakhstan	EUR	Upper-middle	Negaj Nikolay
Kenya	AFR	Lower-middle	Simon Njuguna
Kiribati	WPR	Lower-middle	Arite Kathrine Kauongo
Republic of Korea	WPR	High	Kim Suhwan
Kuwait	EMR	High	Najah Alenezi
Lao People's Democratic Republic	WPR	Lower-middle	Bouathep Phoumin
Latvia	EUR	High	Ilze Straume
Lebanon	EMR	Upper-middle	Rabih Chammay
Liberia	AFR	Low	Angie Tarr Nyakoon
Libya	EMR	Upper-middle	Wesam Abdalla Daab
Lithuania	EUR	High	Ignas Rubikas
Madagascar	AFR	Low	Hanitra Odette Randriatsara
Malaysia	WPR	Upper-middle	Ibrahim Nurashikin Bte
Maldives	SEAR	Upper-middle	Aminath Shahuza
Mali	AFR	Low	Ousmane Sy
Malta	EUR	High	Antonella Sammut
Marshall Islands	WPR	Upper-middle	Marita Edwin
Mauritius	AFR	High	Ameenah Sorefan
Mexico	AMR	Upper-middle	Lorena Rodríguez Bores Ramírez
Micronesia (Federated States of)	WPR	Lower-middle	Benido Victor
Republic of Moldova	EUR	Lower-middle	Jana Chihai
Monaco	EUR	High	Eric Voiglio
Mongolia	WPR	Lower-middle	Elena Kazantseva
Montenegro	EUR	Upper-middle	Aleksandra Ražnatović
Morocco	EMR	Lower-middle	Bouram Omar
Myanmar	SEAR	Lower-middle	Tin Oo
Namibia	AFR	Upper-middle	Magdalena Didalelwa

WHO Member State	WHO region	World Bank income category (2019, published 2020)	Contributors to Atlas 2020
Nepal	SEAR	Lower-middle	Phanindra Prasad Baral
Netherlands	EUR	High	Laura van Lint
New Zealand	WPR	High	Barry Welsh
Nicaragua	AMR	Lower-middle	Joaquín Antonio Escoto Galeano
Niger	AFR	Low	Boureima Abdou
Nigeria	AFR	Lower-middle	Nnenna Ezeigwe
Niue	WPR	Upper-middle	Sione Mavaetangi
North Macedonia	EUR	Upper-middle	Lence Miloseva
Norway	EUR	High	Anna Villa
Oman	EMR	High	Amira Al Raidan
Pakistan	EMR	Lower-middle	Malik Muhammad Safi
Palau	WPR	High	Everlynn Joy Temengil
Panama	AMR	High	David Sanjur
Papua New Guinea	WPR	Lower-middle	Monica Hagali
Paraguay	AMR	Upper-middle	Luis Taboada
Peru	AMR	Upper-middle	Miguel Angel Hinojosa Mendoza
Philippines	WPR	Lower-middle	Frances Prescilla Cuevas
Poland	EUR	High	Marek Stańczuk
Portugal	EUR	High	Miguel Xavier
Qatar	EMR	High	Susan Clelland
Russian Federation	EUR	Upper-middle	Moroz Irina
Rwanda	AFR	Low	Frederic Nsanzumuhire
Saint Kitts and Nevis	AMR	High	Delores Stapleton Harris
Saint Lucia	AMR	Upper-middle	Alicia St Juste
Saint Vincent and the Grenadines	AMR	Upper-middle	Elizabeth Medford
Saudi Arabia	EMR	High	Neif El Subhi and Hassan Elkhobrani
Senegal	AFR	Lower-middle	Jean Augustin Diegane Tine
Serbia	EUR	Upper-middle	Zlatibor Lončar
Seychelles	AFR	High	Gina Michel
Sierra Leone	AFR	Low	Kadiatu Savage
Singapore	WPR	High	Not applicable (consolidated input)
Slovenia	EUR	High	Matej Vinko
Solomon Islands	WPR	Lower-middle	Paul Orotaloa
Somalia	EMR	Low	Abdirazak Farah Hassan Baraco
South Africa	AFR	Upper-middle	Sifiso Phakathi

WHO Member State	WHO region	World Bank income category (2019, published 2020)	Contributors to Atlas 2020
South Sudan	AFR	Low	Atong Ayuel Longar
Spain	EUR	High	Andrés Suárez
Sri Lanka	SEAR	Lower-middle	Rohan Ratnayake
Sudan	EMR	Low	Zienat Sanhori
Suriname	AMR	Upper-middle	Savora Omanette
Sweden	EUR	High	Andrea Larsson
Switzerland	EUR	High	Lea Pucci
Syrian Arab Republic	EMR	Low	Amal Shakko
Tajikistan	EUR	Low	Mannonov Olimjon
United Republic of Tanzania	AFR	Lower-middle	Omary Said Ubuguyu
Thailand	SEAR	Upper-middle	Porntip Dumrongpattama
Togo	AFR	Low	Koulou Dassa
Tonga	WPR	Upper-middle	John Lee Taione
Trinidad and Tobago	AMR	High	Hazel Othello
Tunisia	EMR	Lower-middle	Fatma Charfi
Turkey	EUR	Upper-middle	Ugur Ortac
Turkmenistan	EUR	Upper-middle	Ergeshov Muhammet
Tuvalu	WPR	Upper-middle	Katalina Filipo
Uganda	AFR	Low	Hafsa Lukwata
Ukraine	EUR	Lower-middle	Sergii Shum
United Arab Emirates	EMR	High	Muna Alkuwari
United Kingdom	EUR	High	Andrew Herd
United States of America	AMR	High	Brittany Hayes
Uruguay	AMR	High	Horacio Porciúncula
Uzbekistan	EUR	Lower-middle	Chembaev Bulat
Vanuatu	WPR	Lower-middle	Jimmy Obed
Venezuela (Boliviaran Republic of)	AMR	Upper-middle	Lia Rodríguez Sánchez
Viet Nam	WPR	Lower-middle	Vuong Van Tinh
Yemen	EMR	Low	Abdulqodos Abdulwahab Harmmal
Zambia	AFR	Lower-middle	John Mayeya
Zimbabwe	AFR	Lower-middle	SM Chirisa

MENTAL HEALTH ATLAS 2020

APPENDIX B

GLOSSARY OF TERMS

TYPES OF FACILITY

Mental hospital

A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental health conditions. Other names include mental health hospital and psychiatric hospital. **Includes:** Public and private non-profit and for-profit facilities; forensic inpatient facilities; mental hospitals for children and adolescents and other specific groups (e.g. older adults). **Excludes:** Community-based psychiatric inpatient units; facilities that treat only people with alcohol and substance use problems or intellectual disability; psychiatric units in general hospitals; and mental health community residential facilities.

Psychiatric unit in a general hospital

A psychiatric unit that provides inpatient care within a community-based hospital facility (e.g. general hospital); the period of stay is usually short (weeks to months) and the hospital also provides services related to other medical specialties. **Includes:** Public and private non-profit and for-profit facilities; psychiatric wards or units in general hospitals, including those for children and adolescents or other specific groups (e.g. older adults). **Excludes:** Mental hospitals; community residential facilities; facilities for alcohol and substance use problems or intellectual disability only.

Mental health community residential facility

A non-hospital, community-based mental health facility providing overnight residence for people with mental health conditions. Both public and private non-profit and for-profit facilities are

included. **Includes:** Staffed or unstaffed group homes or hostels for people with mental health conditions; halfway houses; therapeutic communities. **Excludes:** mental hospitals; facilities for alcohol and substance use problems or intellectual disability only; residential facilities for older adults; institutions treating neurological disorders or physical disability problems.

Mental health day treatment facility

A facility providing care and activities for groups of users during the day that last for half a day or one full day (including those for children and adolescents only or other specific groups, e.g. older adults). **Includes:** Day or day-care centres; sheltered workshops; club houses; drop-in centres. Both public and private non-profit and for-profit facilities are included. **Excludes:** Day treatment facilities for inpatients; facilities for alcohol and substance use problems or intellectual disability only.

Mental health outpatient facility

An outpatient facility that manages mental health conditions and related clinical and social problems. **Includes:** Community mental health centres; mental health outpatient clinics or departments in general or mental hospitals (including those for specific mental health conditions, treatments or user groups, e.g. older adults). Both public and private non-profit and for-profit facilities are included. **Excludes:** Private practice; facilities for alcohol and substance use problems or intellectual disability only.

Other residential facility

A residential facility that houses people with mental health conditions but does not meet the definition for community residential facility or any other defined mental health facility. **Includes:** Residential facilities specifically for people with intellectual disability, for people with substance use problems or for people with dementia; residential facilities that formally are not mental health facilities but where most residents have diagnosable mental health conditions.

Primary health care clinic

A clinic that often offers the first point of entry into the health-care system. Primary health care clinics usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities that have staff with a higher level of training.

TYPES OF WORKER

Nurse

A health professional who has completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

Occupational therapist

A health professional who has completed formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

Other specialized mental health worker

A health or mental health worker who possesses some training in health care or mental health care (e.g. occupational therapist) but does not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers). **Includes:** Non-doctor/non-nurse primary care workers, psychosocial counsellors, auxiliary staff. **Excludes:** General staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Primary health care doctor

A general practitioner, family doctor or other non-specialized medical doctor working in a primary health care clinic.

Primary health care nurse

A nurse working in a primary health care clinic.

Psychiatrist

A medical doctor who has had at least two years of postgraduate training in psychiatry at a recognized teaching institution. This period may include training in any subspecialty of psychiatry.

Psychologist

A professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. The Mental Health Atlas asks for information only on psychologists working in mental health care.

Social worker

A professional who has completed formal training in social work at a recognized, university-level school for a diploma or degree in social work. The Mental Health Atlas asks for information only on social workers working in mental health care.

Speech therapist

A professional who has completed formal training in speech therapy at a recognized, university-level school for a diploma or degree in speech therapy. In some countries, speech therapy is a part of audiology training. The Mental Health Atlas asks for information only on speech therapists working in mental health care.

OTHER TERMS USED

Admissions

The number of admissions in one year is the sum of all admissions to the facility within that year. This number is a duplicated count; in other words, if one user is admitted twice, it is counted as two admissions.

Legal capacity

The UN Convention on the Rights of Persons with Disabilities recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity and make decisions and choices about all aspects of their lives, on an equal basis with others. The Convention promotes a supported decision-making model, which enables people with mental disabilities to nominate a trusted person or a network of people with whom they can consult and discuss issues affecting them.

Mental health conditions

This term refers to a broad range of problems, with different symptoms including mental, neurological and substance use (MNS) disorders, encompassing a wide range of conditions of the brain from depression to epilepsy to alcohol use problems. However, such conditions are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.

Mental health legislation

Legal provisions related to mental health. Such provisions typically focus on issues such as civil and human rights protection for people with mental health conditions, along with treatment facilities, personnel, professional training and service structure.

Mental health plan

A detailed scheme for implementing strategic actions that addresses the promotion of mental health, the prevention of mental health conditions, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles and objectives defined in mental health policy.

Mental health policy

Mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental health conditions in a population. It defines a vision for future action.

National health insurance or reimbursement scheme

Refers to a system of health insurance that insures a national population against the costs of health care. It may be administered by the public sector, the private sector or

a combination of both. Funding mechanisms vary with the particular programme and country. National or statutory health insurance does not equate to government-run or government-financed health care but is usually established by national legislation.

Persons treated in a mental hospital

(a) The number of users in the mental hospital at the beginning of the year plus (b) the number of admissions during the year.

Persons treated in a community residential facility

(a) The number of users in the facility at the beginning of the year plus (b) the number of admissions to the facility during the year.

Persons treated through a mental health day treatment facility

The number of users with at least one attendance for treatment at the facility within the year.

Persons treated in a mental health outpatient facility

The number of users with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a mental health outpatient facility, whether the intervention occurs within the facility or elsewhere.

Pharmacological interventions for mental health conditions

Pharmacological interventions involve psychotropic medicines to reduce the symptoms of mental health conditions and improve functioning. Four main groups of medicines are used in mental health conditions and are recommended in the mhGAP-IG version 2.0 for use in non-specialized health-care settings (e.g. primary health care): antipsychotics for psychotic disorders, drugs for mood disorders (depression or bipolar), anticonvulsants and antiepileptics, and medicines for management of substance withdrawal, intoxication or dependence. Psychotropic medicines are on the WHO Model List of Essential Medicines, which defines the minimum medicine requirements for a basic health system.

Psychosocial disabilities

This term refers to people who have received a mental health diagnosis and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users and current users of mental health care services, as well as persons who identify themselves as survivors of these services or with the psychosocial disability itself.

Psychosocial interventions for mental health conditions

This refers to interpersonal or informational activities, techniques or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social or environmental factors with the aim of improving health functioning and well-being. The term is applied to psychoeducation, psychotherapy, counselling and other non-pharmacological interventions.

Recovery approach

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life and having personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure.

Seclusion and restraints

"Seclusion" means the voluntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving. "Restraint" means the use of a mechanical device or medication to prevent a person from moving his or her body. "Alternatives to seclusion" include prompt assessment and rapid intervention in potential crises; and using problem-solving methods and/or stress management techniques such as breathing exercises.

Coverage

Service coverage is defined as the proportion of people with a mental health condition contacting a mental health service (from service utilization data) among those estimated to have the condition (population prevalence) during a 12-month period.

At-risk populations

Certain groups have an elevated risk of developing mental health conditions. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports and living conditions, including stigma and discrimination; violence and abuse; restrictions in exercising civil and political rights; exclusion from participating fully in society; reduced access to health and social services; reduced access to emergency relief services; lack of educational opportunities; exclusion from income generation and employment opportunities; increased disability and premature death.

Service user

A person who is receiving mental health care. This term is used in different places and by different groups of practitioners and people with mental health conditions.

Mental health and psychosocial support

The composite term “mental health and psychosocial support” (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders”. The global humanitarian system uses the term MHPSS to unite a broad range of actors responding to emergencies (such as the COVID-19 outbreak), including those working with biological approaches and sociocultural approaches in health, social, education and community settings, as well as to “underscore the need for diverse, complementary approaches in providing appropriate support.”

Work-related mental health prevention and promotion programme

Programmes coordinated by health (occupational and/or mental health), labour or employment sectors with the intention of promoting mental health and preventing mental health conditions in workers.

The Mental Health Atlas series is considered the most comprehensive resource on global information on mental health and an important tool for developing and planning mental health services within countries and regions. The Mental Health Atlas 2020 acquires new importance as it includes information and data on the progress towards the achievement of objectives and targets of the Comprehensive Mental Health Action Plan 2013–2030.

For more information, please contact:

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