Mental Health Atlas 2024

World Health Organization

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Preface

Mental health is essential to the health and well-being of individuals, communities and societies. Yet, as an area of public health, it remains under-prioritized, under-funded and under-evaluated, resulting in extreme distress and disability, service gaps and inequity.

The WHO Mental Health Atlas 2024 is a vital tool for assessing and documenting such challenges. Now in its seventh edition, the Mental Health Atlas offers a comprehensive global overview of mental health system activity and performance, tracking progress, identifying gaps and guiding action toward the goals of the WHO Comprehensive mental health action plan 2013–2030. This edition, the first since the coronavirus disease 2019 (COVID-19) pandemic, provides insight into how countries have responded to disrupted mental health services and have upheld the human rights and dignity of individuals with mental health conditions. This edition also brings a focus on areas such as psychosocial support in emergencies, digital service delivery and the inclusion of people with lived experience in shaping policies.

Without accurate, up-to-date information, countries cannot plan, fund or deliver the services their populations require. The 2024 Atlas reflects WHO's continued investment in strengthening mental health information systems and underscores the importance of data availability and transparency, even amid competing priorities. We are deeply grateful to the 144 countries that contributed to this edition and to WHO's regional and country offices for their steadfast collaboration.

But data alone are not enough. Data must drive investment and action. The 2024 Atlas shows that, while awareness of mental health is growing, political and financial commitments have not kept pace. Underfunding, workforce shortages and service gaps persist, especially in low-resource settings. Alarmingly, the response rates from certain areas tended to decrease, indicating the urgency of improving data systems, digital health records and disaggregated reporting. Despite these challenges, there are signs of progress: more countries are adopting mental health policies aligned with human rights standards. Integration into primary care is advancing. Community-based approaches and emergency preparedness are gaining traction. But this momentum must be matched by sustained financing, strong leadership and effective implementation. WHO remains committed to supporting countries through technical guidance, capacity-building, advocacy and partnership, with a view to closing treatment gaps, protecting the dignity and rights of individuals and integrating mental health into universal health coverage and broader development efforts. The Atlas is central to this effort: empowering decision-makers, informing policy and driving accountability.

I urge all governments, partners and stakeholders to use the findings of this report to accelerate progress. Together, we can transform the future of mental health, through data, through action and, above all, through our shared commitment to dignity, equity and inclusion.

Dévora Kestel
Director a.i.
Department of Noncommunicable Diseases and Mental Health

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The Mental Health Atlas is a project of the World Health Organization (WHO). The overall vision and conceptualization of the project were provided by Dévora Kestel. This edition of the Atlas was coordinated by Dan Chisholm and Audrey Fontaine.

In WHO Member States, the key collaborators were 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 in the Annex.

People in the WHO regional offices who contributed to planning and collation of data and liaised with focal points in Member States were: Chido Rwafa Madzvamutse (WHO Regional Office for Africa); Renato Oliveira E Souza, Maria del Carmen Martínez Viciana, Matías Irarrázaval and Catalina Ortuzar-Lyon (WHO Regional Office for the Americas); Andrea Bruni and Shabana Khan (WHO Regional Office for South-East Asia); Ledia Lazeri and Cassie Redlich (WHO Regional Office for Europe); Khalid Saeed, Duaa Mohsen and Zaki Metwally (WHO Regional Office for the Eastern Mediterranean); and Atsuro Tsutsumi, Jasmine Vergara, Sendelyn Tan and Jiang Long (WHO Regional Office for the Western Pacific). The contributions and support of colleagues in WHO country offices are also gratefully acknowledged.

At WHO headquarters, a core team comprising Dan Chisholm and Audrey Fontaine developed the survey questionnaire and its online version, oversaw the collection of data in collaboration with WHO regional offices, designated national focal points and analysed and reported the survey findings. They were supported by the following WHO staff members and consultants in the Department of Noncommunicable Diseases and Mental Health, who provided advice and reviewed the survey questionnaire and final report: Ken Carswell, Sudipto Chatterjee, Neerja Chowdhary, Nathalie Drew, Tarun Dua, Alexandra Fleischmann, Michelle Funk, Fahmy Hanna, Aiysha Malik, Alison Schafer, Chiara Servili, Mark van Ommeren and Inka Weissbecker. Comments on the draft report were also received from Jennifer Hall and Jason Maurer in the WHO Regional Office for Europe.

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Abbreviations

AFR	African Region
AMR	Region of the Americas
COVID-19	coronavirus disease 2019
EMR	Eastern Mediterranean Region
EUR	European Region
HIC	high-income countries
LIC	low-income countries
LMIC	lower–middle-income countries
MHPSS MSP	Mental health and psychosocial support minimum service package
NGO	nongovernmental organization
SEAR	South-East Asian Region
UMIC	upper–middle-income countries
WHO	World Health Organization
WPR	Western Pacific Region

Glossary

Types of facility

Psychiatric hospital (or mental hospital): A specialized hospital facility that provides inpatient care and long-stay residential services for people with mental disorders. Includes public and private non-profit and for-profit facilities and mental hospitals for children, adolescents and other groups (e.g. elderly people). Excludes community psychiatric inpatient units and facilities for treating people with alcohol and substance abuse disorders or intellectual disability only.

Psychiatric unit in a general hospital: Provides inpatient care in a community hospital facility (e.g. general hospital). The period of stay is usually short (weeks to months). Includes public and private non-profit and for-profit facilities and psychiatric wards and units in a general hospital, including those for children and adolescents and other groups (e.g. elderly people). Excludes mental hospitals, community residential facilities and facilities to treat people with alcohol and substance abuse disorder or intellectual disability only.

Mental health community residential facility: A non-hospital facility that provides overnight stays for people with mental disorders. Includes both public and private nonprofit and for-profit facilities. Also includes staffed or un-staffed homes or hostels for people with mental disorders, halfway houses and therapeutic communities. Excludes mental hospitals, facilities for alcohol and substance abuse disorder or intellectual disability only, residential facilities for elderly people and institutions for treating neurological disorders or physical disability.

Mental health outpatient facility: Facility that manages mental disorders and related clinical and social problems. Includes public and private non-profit and for-profit community mental health centres, mental health outpatient clinics and departments in general or mental hospitals (including those for specific mental disorders, treatment or user groups, such as the elderly). Excludes private practice and facilities for alcohol and substance abuse disorder or intellectual disability only.

Primary health care centre: Often the first point of entry into the health-care system. Usually provides an initial assessment and treatment for common health conditions and refers people who require a specialized diagnosis and treatment to a facility with staff who have a higher level of training.

Personnel

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 health or specialized mental health worker: A health or mental health worker who has had some training in health care or mental health care but is not a medical doctor, nurse, psychologist, social worker or occupational therapist. Includes primary care workers, psychosocial counsellors and auxiliary staff.

Peer-support worker: An individual with lived experience who has been trained to provide support and care to people with mental health conditions.

Psychiatrist: A medical doctor who has had at least 2 years of post-graduate training in psychiatry at a recognized teaching institution. May have training in a sub-specialty 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. For the Mental Health Atlas, information was sought only about 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. For the Mental Health Atlas, information was sought only about social workers working in mental health care.

Other terms

Legal capacity: The United Nations 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 on all aspects of their lives, on an equal basis with others". The Convention promotes a model for supported decision-making, which enables people with mental disabilities to nominate a trusted person or a network of people with whom they can consult and discuss issues that affect them.

Mental health and psychosocial support minimum service package (MHPSS MSP): The MHPSS MSP outlines a set of activities that are considered to be of the highest priority for meeting the immediate critical needs of populations in emergencies. Based on guidelines, evidence and expert consensus.

Mental health condition: A broad term covering mental disorders and psychosocial disabilities. Includes other mental states associated with significant distress, impairment in functioning or risk of self-harm.

Mental disorder: As defined in the International Classification of Diseases, 11th Revision (ICD-11), a mental disorder is a syndrome characterized by cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning. The disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Publicly funded health or financial protection scheme: System to insure a national population against the costs of health care. Financial protection is achieved when direct payments made to obtain health services do not expose people to financial hardship and do not threaten their living standards.

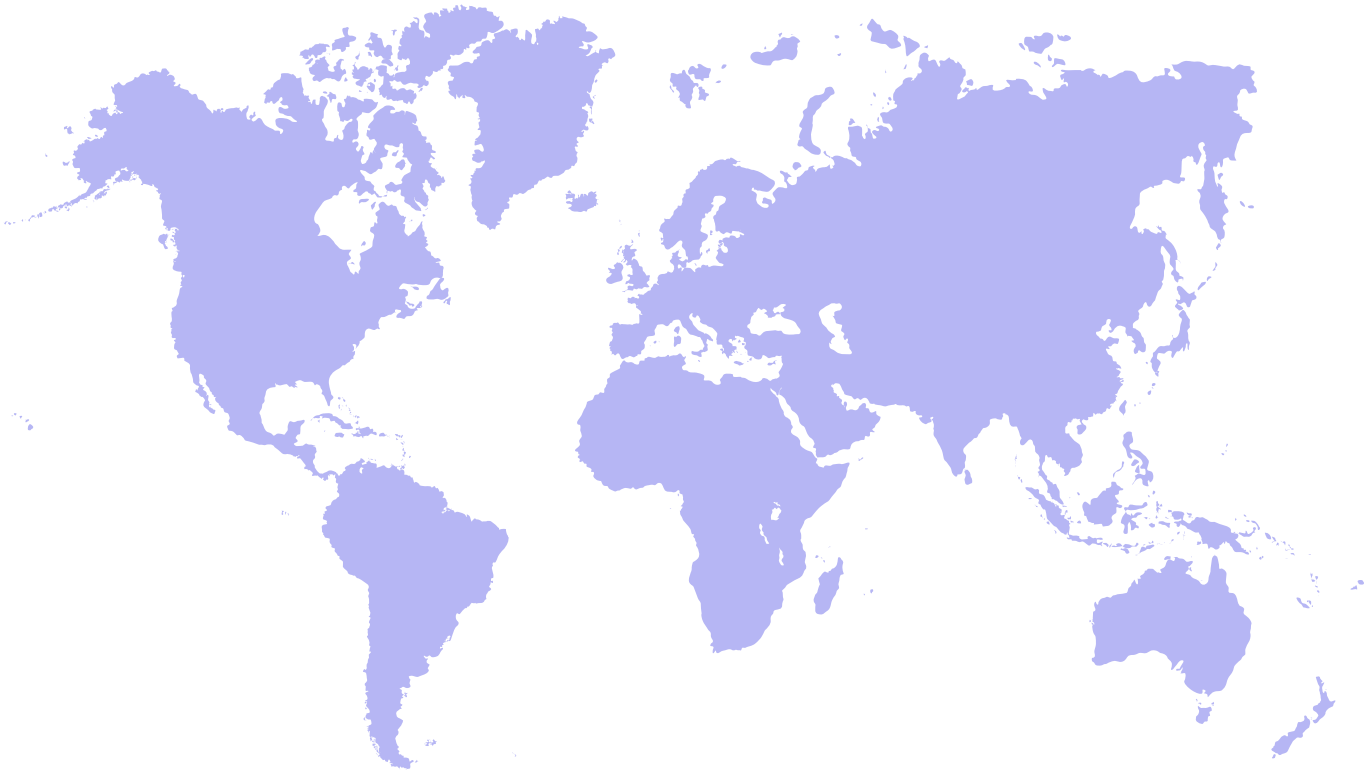
Pharmacological intervention for mental health conditions: Use of psychotropic medicines to reduce the symptoms of mental health conditions and improve functioning. Psychotropic medicines are listed on the WHO Model List of Essential Medicines, which defines the minimum medicine requirements for a basic health system.

Psychosis: Characterized by distorted thoughts and perceptions and disturbed emotions and behaviour. Incoherent or irrelevant speech may also be present. Symptoms such as hallucinations – hearing voices or seeing things that are not there; delusions – fixed, false beliefs; severe behavioural abnormalities – disorganized behaviour, agitation, excitement, inactivity or hyperactivity; disturbances of emotion – marked apathy or disconnect between reported emotion and observed affect, such as facial expression and body language, may also be detected.

Psychosocial interventions for mental health conditions: Interpersonal or informational activities, techniques or strategies for biological, behavioural, cognitive, emotional, interpersonal, social or environmental factors for improving health, functioning and well-being. The term is applied to psychoeducation, psychotherapy, counselling and other non-pharmacological interventions.

Seclusion and restraints: "Seclusion" means voluntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving. "Restraint" is 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 with problem-solving methods and/or stress management techniques such as breathing exercises.

Tele-mental health services, telemedicine services: Delivery of health-care services when distance is a critical factor by health-care professionals using information and communications technology for exchanging valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation and for continuing education of health-care workers to improve the health of individuals and communities.



Executive summary

The Mental Health Atlas initiative was established in 2000, and the first global report was published in 2001. Several reports on the Atlas survey followed, in 2005, 2011, 2014, 2017 and, most recently, 2020.[1] Information collected from WHO Member States and other countries or territories through these periodic surveys have provided up-to-date summaries of the state of the world's response to addressing the mental health needs of populations, in terms of policy and legislation, financial and human resources, as well as delivery of services and programmes for mental health promotion, protection and care. Data generated and made accessible through the series of Mental Health Atlas surveys are used by governmental and nongovernmental entities, academic organizations, professional associations, the media and the general public to assess and monitor the national, regional and global situation, including progress against internationally agreed goals and targets set out in the Comprehensive mental health action plan 2013–2030[2] and equivalent plans or strategies at the level of WHO regional offices.

WHO's Mental Health Atlas 2024 survey builds on the experience of previous ones, with many of the same survey questions and items to enable analysis of trends or changes over time. This latest edition includes new items or sections on topics such as tele mental health and mental health and psychosocial support preparedness and response in emergencies, which reflect the changing landscape of mental health and associated gaps in data or information. As the first Atlas survey to be carried out since the COVID-19 pandemic, this edition provides insights and evidence on the extent to which countries have stepped up their response to the many challenges and shortcomings in service access and quality that were exposed during this pandemic.

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 data collection period was July 2024 to March 2025, following which data were checked, finalized and analysed. Key findings and insights from Mental Health Atlas 2024 – overall and for each main section of the survey – are summarised overleaf.

1. Mental health atlas 2020. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/345946. License: CC BY-NC-SA 3.0 IGO.
4. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/345301. License: CC BY-NC-SA 3.0 IGO.

Key messages and insights

- **Participation** in WHO's Mental Health Atlas survey in 2024 was lower than in previous rounds yet still included three quarters of WHO's Member States (144 countries). The survey provides the most comprehensive, up-to-date information on the world's response to the challenge of mental ill health.
- **Data** for the Mental Health Atlas 2024 indicate that, since the COVID-19 pandemic (during which the previous survey was administered), mental health policy and planning have been strengthened, with increased pursuit of rights-based approaches, high rates of policy revision, more effective implementation of policies and better preparedness for mental health and psychosocial support in the context of emergencies. In contrast, indicators of the development and implementation of rights-based mental health legislation are more negative.
- **Resources** available for the provision of mental health services have not increased since the last survey. Budgets remain at a median of 2% of government health spending and staff at one government mental health worker per 10 000 population. The differences between lower- and higher-income countries with respect to mental health resources are severe.
- **Service availability, delivery and uptake** show similarly large differences among WHO regions and by country income. Most countries remain at an early stage of moving towards community-based service delivery, although key elements of integration of mental health into primary health care are in place. Most countries that provided data for the Mental Health Atlas 2024 have functioning programmes to promote mental health and to prevent suicide.
- **Targets:** This edition of the Atlas shows that, despite some progress, countries remain significantly off track for meeting the targets set in the comprehensive mental health action plan, indicating the urgent, ongoing importance of transforming mental health systems worldwide.

Mental health reporting and information systems

- **Participation in the Mental Health Atlas 2024 survey**: 144 of WHO's 194 Member States submitted a response, representing a participation rate of 74%. This rate is lower than that for earlier Atlas surveys (for example, 171 responses in 2020, equivalent to 88% of Member States).
- **National mental health reporting:** 85% of the 144 responding countries reported having compiled national data on mental health data in the past 2 years, of which nearly half (42%) compiled data as part of general health statistics and the other half compiled data specifically for reporting on mental health.
- **National surveys and digital records**: Slightly over a third of responding countries (36%) had conducted a national mental health survey in the past 10 years, and 58% reported having a nationwide digital health record system that includes data on mental health.

Mental health system governance

- **Policies and plans:** 81% of responding countries reported having distinct policies or plans for mental health; slightly over a half (56%) reported that they had distinct or integrated mental health plans or policies for children and adolescents, and 42% reported one for older adults. Most of the responding countries reported that they largely (85%) or fully (72%) complied with human rights instruments (as measured on a five-point checklist); however, only 50% reported that they were both fully compliant with human rights and also had the appropriate resources to implement the national mental health policy or plan effectively.
- **Legislation:** 72% of the 144 responding countries reported that they had a distinct law for mental health. Of 98 countries that completed a checklist on compliance of their laws with international human rights instruments, 73% were partially compliant and only 45% fully compliant.
- **Collaboration:** A high, increasing level of collaboration between governmental and nongovernmental stakeholders was observed, with 79% of responding countries reporting functional collaboration with nongovernmental organizations (NGOs).

Mental health financing and workforce

- **Financial protection:** Four of five responding countries (81%) reported that mental health care and treatment were included in a publicly funded health or financial protection scheme. In at least 50% of the responding countries, there is little or nothing to pay (≤ 5%) towards the cost of mental health inpatient care, outpatient care and psychotropic medication. In some countries, however, people with mental health conditions contribute mostly or entirely to their care (> 50%); for example, 28% of responding countries reported a high contribution for psychological therapy. Major discrepancies were observed among income groups.

- **Expenditure:** Data from 75 responding countries showed that the global median expenditure on mental health was US$ 2.69 per capita, with wide variation among country income groups, from < US$ 1 in low-income (US$ 0.04 per capita) and lower–middle-income countries (LMIC) (US$ 0.34 per capita) to US$ 65.89 in high-income countries (HIC). The global median percentage of total government health expenditure allocated to mental health is 2.1%, which is the same as that derived and reported in both 2017 and 2020, ranging from ≤ 1.5% in LMIC to 4.3% in HIC.

- **Workforce:** The global median number of specialized mental health workers is 13.5 per 100 000 population, ranging from 1.1–2.4 in LIC and LMIC to 67.2 in HIC. A median of 1.5 specialized mental health workers was reported per 100 000 children and adolescents. Mental health nurses comprise the single largest proportion of the specialized mental health workforce (globally, 43% of the total), followed by psychologists (22%) and psychiatrists (16%).

Mental health services

- **Service reform:** Globally, mental health service reform is progressing slowly: less than 10% of responding countries have fully moved from institutional-based models of care to community-based care. Most (52.9%) remain in the early stage of transition, with more beds and services still concentrated in psychiatric hospitals.

- **Integration of mental health into primary care:** Of the 138 responding countries, most (74%) met three of the five criteria for functional integration of mental health into primary care; 32% met four, and only 12% met all five criteria.

- **Telehealth services:** 63% of the responding countries declared that telehealth services were available and were being used. In tele mental health, services are delivered by health-care professionals using information and communication technologies to exchange valid information for diagnosis, treatment and prevention of disease and injuries.

- **Social support:** Globally, a large majority (88%) of responding countries reported that people with mental health conditions benefited to some extent from social support (e.g. disability payments or income support), and over half (59%) reported that most people with severe mental health conditions received such support. The proportion differed widely among WHO regions and country income groups.

- **Emergencies:** 65% of responding countries reported having a system for MHPSS for emergency preparedness and/or disaster risk management (a large increase from 45% in the Mental Health Atlas 2020). An even higher percentage (81%) reported that mental health and psychosocial support were provided as part of their emergency response.

- **Outpatient care:** The global median of 0.45 facilities per 100 000 population is underlied by wide differences, from more than 1 facility in upper–middle-income countries (UMIC) and more than 2 in HIC, to fewer than 0.1 in LIC and LMIC. The proportion of responding countries that offer outpatient services in community-based facilities also differed widely, from 25% in LIC and 50% in LMIC to 76–80% in UMIC and HIC.

- **Inpatient care:** Globally, a median of one mental health inpatient and residential care bed per 10 000 population was reported; most inpatient beds are in specialized psychiatric hospitals (62%). Data from 45 countries indicate that 49% of all admissions to psychiatric hospitals and psychiatric units in general hospitals are involuntary. In more than one in five admissions to psychiatric hospitals, the length of stay is > 1 year.

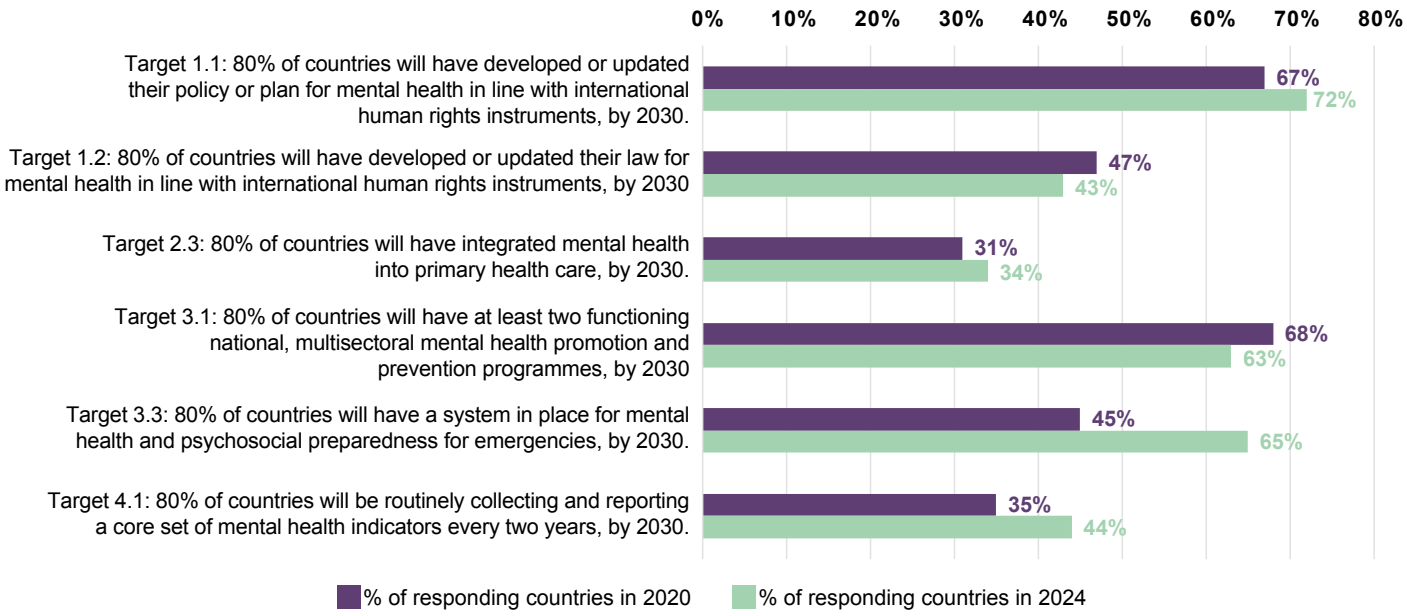
- **Service coverage:** Based on a small sample of 22 countries that provided complete data, service coverage for psychosis was estimated to be 40%, ranging from < 10% in LIC and > 50% in UMIC and HIC.

Mental health promotion and prevention programmes

- Mental health promotion and protection: 63% of responding countries reported at least two functional mental health promotion and protection programmes. Most of the programmes addressed early childhood development (86% of responding countries), suicide prevention (80%) and school mental health (78%).
- Suicide prevention: Nearly half of 138 responding countries (47%) reported having a distinct or integrated national suicide prevention strategy, policy or plan and a suicide prevention programme. In a smaller sample, of 54 responding countries, 80% were found to have a well-functioning suicide prevention programme.

Data and findings from the Mental Health Atlas are also used to measure progress in achieving the targets and indicators of the Comprehensive mental health action plan 2013–2020,[3] which was subsequently extended to 2030. Table 1 shows baseline values for 2020 (based on data from the Mental Health Atlas 2020) and in the current Atlas in relation to agreed global targets. Results are presented as a percentage of both WHO Member States that provided responses to the Atlas survey at these times and of all WHO Member States. As the rate of participation in Atlas 2024 survey was substantially lower than in previous editions, the most appropriate measure of change or progress over time with respect to these global targets is the percentage of responding countries at each time point. Fig.1 indicates significant progress in mental health and psychosocial support preparedness; modest progress in rights-based mental health policies, integration of mental health into primary health care and reporting on core mental health indicators; and a slight decrease in rights-based mental health legislation and functioning mental health promotion and prevention programmes.

Figure 1. Progress in meeting national global mental health targets, 2020–2024 (percentage of responding countries)



3. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/345301. License: CC BY-NC-SA 3.0 IGO.

Table 1. Mental health action plan 2013–2030: baseline values and progress in meeting global targets

	Target	Value for 2020 (baseline)		Value for 2024 (progress)	
Objective 1 Strengthen effective leadership and governance for mental health	**Target 1.1** Target 1.1: 80% of countries will have developed or updated a policy or plan for mental health in line with international human rights instruments by 2030	**67%** responding countries (99/147)	**60%** Member States (119/194)	**72%** responding countries (79/109)	**63%** Member States (125/194)
	Target 1.2 80% of countries will have developed or updated their law for mental health in line with international human rights instruments by 2030	**47%** responding countries (74/156)	**49%** Member States (95/194)	**43%** responding countries (42/98)	**48%** Member States (94/194)
Objective 2 Provide comprehensive, integrated, responsive mental health and social care services in communities	**Target 2.1** Service coverage for mental health conditions will have increased by at least half by 2030	*(See Table 2.)*		*(See Table 2.)*	
	Target 2.2 80% of countries will have doubled the number of community mental health facilities by 2030	*(See Table 2.)*		*(See Table 2.)*	
	Target 2.3 80% of countries will have integrated mental health into primary health care by 2030	**31%** responding countries (49/160)	**25%** Member States (49/194)	**34%** responding countries (47/138)	**24%** Member States (47/194)
Objective 3 Implement strategies for promotion and prevention in mental health	**Target 3.1** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by 2030	**68%** responding countries (101/148)	**52%** Member States (101/194)	**63%** responding countries (39/62)	**20%** Member States (39/194)
	Target 3.2 The rate of suicide will be reduced by one third by 2030	*(See Table 2.)*		*(See Table 2.)*	
	Target 3.3 80% of countries will have a system for mental health and psychosocial preparedness for emergencies and/or disasters by 2030	**45%** responding countries (54/119)	**28%** Member States (54/194)	**65%** responding countries (93/142)	**48%** Member States (93/194)
Objective 4 Strengthen information systems, evidence and research for mental health	**Target 4.1:** 80% of countries will routinely collect and report at least a core set of mental health indicators every 2 years in their national information systems by 2030	**35%** responding countries (62/178)	**32%** Member States (62/194)	**44%** responding countries (63/144)	**32%** Member States (63/194)
	Target 4.2: The output of global research on mental health has doubled by 2030	*(See Table 2.)*		*(See Table 2.)*	

Percentage of responding countries: The numerator is the number of countries at each survey point that met the target criteria; the denominator depends on data availability and country capacity to provide information.

Percentage of Member States: The numerator is the number of countries that met the target criteria, cumulatively over time (target 1.1 and 1.2) or at each survey point; the denominator is the total number of WHO Member States in 2024.

The Comprehensive mental health action plan 2013–2030 also includes several indicators that complement or provide information for the agreed targets. Data from the Mental Health Atlas in 2020 and in 2024 in respect of these indicators are shown in Table 2. The table also includes data from sources other than the Atlases, specifically for estimates of the coverage of depression treatment, suicide mortality rates and the outputs of research on mental health. In the cases of integration of mental health into primary health care, functioning programmes for mental health promotion and prevention, mental health and psychosocial support preparedness and reporting on mental health indicators, the indicators equate to the targets.

Table 2. Mental health action plan 2013–2030: baseline and progress in global indicators

	Indicator	Value for 2020 (baseline)	Value for 2024 (progress)
Objective 1 Existence of a national policy or plan for mental health that is being implemented and is in line with international human rights instruments	**Indicator 1.1** Existence of a national policy or plan for mental health that is being implemented and is in line with international human rights instruments	**24%** responding countries (41/173)	**50%** responding countries (55/109)
	Indicator 1.2 Existence of a national law on mental health that is being implemented and is in line with international human rights instruments	**35%** responding countries (54/156)	**27%** responding countries (36/135)
Objective 2 Provide comprehensive, integrated, responsive mental health and social care services in communities	**Indicator 2.1.1** Proportion of people with psychosis who used services in the past 12 months (%)	**29%** (median, 47 countries)	**40%** (median, 22 countries)
	Indicator 2.1.2 Proportion of people with depression who used services in the past 12 months (%)[a]	**9.1%**	
	Indicator 2.2 Number of community-based mental health facilities	**0.64 per 100 000** population (median, 112 countries)	**0.52 per 100 000** population (median, 48 countries)
	Indicator 2.3 A system for integration of mental health into primary care is available	**31%** responding countries (49/160)	**34%** responding countries (47/138)
Objective 3 Implement strategies for promotion and prevention in mental health	**Indicator 3.1** Functioning programmes for multisectoral mental health promotion and prevention are available	**68%** responding countries (101/148)	**63%** responding countries (39/62)
	Indicator 3.2 Suicide mortality rate (per 100 000 population) (age-standardized rate)[a]	**9.0 per 100 000** population (2019)	**8.9 per 100 000** population (2021)
	Indicator 3.3 A system is available for mental health and psychosocial preparedness for emergencies and/or disasters	**45%** responding countries (54/119)	**65%** responding countries (93/142)
Objective 4 Strengthen information systems, evidence and research for mental health	**Indicator 4.1** Core set of identified, agreed mental health indicators routinely collected and reported every 2 years	**35%** responding countries (62/178)	**44%** responding countries (63/144)
	Indicator 4.2 Number of published articles on mental health research (as defined in databases)[a]	**64 646** published articles	**68 590** published articles

[a] *Estimates are from data sources other than the WHO Mental Health Atlas (see main text for details).*

With respect to leadership and governance (Objective 1), indicators 1.1 and 1.2 are more stringent versions of the global targets, as they require both alignment of policies and legislation with international human rights instruments and their effective implementation. The results indicate good progress in implementation of rights-based policies and plans but a modest regression with respect to mental health legislation.

In terms of service development and treatment coverage (Objective 2), use of a consistent method for measuring service coverage for psychosis resulted in a much-reduced sample of only 22 countries, for which a global median of 40% in 2024 was estimated (29% in 2020). Coverage of depression treatment could not be computed from Atlas data; instead, an estimate of 9.1% is reported for 2021 from a global analysis of minimally adequate treatment coverage for major depressive disorders.[4] With respect to service development, the estimated number of community-based mental health facilities was smaller in 2024 than in 2020, although the sample for the current edition of the Atlas was also notably smaller.

With respect to strategies for promotion and prevention in mental health (Objective 3), the 2001 edition of WHO Global Health Estimates indicate that the (age-standardized) rate of suicide mortality globally has changed only marginally, from 9.0 per 100 000 population in 2019 to 8.9 in 2021.[5]

With respect to information, evidence and research (Objective 4), re-running the search algorithm used in 2020 to estimate the total number of mental health publications in that year showed a modest increase of 6% in 2024, to 68 590 publications.

4 . Santomauro DF, Vos T, Whiteford HA, Chisholm D, Saxena S, Ferrari AJ. Service coverage for major depressive disorder: estimated rates of minimally adequate treatment for 204 countries and territories in 2021. Lancet Psychiatry. 2024;11:1012–21. https://doi.org/10.1016/S2215-0366(24)00317.

5. Suicide worldwide in 2021: global health estimates. Geneva: World Health Organization; 2025. https://iris.who.int/handle/10665/381495. License: CC BY-NC-SA 3.0 IGO.

Introduction

Surveillance and monitoring are essential public health functions, involving the collection, analysis and interpretation of health data and timely communication of those data to policy-makers and others. The availability of relevant information allows monitoring of activities and detection of improvements in service provision. Critical aspects of public mental health surveillance include epidemiological assessment of mental disorders and the associated requirements for care and support and measurement of mental health service inputs, throughput, outcomes and overall system performance. One of the four core objectives of the WHO Comprehensive mental health action plan 2013–2030[6] is therefore to strengthen information systems, evidence and research. Generation of new knowledge through research ensures that policies and actions are based on evidence and best practice, while the availability of timely, relevant information from surveillance allows monitoring of actions and detection of improvements to service provision.

The Mental Health Atlas programme was established in 2000 to provide a standard global approach to the collection and reporting of data on mental health policies, legislation, resources and services, and the first global report was published in 2001. Updates of the Atlas survey followed in 2005, 2011, 2014, 2017 and, most recently, 2020.[7] Information collected in these periodic surveys has been used to complement international data on the epidemiology of mental disorders and the effectiveness or impact of mental health interventions and services. The collection of information in the Mental Health Atlas surveys complements other WHO data collection and monitoring mechanisms, such as the Global Health Observatory (https://www.who.int/data/gho), by providing detailed national data on mental health systems, policies and service availability. While the Atlas survey solicits information on system indicators, epidemiological data such as on the prevalence of mental disorders, dementia and substance use are collected

6. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/345301. License: CC BY-NC-SA 3.0 IGO.
7. Mental health atlas 2020. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/345946. License: CC BY-NC-SA 3.0 IGO.

through other WHO reporting mechanisms and mandates. Together, these data sources provide comprehensive information on global trends in mental health.

The survey for the Mental Health Atlas 2024 was based on the experience of previous editions and includes many of the same questions or items for use in analysing trends and changes over time. This edition also has new items and sections that reflect the changing landscape of mental health globally and the associated gaps in data and information. New sections and questions have been added, on mental health and psychosocial support in emergencies, telemedicine mental health services, the physical health of people with severe mental health conditions and engagement of people with lived experience in developing mental health policy and legislation.

The Mental Health Atlas surveys were designed and have proven to be a useful repository of data on each Member State's progress with respect to mental health policy and service development. The latest country-level profiles accompany the production of this report, which summarises findings at the regional and global level. Since the 2014 edition, Mental Health Atlas surveys have gained additional importance, as they have provided much of the evidence for tracking progress towards the objectives and targets of the Comprehensive mental health action plan 2013–2020. With extension of the action plan to 2030, the 2020 edition also provided baseline values for updated targets for the period 2020–2030.

The updated targets and progress indicators for the plan are listed in Tables 1 and 2, with baseline values for 2020 and the latest values, for 2024. With the exception of global targets reported in Table 1 (which includes both), the values in this report represent the percentages of WHO Member States that provided responses to the survey, not all Member States, as the participation rate in the 2024 survey was significantly lower than for previous surveys, resulting in a reduced sample size and thus a lower percentage of all countries contributing to the global targets. Future editions of the Mental Health Atlas will continue to provide information and evidence on progress towards the globally agreed targets as well as national policy and services. High levels of participation and engagement by countries are necessary to ensure optimal information value and impact.

Methods

The Mental Health Atlas 2024, like previous editions, was developed in several administrative and methodological steps, beginning with revision and updating of the questionnaire to be sent to country focal points and ending with analysis and presentation of data. The process was broadly similar to that used for previous editions.

Stage 1
Development and testing of the questionnaire

The 2024 questionnaire was developed in accordance with the updated indicators of the Comprehensive mental health action plan 2013–2030, with complementary indicators for service development. Input was collected from WHO Member States and regional offices and from experts in measurement of mental health care. Declarations of interest for these external experts were requested, obtained and reviewed by the Secretariat; it was concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the content of the survey and this report.

The questionnaire was revised on the basis of feedback from users and administrators of the Atlas surveys in 2017 and 2020 and assessment of data quality and response rates for different sections of the Mental Health Atlas 2020. Additional questions were included to fill gaps, such as with respect to meaningful engagement of people with lived experience in mental health policy and planning, tele-mental health services and mental health and psychosocial support preparedness and response in emergencies. The final questionnaire was drafted in English and translated into French, Portuguese, Russian and Spanish. Arabic and Chinese versions were not prepared because the focal points in relevant countries were able to use the English version of the survey.

WHO's standard data collection tool, DataForm (a tailored version of LimeSurvey), was used to host the questionnaire and to manage data submissions. To facilitate data collection, a glossary of terms and guidance on completing different sections were included (terms used in the preparation of this report can be found in the Glossary). These resources provided definitions and instructions to ensure consistent understanding and standardized reporting.

Stage 2
Dissemination and submission of the questionnaire

WHO, through its regional offices, requested ministries of health and equivalent authorities to nominate a national focal point to complete the questionnaire. Focal points were given the opportunity to attend regional briefings on the purpose and content of the new Atlas survey. They were

also encouraged to consult relevant national stakeholders and experts to ensure accurate, comprehensive responses, and questions were included to assess whether stakeholder groups had been consulted in completing the Atlas survey. WHO maintained close communication with the focal points during data collection to provide guidance and address queries. A WHO staff member was available for technical support throughout preparation and submission. While countries were encouraged to complete the questionnaire online, a Microsoft Word version was provided on request for offline use and consultation.

Data collection was planned to last for a period of 6 months but was conducted over 9 months, starting in July 2024 and finishing in March 2025. The extension was due to delays in the start of data collection in some WHO regions, due to competing work priorities or commitments, and delayed submission of completed surveys, some of which required national review and clearance before transmission to WHO.

Stage 3
Data clarification, cleaning and reporting

Once a completed questionnaire was submitted, it was reviewed for completeness and internal consistency, including comparison with data from the 2017 and 2020 editions. To enhance data quality and completeness, many focal points were asked to provide clarifications or updated responses. The majority of countries that submitted completed questionnaires responded actively and engaged in the quality-checking process. Upon receipt of the final submissions from all responding countries, data were aggregated according to WHO region and World Bank income group for 2024 (see Annex for a list of responding countries, their focal points and other contributors; the WHO region and World Bank income group to which each country belonged in 2024 is also indicated).

Descriptive statistics, including frequency distributions and measures of central tendency (e.g. means, medians), were calculated as appropriate, with population-based rates (e.g. per 100 000 population) and United Nations World Population Prospects estimates (2023 revision, the dataset available at the time of analysis). For comparisons of small samples ($n < 30$), results are presented with the appropriate caveats about statistical power and generalizability. Cross-sectional data analysis was conducted in Microsoft Excel®, while Stata was used for longitudinal comparisons of new results for global targets and selected service development indicators with previous Atlas data (2017, 2020).

Data were also analysed by WHO region and by World Bank income group.

- Regional classification: Countries are categorized according to the WHO Region in which they were in 2024: the African Region (AFR), the Region of the Americas (AMR), the South-East Asia Region (SEAR), the European Region (EUR), the Eastern Mediterranean Region (EMR) and the Western Pacific Region (WPR).

- Classification by income group: Countries are also categorized into LIC, LMIC, UMIC and HIC according to their World Bank income group for fiscal year 2024. The classification of countries may differ occasionally from that used in previous Atlas editions because of annual updates in country income status.

Country profiles based on the responses of individual countries will be published separately.

Limitations

The global Mental Health Atlas survey of WHO Member States and certain other countries and territories is a substantial undertaking, which requires dedicated data collection by country focal points and other national data contributors, and also sustained data planning, coordination, management and analysis by WHO staff at global, regional and country levels.

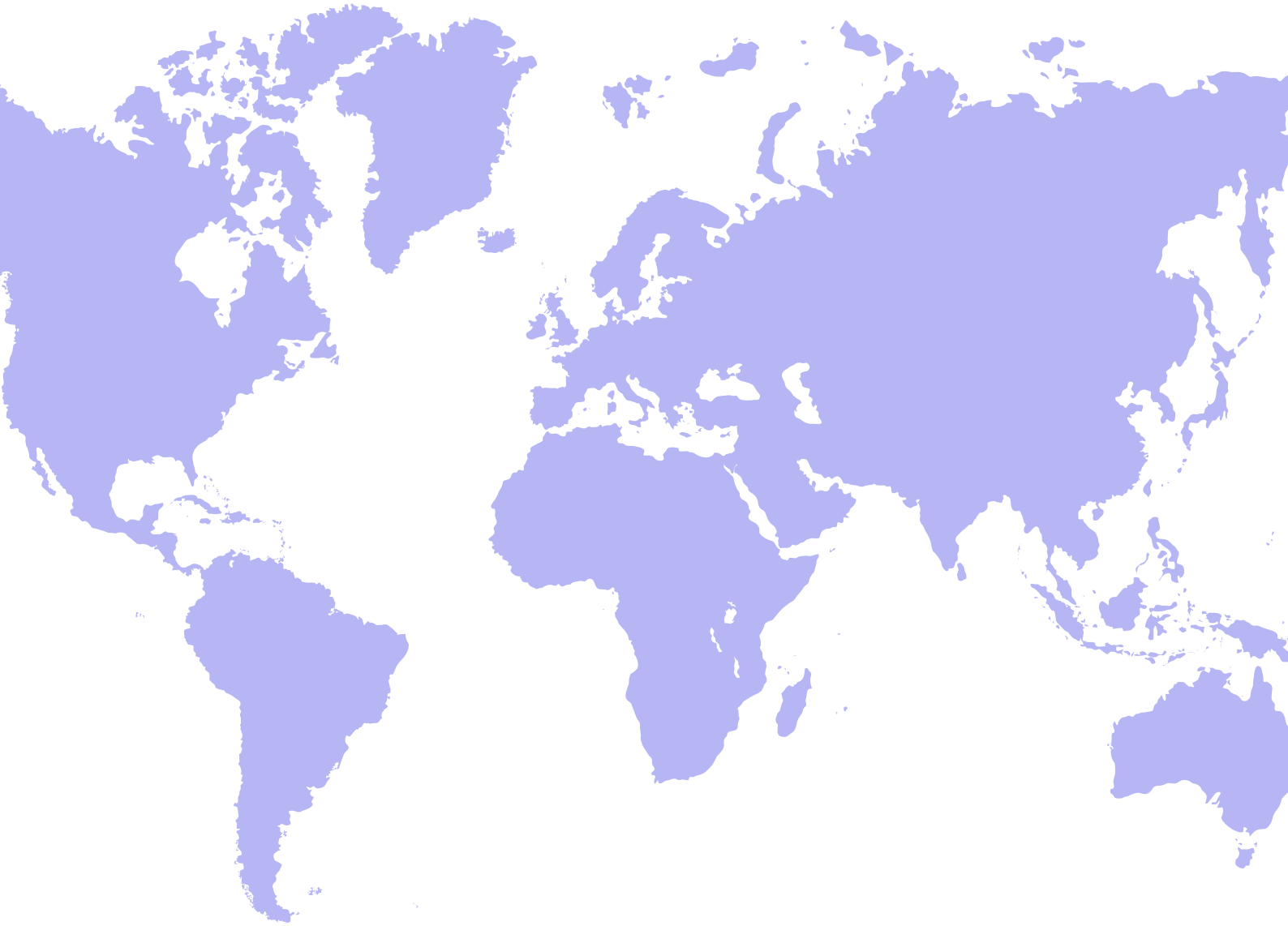
As mentioned above, overall participation in the 2024 survey for the Mental Health Atlas (144 Member States) was lower than in previous years (e.g. 171 in 2020). This lower submission rate may be due to various factors, including competing priorities, lack of systematic data collection and limited funding or technical capacity, particularly in LIC. The demands of post-COVID-19 recovery, survey fatigue and institutional changes such as staff turnover may also have played a role. Some countries may have perceived some overlap with other global or regional reporting requirements.

As a result of the lower submission rate, direct comparisons of data over time based on the percentage of all WHO Member States were not used; instead, results are presented mainly as a percentage of responding countries. The lower participation rate also affected the analysis and presentation of results for few country data, for example for SEAR (< 10 responses), or for variables with substantial missing or unreported data, for example on service coverage.

The Mental Health Atlas survey is completed by nominated individuals in ministries of health, which may introduce unintended reporting bias or variations over time, particularly when information is provided by a single focal point. Some countries found it difficult to report data in the requested format, especially those with federal or decentralized health systems, where information is often available at subnational levels but is not consolidated nationally. In many cases also, the required data simply do not exist or are not systematically collected and reported, particularly on use of services and the mental health workforce in NGOs and the private sector. Additionally, most of the data reported reflect national aggregates, which can mask significant differences within countries, such as disparities between urban and rural areas or between regions in terms of service availability, policy implementation and monitoring. Furthermore, lack of data disaggregated by age, sex or disease category restricts assessments of equity and the coverage of specific population groups. Although efforts were made to validate the reported data with publicly available sources, the opportunities for external verification were limited. These methodological and data limitations should be considered carefully in interpreting the results and in assessing global and national progress in mental health systems.

These limitations and weaknesses will only be overcome by strengthening mental health information systems, including by specifying measures or indicators of service delivery and performance, further investment in digital health records and collection of data on service user experiences and outcomes in routine health care.

Results



1 Mental health information

1.1 Reporting

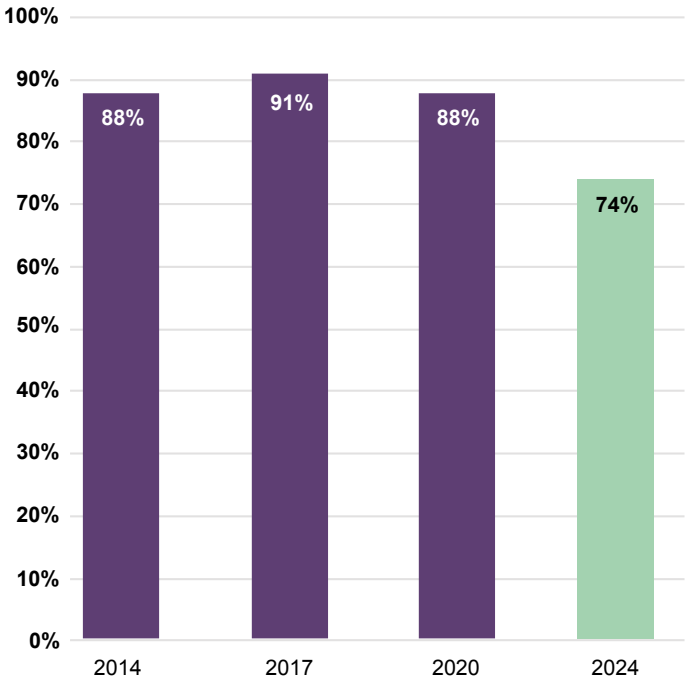
International reporting: WHO Mental Health Atlas 2024 participation and data submission

A core objective of the WHO Mental Health Atlas survey since it was first conducted, in 2001, is to obtain and present data on the state of the world's mental health services and systems, by periodic surveys of WHO Member States and territories. For this latest edition, 144 of WHO's 194 Member States submitted responses, representing a participation rate of 74% (see Table 3). The participation rates of the WHO regions differed from 55% in the EUR to 95% in the EMR. As illustrated in Fig. 2, this participation rate is lower than in other recent editions, mainly because there were five fewer submissions each in the AFR and the WPR regions and 17 fewer in the EUR. Administration of the survey in the EUR was delayed by a concurrent European Union survey on mental health system capacity and implementation of policy on mental health.[8]

Table 3. Participation of WHO Member States in the survey for the Mental Health Atlas 2024

	Total number of WHO Member States in 2024	Number (%) of WHO Member States represented in the Mental Health Atlas 2024
All	194	144 (74)
By WHO Region		
AFR	47	34 (72)
AMR	35	32 (91)
SEAR	11	9 (82)
EUR	53	29 (55)
EMR	21	20 (95)
WPR	27	20 (74)

Figure 2. Rates of participation in the Mental Health Atlas survey, 2014–2024



8. Mental health systems capacity in European Union Member States, Iceland and Norway. Copenhagen: WHO Regional Office for Europe; 2024. https://iris.who.int/handle/10665/378308. License: CC BY-NC-SA 3.0 IGO.

National reporting on mental health

Monitoring and surveillance involve the collection, analysis and interpretation of health data and timely communication of the data to policy-makers and others. Collection of mental health data is essential for tracking population needs, evaluating the effectiveness of services and guiding policy decisions. The WHO Mental Health Atlas survey consistently assesses the capacity of WHO Member States to compile and report such data. As shown in Fig. 3, 85% of the 144 Member States that responded to this item of the Atlas survey reported having compiled data on mental health in the past 2 years, of which nearly half (42%) were compiled as part of general health statistics and the other half were specifically compiled for reporting on mental health, either for the public sector alone (30%) or for both the public and private sector (14%). These proportions have changed little since 2017.

The extent and nature of data compilation and reporting differ substantially among countries with different income levels and in different WHO regions (Fig. 4). No data on mental health were reported to have been compiled in the past 2 years in > 20% of responding LMIC and < 10% in higher-income country groups. By WHO region, the percentage of responding countries that had not compiled data on mental health in the past 2 years ranged from 0–5% in the SEAR, the EUR and the WPR to 19–29% in the AFR, the AMR and the EMR.

Figure 3. National reporting on mental health (% of responding countries, WHO Mental Health Atlas 2017, 2020 and 2024)

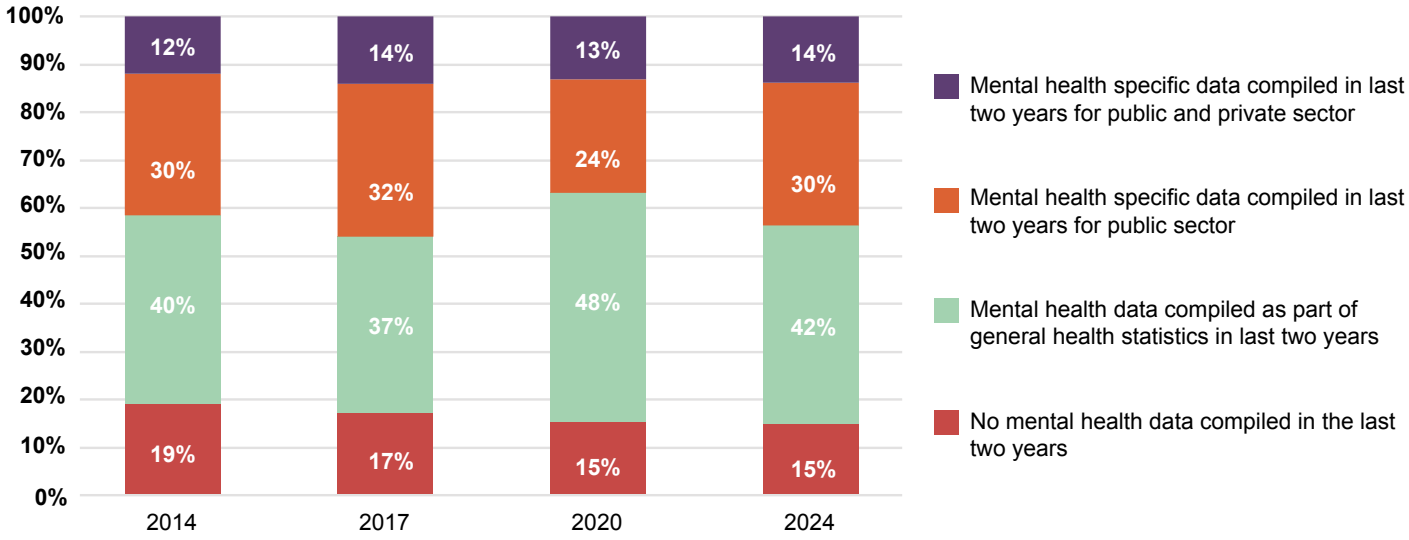
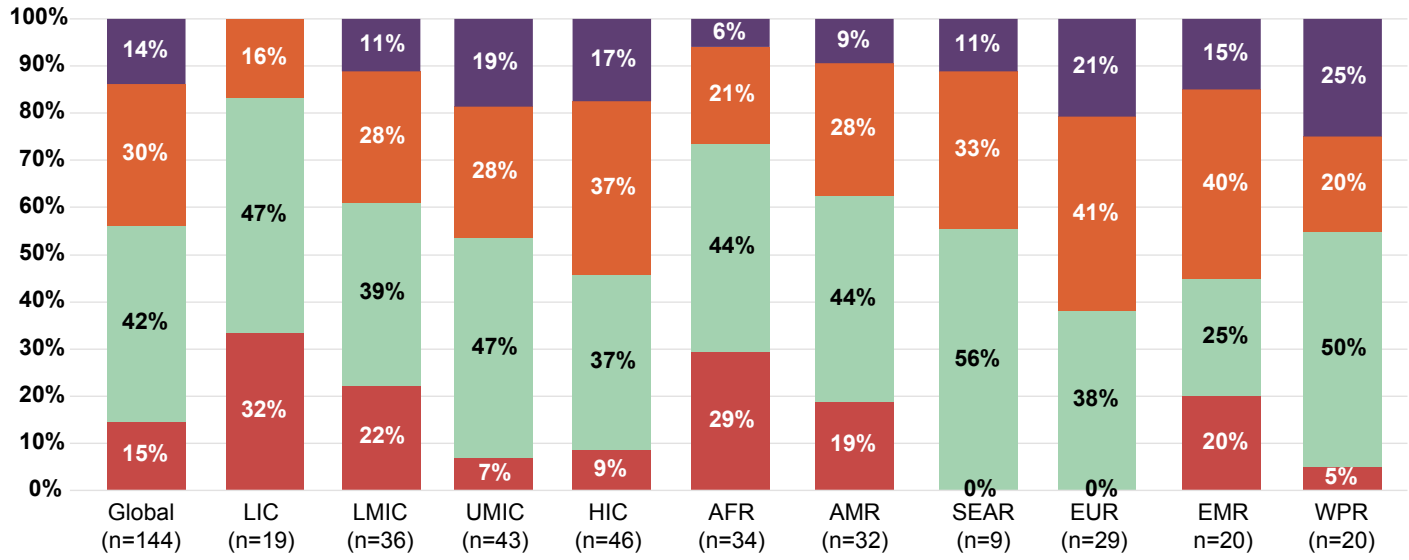


Figure 4. National reporting on mental health (% of responding countries by WHO region and World Bank income group)



1.2 Information systems

National mental health surveys

A periodic nationally representative, population-based mental health survey is an important source of information on the local epidemiology of mental disorders, related help-seeking behaviour and underlying determinants. Data derived from such surveys provide timely information for identifying population needs and consequent planning of services. A new item added to the survey in 2024 elicited information on whether countries had conducted a national mental health survey in the previous 10 years. The results are summarized in Fig. 5, which shows that just over one third (36%) of the 144 responding countries had done so. The percentage of HIC was 50% but only 21% of LIC. When data were disaggregated by WHO region, the rate ranged from nearly 20% in the AFR and the AMR to approximately half (45–56%) in the other four regions.

To elicit further information on the content of national mental health surveys, apart from their essential function of measuring the prevalence of various mental disorders or health conditions, questions were posed about the inclusion of risk factors for mental health conditions (such as demographic or socioeconomic factors), the physical health of people with mental health conditions and service uptake by people with these conditions. Table 4 summarizes the results for the 50 countries that had conducted a national mental health survey in the past 10 years. It shows that nearly 80% of the responding countries globally included all three topics; assessment of the physical health of people with mental health conditions was less commonly addressed.

Figure 5. Conduct of a national mental health survey in the past 10 years (percentage of responding countries by World Bank income group and by WHO region)

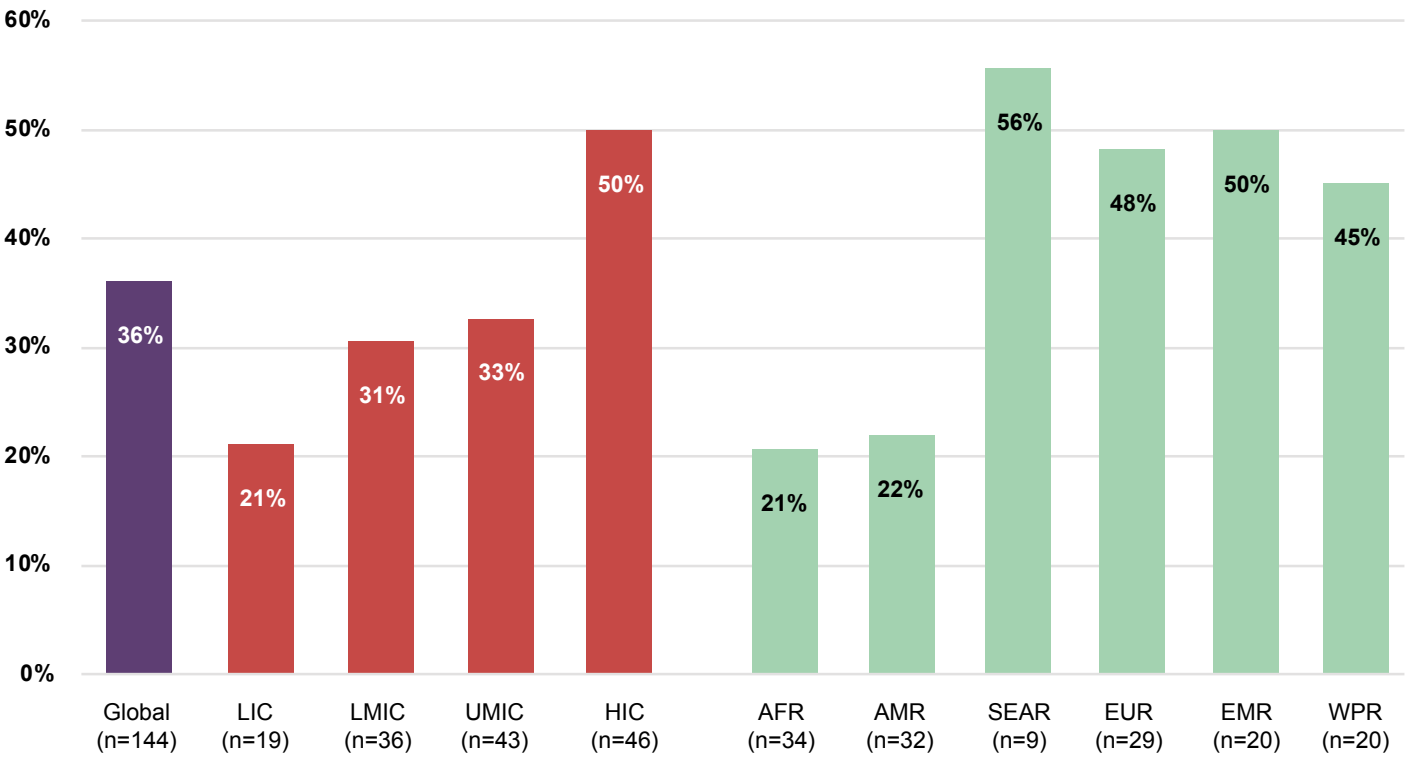


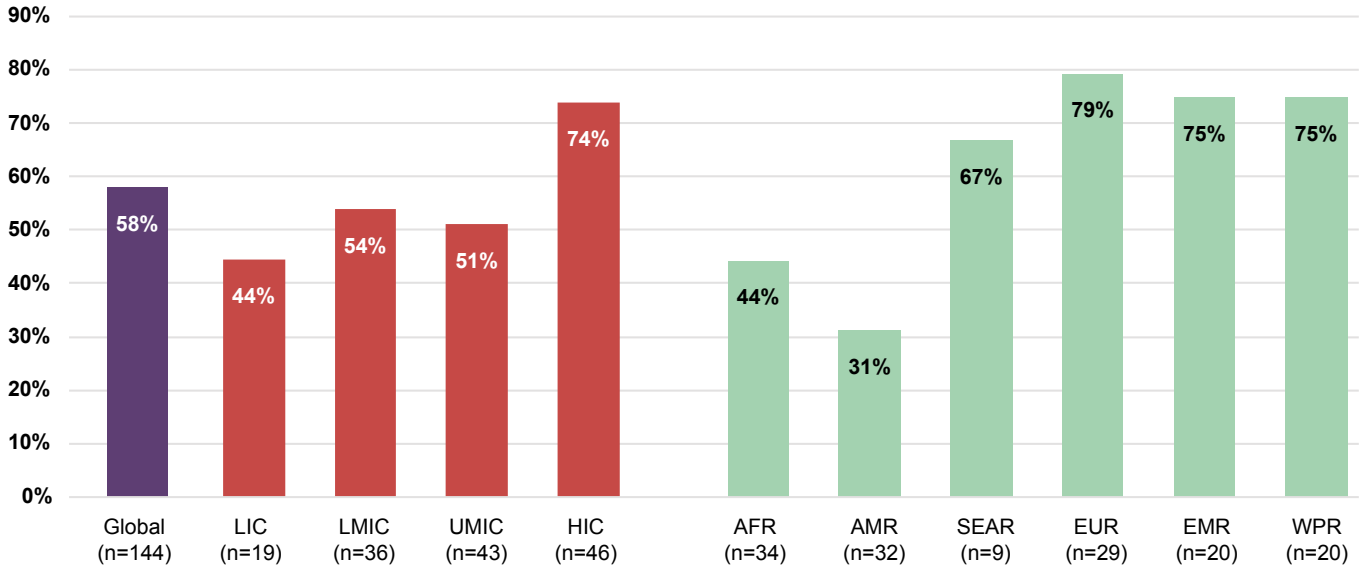
Table 4. Items included in national mental health surveys (proportion of responding countries that conducted a survey in the past 10 years, by World Bank income group and WHO region)

No. of responding countries	Included risk factors (%)	Included use of services (%)	Included assessment of physical health (%)
Globally (n=50)	82	82	78
By World Bank income level			
LIC (n=4)	100	75	100
LMIC (n=11)	82	91	45
UMIC (n=12)	92	92	92
HIC (n=23)	74	74	83
By WHO region			
AFR (n=7)	86	86	86
AMR (n=7)	100	86	100
SEAR (n=5)	80	100	40
EUR (n=13)	77	62	85
EMR (n=9)	78	89	67
WPR (n=9)	78	89	78

Digitalization of mental health record systems

A further important measure and marker of the availability and quality of data on mental health is use of digitalized health records. This was assessed for the first time in the 2024 Atlas survey by asking countries to report whether they had a nationwide digital health record system that included data on mental health. For those that replied positively, additional questions were asked about their use in both specialized and non-specialized mental health services (e.g. primary care) and whether each user of the services was assigned a unique identifier. As shown in Fig. 6, the percentage of responding countries that used a nationwide digital health records system that included data on mental health ranged from 44% in LIC to 74% in HIC, with a global average of 58%. According to WHO region, the lowest rates were observed in the AFR and the AMR, with 44% and 31% of responding countries, respectively.

Figure 6. Availability of digital health records systems that include mental health (% of responding countries), globally, by World Bank income group and WHO region



Of the countries with a digital health records system, 79% reported that they assigned a unique service number to monitor individual uptake of mental health services over time and at different levels of the health system (see Table 5). Similar percentages of responding countries (76–83%) stated that digital health record systems were being used in both specialized mental health service settings (e.g. psychiatric hospitals, outpatient services) and non-specialized settings such as primary care.

The percentages of countries in all income groups and WHO regions ranged from 60–90% for all three indicators of the availability of a digital health record system, indicating relatively good functionality and operationalization.

Table 5. Functioning of digital health record systems (% of responding countries that operate nationwide digital health records that include mental health data)

No. of responding countries	Unique service user identifiers used (%)	Digital health records used in specialized mental health services (%)	Digital health records used in non-specialized mental health services (%)
Globally (n=82)	79	83	76
By World Bank income level			
LIC (n=8)	63	75	88
LMIC (n=20)	75	75	70
UMIC (n=20)	80	80	90
HIC (n=34)	85	91	68
By WHO region			
AFR (n=15)	60	80	87
AMR (n=10)	90	70	90
SEAR (n=6)	83	100	100
EUR (n=22	86	86	64
EMR (n=14)	86	71	79
WPR (n=15)	73	93	60

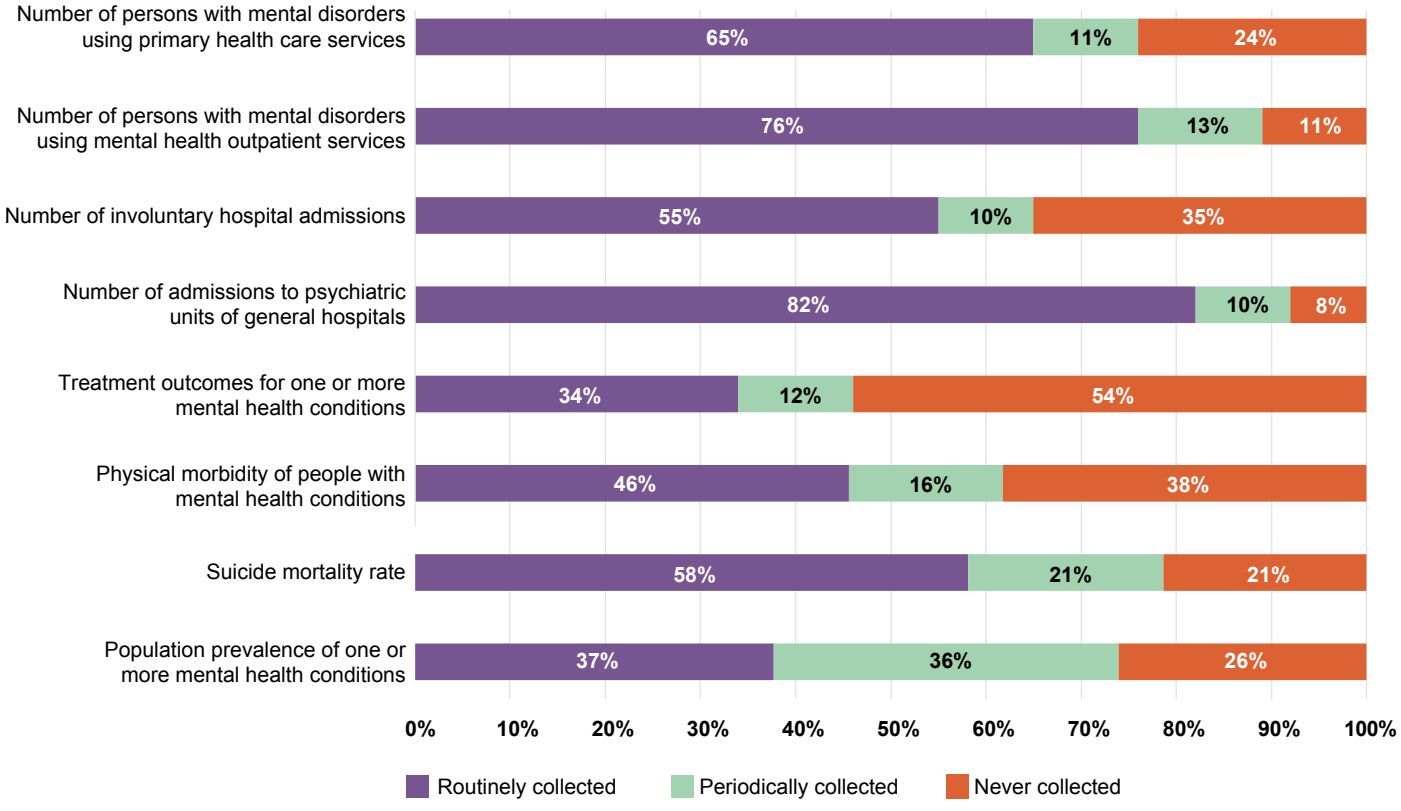
Mental health indicators

Measures of health status and outcomes and of health system function are vital for understanding and strengthening national mental health responses. Indicators of health status, such as prevalence and rates of suicide mortality, morbidity and treatment coverage, help to assess the burden of mental disorders and to identify priorities for intervention, while health systems indicators, such as the number of admissions to inpatient facilities and use of primary health care facilities, reflect the structural readiness of a country to deliver effective mental health care.

The Mental Health Atlas 2024 survey collected information on the extent to which countries are monitoring a defined set of core indicators (Fig. 7). The most frequently collected indicators are the number of admissions to psychiatric units in general hospitals (82% of responding countries) and the number of people who use mental health outpatient services (76% of responding countries). These reflect the capacity of health systems to monitor service use. The number of involuntary hospital admissions (55%) and the number of people who use primary health care for treatment of mental disorders (65%) are also relatively well monitored, although there is room for improvement.

The indicator of health outcomes that was less frequently collected is treatment outcomes (not collected by 54% of responding countries), indicating a critical gap in assessing the effectiveness of mental health services. Similarly, data on the physical morbidity of people with mental health conditions was not collected in 38% of responding countries, indicating lack of integration of monitoring of mental and physical health. Overall, data on service use, such as admissions and service use, were collected more consistently than indicators of health status and outcomes, such as prevalence and physical comorbidity. This suggests that the systems in many countries are oriented more towards administrative tracking than evaluating the health and well-being of service users. For more effective, data-based mental health policies, it is essential to strengthen regular collection of indicators of health status and outcome.

Figure 7. Collection and reporting of selected core mental health indicators



With respect to disaggregation of data by age, sex and diagnosis, the survey showed that disaggregation by diagnosis is the least common overall, despite its importance for understanding service use and outcomes by condition. While many countries report disaggregated data on service use by age and sex, particularly for outpatient and involuntary care, major gaps remain in disaggregation of treatment outcomes, physical comorbidity and hospital admissions. Substantial disparities were found among income groups and WHO regions in the collection of indicators of their mental health systems. HIC consistently reported higher rates of routine data collection, particularly on hospital admissions, involuntary admissions and use of outpatient services, while LIC reported less routine data collection and were more likely not to collect data on key indicators, such as treatment outcomes and involuntary admissions. The EUR and the EMR had the most comprehensive data collection, while the AFR and the SEAR lagged behind, particularly in areas such as treatment outcomes and involuntary hospitalization. Improving the breadth and consistency of disaggregation for all indicators is crucial for identifying inequity, for tailoring services and for informing mental health policy and planning (Table 6). Information systems must be strengthened to improve the quality of mental health care and to ensure that all countries can effectively plan, deliver and evaluate their mental health services.

Table 6. Availability of disaggregated data by age, sex and diagnosis for core indicators

Indicator	Disaggregation by age		Disaggregation by sex		Disaggregation by Diagnosis	
	Yes (%)	No (%)	No (%)	No (%)	No (%)	No (%)
Population prevalence of one or more mental health conditions	79	21	77	23	75	25
Suicide mortality	80	20	80	20	/	/
Physical morbidity of people with mental health conditions	62	38	63	38	61	39
Treatment outcomes for one or more mental health conditions	49	51	48	52	48	52
Number of admissions to psychiatric units of general hospitals	49	51	48	52	47	52
Number of involuntary hospital admissions	84	16	84	16	84	16
Number of people with mental disorders using mental health outpatient services	86	14	84	16	85	15
Number of people with mental disorders using primary health care services	65	35	66	34	62	38

2 Governance of mental health systems

2.1 Policies and plans

Existence of mental health policies and plans

Effective governance and strong leadership are crucial for developing effective policies and plans addressing mental health. A mental health policy is an official statement by a government of the vision, values, principles and objectives of an overall plan of action to improve the mental health of a population. The policy should be accompanied by a detailed plan, with concrete strategies and activities to be implemented within established timelines, and the necessary resources. Policies and plans for mental health may be distinct or be integrated into policies for general health or disability. They are considered valid when they have been approved or published by the ministry of health, another line ministry or the country's parliament.

As for previous editions, the Mental Health Atlas 2024 survey assessed whether countries had distinct and/or integrated mental health policies or plans and whether those policies or plans had been updated recently. To evaluate the compliance of policies and plans with international human rights instruments, countries completed the following checklist:

- transition towards mental health services based in the community;
- respect for the rights of people with mental health conditions and psychosocial disabilities and of at-risk populations;
- a full range of services and support to enable people to live independently and be included in the community;
- a recovery approach to mental health care, which emphasizes support for individuals to achieve their aspirations and goals; and
- participation of people with mental health conditions and psychosocial disabilities in decisions about issues that affect them.

The 2024 questionnaire also enquired about implementation of policies and plans. Mental health plans and policies were considered to be being implemented only if at least two of the following three criteria were fulfilled: 1) human resources have been estimated and allocated for implementation of mental health policies and plans; 2) financial resources have been estimated and allocated for implementation of mental health policies and plans; and 3) the policy or plan specifies indicators or targets against which implementation is to be monitored.

A total of 117 countries (81% of responding countries, 60% of WHO Member States) reported that they had a distinct policy or plan for mental health, including more than 80% of responding countries in the EUR, the EMR and the WPR (Table 7). In 86% of responding countries, the policy was reported to have been developed in consultation with people with lived experience.

Table 7. Existence of a distinct mental health policy or plan: Mental Health Atlas 2017, 2020 and 2024 (% of responding countries, by WHO region)

Location	2017 (n=175) (%)	2020 (n=170) (%)	2024 (n=143) (%)
Globally	79 (n=139)	86 (n=146)	81 (n=117)
By WHO region			
AFR	72 (n=31)	76 (n=29)	74 (n=25)
AMR	82 (n=27)	91 (n=30)	77 (n=24)
SEAR	90 (n=9	100 (n=8)	78 (n=7)
EUR	81 (n=39)	91 (n=42)	96 (n=27)
EMR	78 (n=14)	80 (n=16)	81 (n=17)
WPR	83 (n=19)	84 (n=21)	85 (n=17)

Publication or updating of policies or plans since the previous Mental Health Atlas was reported by 61 of responding countries; the largest proportion of countries was in the SEAR (> 80% of responding countries). This is an important finding, as only 25% of responding countries had published or updated their policies or plans between 2013 and 2020 and only 14% of responding countries before 2013 (Table 8). Of the 27 countries that reported that they did not have a distinct policy or plan, 12 noted that policies or plans for mental health were integrated into policies and plans for general health or disability. A policy or plan for mental health was being developed in 13 countries.

Table 8. Status of revision of mental health policies or plans, by WHO region and World Bank income group (% of responding countries, by WHO region)

Number of responding countries	Policy or plan updated since 2020 (%)	Policy or plan updated between 2013 and 2019 (%)	Policy or plan updated before 2013 (%)
Globally (n=115)	61	25	14
By WHO region			
AFR (n=24)	50	21	29
AMR (n=24)	50	29	21
SEAR (n=6)	83	17	0
EUR (n=27)	78	19	4
EMR (n=17)	47	47	6
WPR (n=17)	71	24	6

Countries were asked whether they had a policy or plan for child and/or adolescent mental health. Of the 141 WHO Member States that responded to the question, 77 (56%) reported that they had a distinct or integrated plan or policy for both children and adolescents. As shown in Table 9, most of the responding countries (> 77%) reported that they had updated their policy or plan for children and/or adolescents since the previous Atlas, and the proportion increased to 100% of responding countries in the WPR.

Table 9. Existence and revision of a policy or plan for child and/or adolescent mental health, by WHO region

Number of responding countries	Existence of a distinct or integrated policy or plan (% all responding countries)	Policy or plan has been updated since 2020 (% all responding countries)
Globally (n=138)	56	77
By WHO region		
AFR (n=33)	45	54
AMR (=31)	45	92
SEAR (=9)	89	86
EUR (n=28)	75	85
EMR (n=20)	60	58
WPR (n=17)	41	100

In a new question for the 2024 version of Atlas, countries were asked whether they had a policy or plan for the mental health of older adults. Of the 142 WHO Member States that responded to the question, 42% reported a distinct or integrated mental health plan or policy for older adults (Table 10). Most countries (58%) reported that they had updated their policy or plan since 2019.

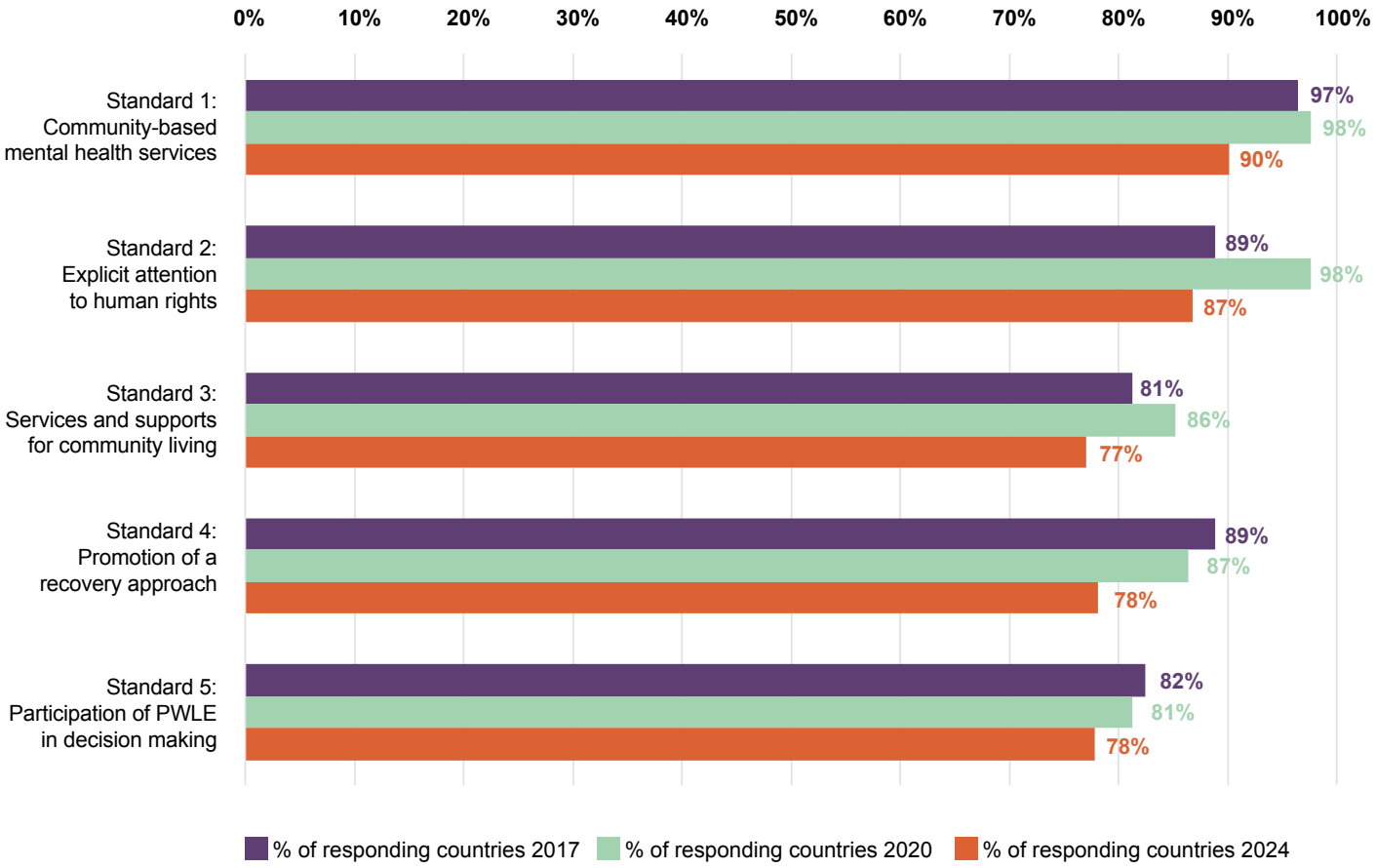
Table 10. Proportions of WHO regions that reported a mental health policy or plan for older adults, globally and by WHO region

	Existence of a distinct or integrated policy or plan (% all responding countries)	Policy or plan has been updated since 2020 (% all responding countries)
Globally (n=142)	42	58
By WHO region		
AFR (n=34)	32	63
AMR (n=31)	32	50
SEAR (n=9)	78	33
EUR (n=29)	61	69
EMR (n=20)	45	33
WPR (n=19)	26	100

Compliance of mental health policies and plans with human rights instruments

Fig. 8 illustrates the self-rating by responding countries according to the five items on the checklist cited above. All responding countries in 2024 (n=109) considered that their policies or 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) (90%); 2) respect for the rights of people with mental health conditions and psychosocial disabilities and of at-risk populations (87%); 3) full range of services and support 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 support) (77%); 4) a recovery approach to mental health care, which emphasizes support for individuals to achieve their aspirations and goals, with users of mental health service involved in development of their treatment and recovery plans (78%); and 5) participation of people with mental health conditions and psychosocial disabilities in decisions about issues that affect them (e.g. policies, laws, service reform, service delivery) (78%). The rate of positive responses is similar to that in 2017 but has decreased since 2020, indicating that major work remains to be done in this area.

Figure 8. Compliance of mental health policies and plans with human rights instruments (2017, 2020 and 2024)



The scores for all items on the checklist ranged from zero (no compliance) to five (full compliance), indicating the extent to which countries considered that their mental health policies or plans were in line with human rights instruments (Fig. 9). Most countries scored at least four (85% of responding countries) or five (72% of responding countries).

Figure 9. Mental health policies or plans and human rights: checklist score (percentage of responding countries) by WHO region

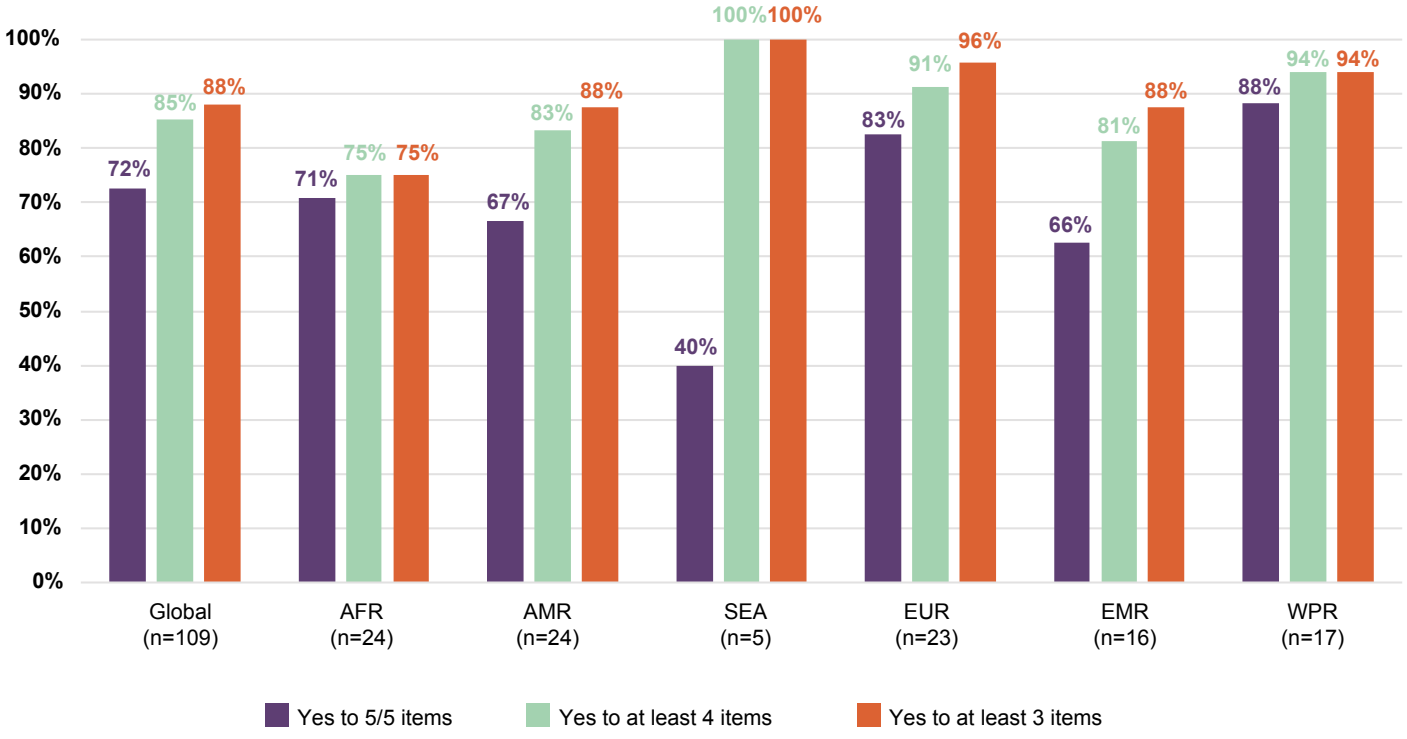
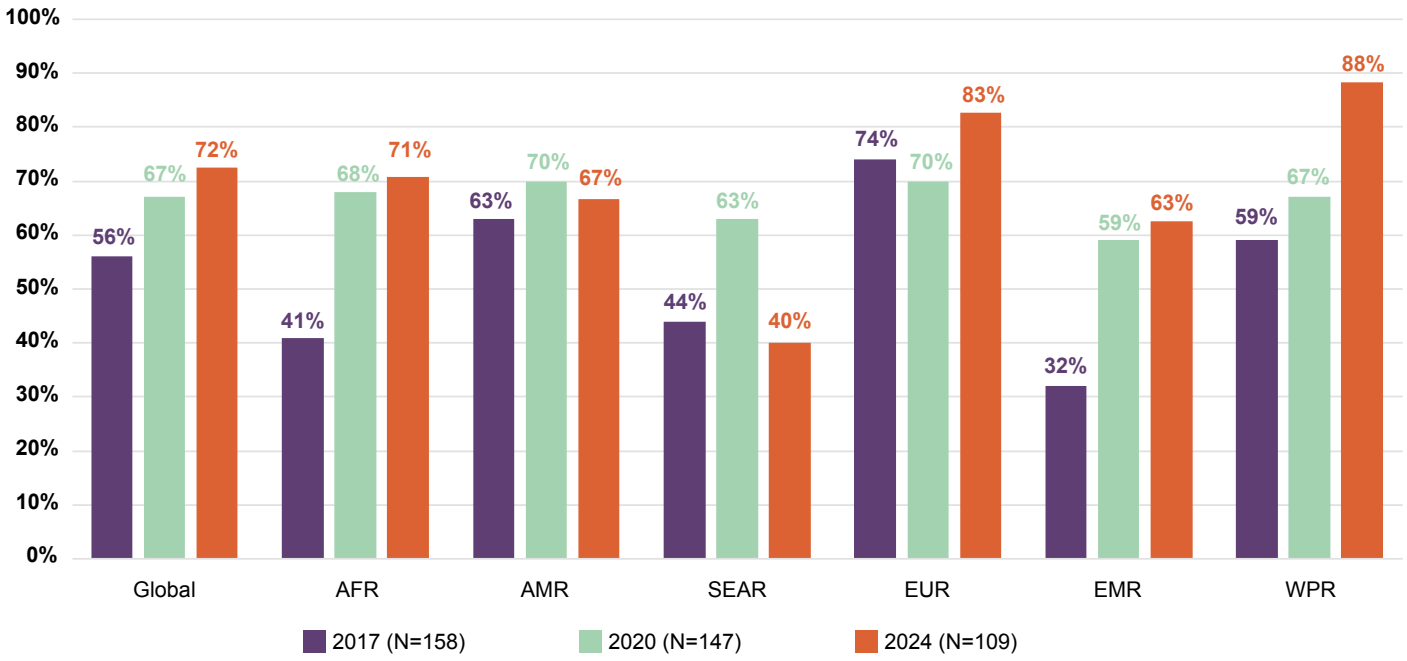


Fig. 10 provides a comparison of WHO regions with respect to full compliance of mental health policies or plans with human rights instruments over time. The proportion of countries that reported full compliance has increased notably in all WHO regions since 2017. This might reflect an increase in countries' awareness of human rights and a more critical attitude towards the compliance of their policies or plans with international instruments. It should be noted, however, that the number of responding countries has decreased over the years, which could create bias.

Figure 10. Reported full compliance of mental health policies and plans with human rights instruments, by WHO region (2017, 2020 and 2024)



Human and financial resources for mental health policies and plans

The questionnaire asked whether human and financial resources have been allocated to a costed plan for implementation of the policies or plans. It should be noted that these are self-reported assessments and may be subject to reporting bias. Table 11 shows countries' reporting on the allocation of human and financial resources, by WHO region and World Bank income group. Of the 133 countries that answered this question, the majority reported that human resources have been partially (55%) or fully (18%) allocated to their mental health policies or plans. Wide differences were found among WHO regions and World Bank income groups, fewer than half of LIC reporting allocation of human resources for implementation of their mental health plan, as compared with 85% of HIC. Partial or full allocation for their mental health policy or plan was reported by 69% of responding countries. Higher-income countries also allocated more financial resources than lower-income countries, signalling challenges in lower-income countries in making resources available to implement their policies and plans.

Table 11. Partial or full allocation of human and financial resources for mental health policies and plans, by WHO region and World Bank income group

	Allocation of human resources (%)			Allocation of financial resources (%)		
	Not allocated	**Partially allocated**	**Fully allocated**	**Not allocated**	**Partially allocated**	**Fully allocated**
Globally (n=133)	28	55	18	31	53	16
By World Bank income group						
LIC (n=17)	59	35	6	59	35	6
LMIC (n=34)	38	56	6	38	56	6
UMIC (n=41)	32	51	20	31	50	19
HIC (n=41)	15	61	27	14	60	26
By WHO region						
AFR (n=33)	55	33	12	52	39	9
AMR (n= 30)	23	60	17	40	47	13
SEAR (n=7)	14	43	43	14	29	57
EUR (n=26)	8	65	27	12	73	23
EMR (n=20)	25	55	20	25	55	20
WPR (n=18)	22	72	6	22	72	6

Indicators and targets for monitoring implementation of mental health policies and plans

Countries were also asked whether they used indicators or targets in monitoring implementation of their mental health policies and plans. Of the 141 countries that responded, 84 stated that their policy or plan included indicators or targets against which its implementation is being monitored (Table 12). The proportion of countries that had set indicators to monitor implementation has increased since 2020. More work will be necessary, especially in LIC, to develop or strengthen strategies to adequately monitor the protection of human rights and 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 12. Proportions of respondents who reported use of indicators or targets to monitor implementation of their policies or plans, by WHO region and World Bank income group

	In 2017 (n=163) (%)	In 2020 (n=168) (%)	In 2024 (n=142) (%)
Globally	79 (n=128)	77 (n=129)	84 (n=119)
By World Bank income group			
LIC	81 (n=22)	88 (n=21)	79 (n=15)
LMIC	69 (n=29)	75 (n=30)	81 (n=29)
UMIC	82 (n=36)	77 (n=40)	86 (n=37)
HIC	82 (n=41)	73 (n=38)	86 (n=38)
By WHO region			
AFR	69 (n=29)	79 (n=30)	71 (n=24)
AMR	75 (n=21)	66 (n=21)	84 (n=26)
SEAR	70 (n=7)	88 (n=7)	100 (n=9)
EUR	87 (n=39)	78 (n=35)	93 (n=26)
EMR	82 (n=14)	85 (n=17)	85 (n=17)
WPR	86 (n=18)	76 (n=19)	85 (n=17)

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

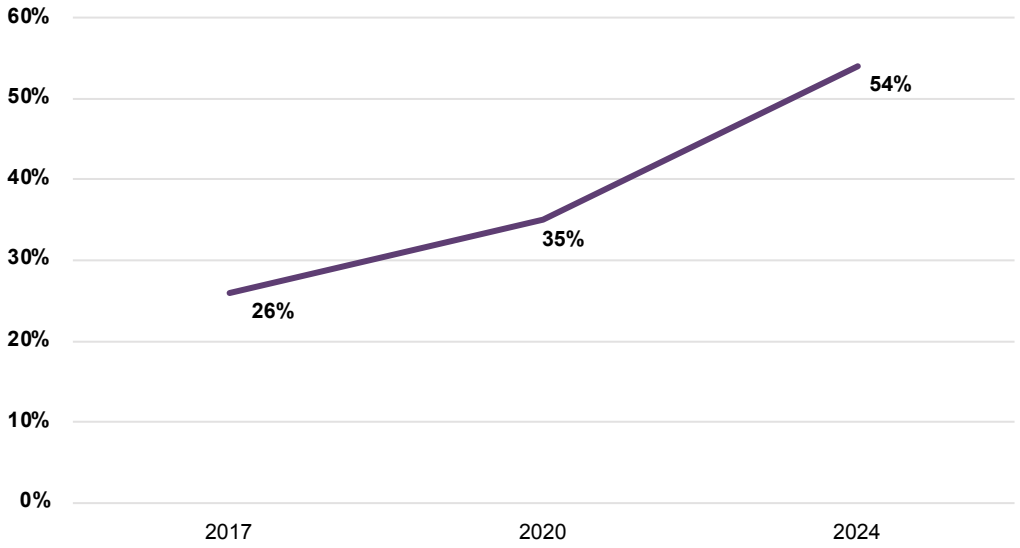
In total, 128 countries (corresponding to 89% of responding countries) reported that they had a distinct policy or plan for mental health (Table 13). Of these countries, 72% reported that their policy or plan was fully compliant with human rights instruments, and 75% reported that human and financial resources had been allocated and that they included indicators to monitor implementation. Half of the responding countries reported that their policies or plans were being implemented and were fully compliant with human rights instruments. EUR included the highest percentage (70%) of responding countries, while the SEAR had the lowest (40%). Notable differences were seen among income groups: 66% of HIC and 29% of LIC.

Table 13. Status of mental health policies and plans, implementation and compliance with human rights instruments, by WHO region and World Bank income group

	Integrated or distinct policy or plan (%)		Compliant with human rights instruments (%)	Being implemented (%)	Being implemented and fully compliant with human rights instruments (%)
Globally (n=144)	89	Globally (n=109)	72	75	50
By World Bank income group					
LIC (n=18)	68	LIC (n=14)	64	39	29
LMIC (n=37)	100	LMIC (n=26)	73	54	46
UMIC (n=43)	91	UMIC (n=34)	71	53	47
HIC (n=46)	87	HIC (n=35)	77	67	66
By WHO region					
AFR (n=34)	85	AFR (n=24)	50	54	42
AMR (n=32)	81	AMR (n=24)	50	67	46
SEAR (n=9)	100	SEAR (n=5)	22	67	40
EUR (n=29)	90	EUR (n=23)	62	87	70
EMR (n=20)	95	EMR (n=16)	50	94	44
WPR (n=20)	95	WPR (n=17)	75	71	59

Longitudinal analysis showed that the proportion of responding countries that have updated their mental health policy, allocated human and financial resources, implemented it and are fully compliant with human rights instruments is increasing steadily over time. Fig. 11 shows that the cumulative number of WHO Member States that meet this composite standard doubled from 25% to 56% between 2017 and 2024.

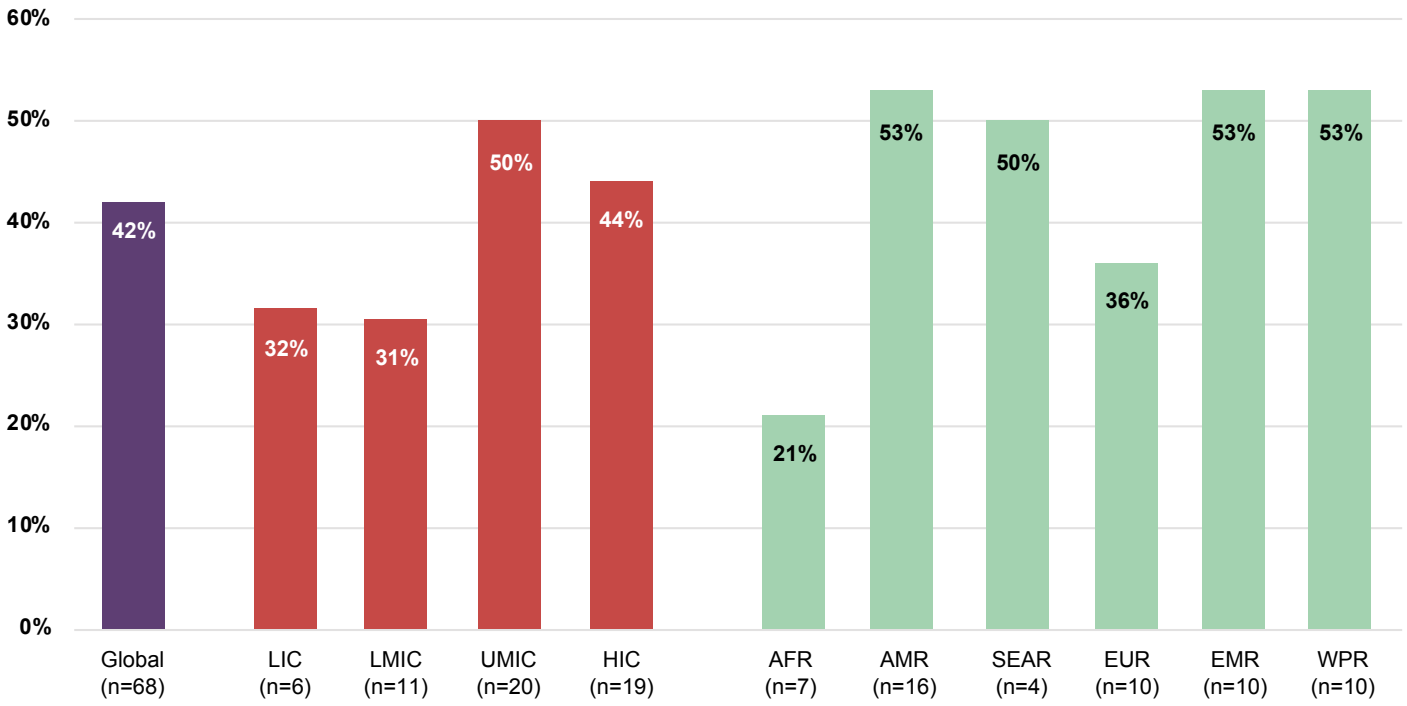
Figure 11. Proportions of responding Member States that have implemented their policy or plan, with human and financial resources allocated, indicators monitored and full compliance with human rights standards (n=194), 2017, 2020 and 2024



Policy and guidance on the physical health of people with mental health conditions

Data in the Mental Health Atlas 2024 on physical health care for individuals with mental health conditions show that significant gaps remain in both policy and guidance. Only 42% of responding countries reported having a policy for monitoring physical health, with wide regional differences, from 21% in the AFR to over 50% in the AMR, the EMR and the WPR (Fig. 12). This highlights continuing neglect of integrated physical and mental health care, especially in resource-limited settings, calling for urgent global policy action and investment.

Figure 12. Countries with a policy for regular screening of the physical health of people with mental health conditions



2.2 Legislation

Legislation on mental health is an essential element of effective governance. It comprises establishing a legal framework to protect the rights and dignity of individuals with mental health conditions and psychosocial disabilities. It must be aligned with the core principles, values and goals of mental health policies, particularly promotion of human rights and reduction of coercive practices. It should provide clear legal provisions for community-based care, informed consent and participation in decision-making, and robust oversight mechanisms must be established to ensure compliance with international human rights standards. Legislation on mental health must reflect the obligations agreed to in the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments to ensure that legal protection is consistent with global commitments to equality, non-discrimination and autonomy.

The questionnaire for Atlas 2024 included questions on whether countries had a distinct and/or integrated mental health law and whether that law had been updated. Countries with new laws completed a checklist to evaluate the compliance of their legislation with international human rights instruments:

- Standard 1: transition to community-based mental health services (including in general hospitals and primary care);
- Standard 2: promotion of the rights of people with mental health conditions and psychosocial disabilities to exercise their legal capacity;
- Standard 3: promotion of alternatives to coercive practices and promotion of informed consent and voluntary treatment (in the 2024 survey, this was broken down further into informed consent for treatment, promotion of voluntary admissions and prevention of seclusion and constraints);
- Standard 4: provisions 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; and
- Standard 5: regular inspection of human rights conditions in mental health facilities by an independent body.

The Comprehensive mental health action plan emphasizes the importance of implementing legislation. Mental health legislation was considered to be implemented if at least two of the following three criteria were met: a dedicated authority or independent body has been assigned; mental health services are inspected regularly; and responses are made systematically to complaints and its findings reported at least once a year.

Of the 104 countries (72% of responding countries) that reported having a law specifically on mental health (Table 14), more than 80% of those in the AMR, the EUR, the EMR and the WPR and only 59% of Member States in the AFR reported that they had such laws. The percentage of responding countries with distinct mental health law has increased in almost all regions since the Mental Health Atlas in 2014. The survey questionnaire acknowledges the importance of integrating mental health laws into other general health or disability laws. They can also be included in other relevant sectors, such as criminal justice, capacity-related legislation and civil codes.

Table 14. Presence of dedicated mental health laws (2017, 2020 and 2024) and percentage of responding countries by WHO region

Dedicated mental health laws	In 2017 (n=173) (%)	In 2020 (n=171) (%)	In 2024 (n=144) (%)
Globally	64 (n=111)	64 (n=110)	72 (n=104)
By WHO region			
AFR	45 (n=19)	49 (n=19)	59 (n=20)
AMR	61 (n=20)	61 (n=20)	81 (n=26)
SEAR	50 (n=5)	63 (n=5)	56 (n=5)
EUR	77 (n=37)	70 (n=32)	79 (n=23)
EMR	61 (n=11)	70 (n=14)	70 (n=14)
WPR	86 (n=19)	80 (n=20)	80 (n=16)

The responses of 39 countries (33% of responding countries) indicated that their law had been updated since 2020. The AMR and the EUR reported the highest percentage of updated mental health laws. When countries were categorized by World Bank income group, variations were observed (Table 15). For 81 countries (59% of responding countries), it was reported that the legislation had been developed in consultation with people with lived experience. In 72% (26 of 36) of countries, the law for mental health was integrated into general laws on health or disability.

Table 15. Updating or revision of mental health legislation before 2013, between 2013 and 2020 and since 2020, by WHO region and World Bank income group

No. of responding countries that had revised their mental health law	Before 2013 (%)	2013–2020 (%)	Since 2020 (%)
Globally (n=117)	40	26	33
By World Bank income group			
LIC (n=8)	38	50	13
LMIC (n=30)	57	30	13
UMIC (n=36)	47	19	33
HIC (n=44)	25	25	50
By WHO region			
AFR (n=21)	57	24	19
AMR (n=28)	39	14	46
SEAR (n=7)	29	57	14
EUR (n=28)	32	21	46
EMR (n=14)	43	36	21
WPR (n=19)	37	37	26

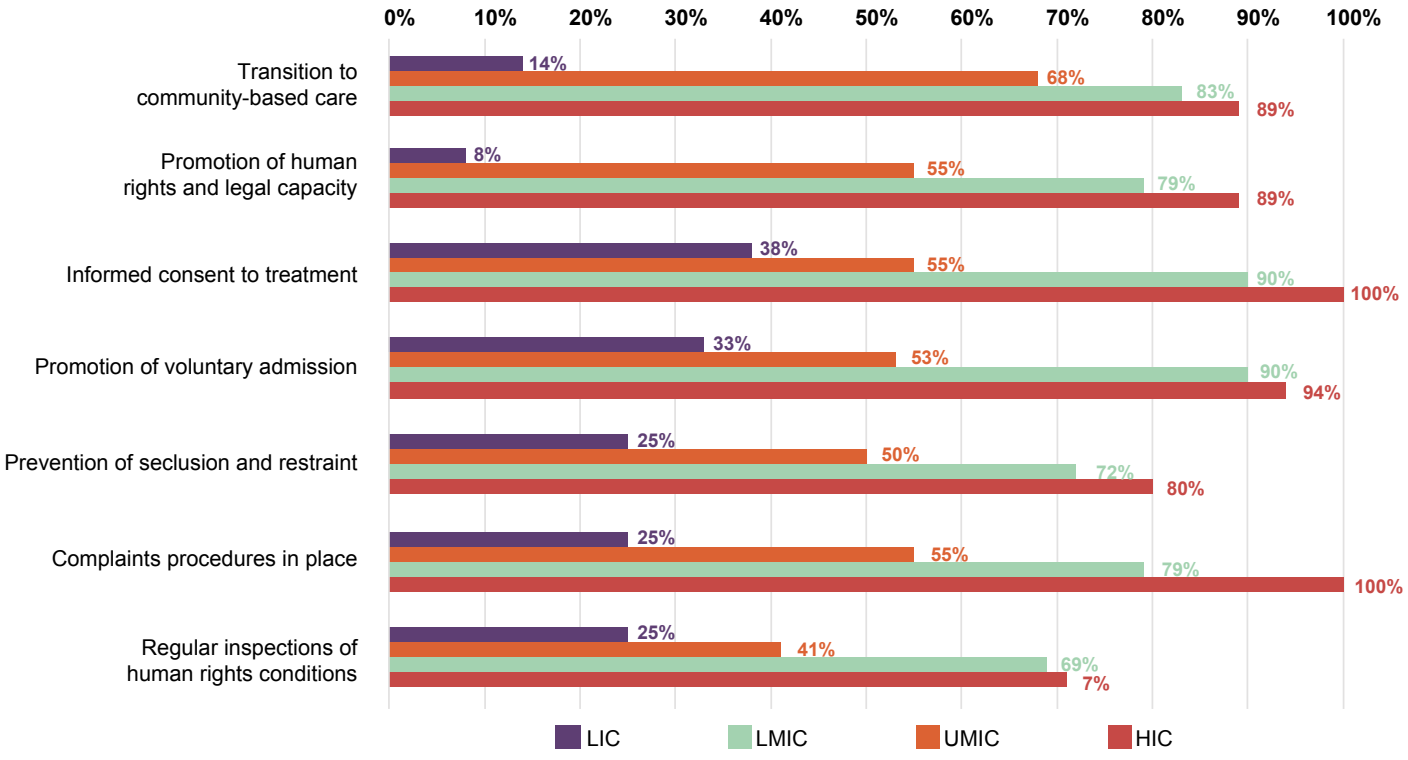
Compliance of mental health law with human rights instruments

Most of the responding countries considered that their laws promoted at least one of the following standards:

- transition towards community-based mental health services (74 countries, 73% of responding countries);
- promotion of the rights of people with mental health conditions and psychosocial disabilities to exercise their legal capacity (68 countries, 68%);
- informed consent to treatment (77 countries, 79%);
- promotion of voluntary admission (74 countries, 77%);
- prevention of seclusion and constraint (62 countries, 65%);
- 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 (74 countries, 75%); and
- provision for regular inspections of human rights conditions in mental health facilities by an independent body (57 countries, 58%).

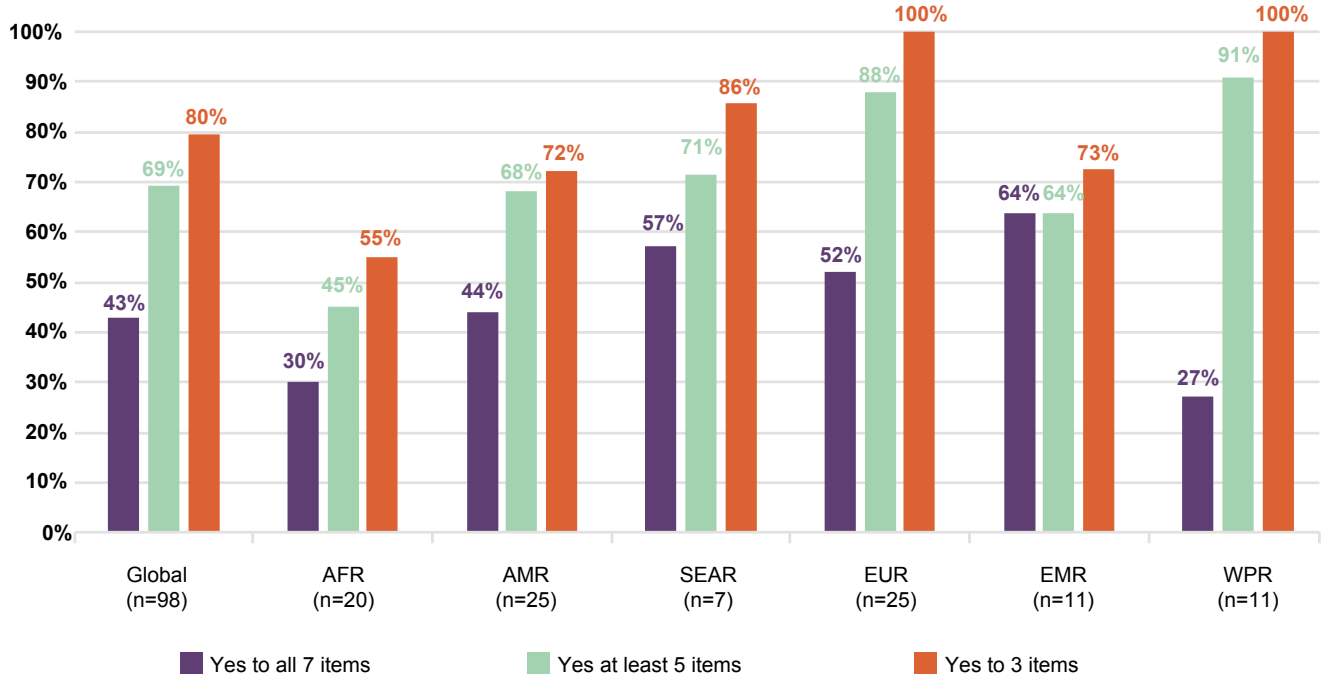
Fig. 13 provides a breakdown by World Bank income group of compliance with the standards. All HIC complied with two of the seven standards, and at least 80% of HIC and UMIC complied with several standards. By contrast, compliance rates among LIC were less than 40% for each standard. It should be noted with respect to this question that self-reported data may result in overestimation of compliance.

Figure 13. Proportion of responding countries that reported compliance of their mental health legislation with human rights, by World Bank income group



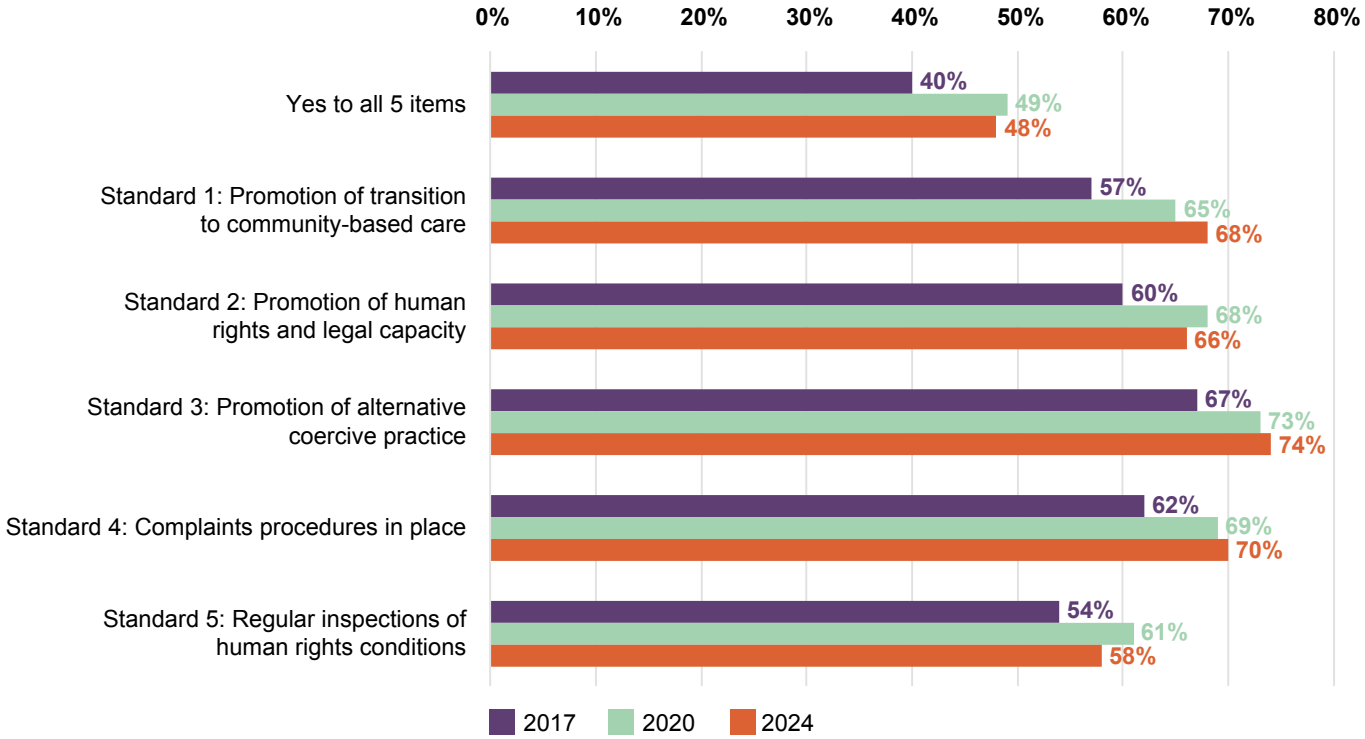
Addition of the scores on the checklist standards provides an overall score ranging from 0 (no compliance) to 7 (full compliance) for the extent to which countries considered their mental health laws to be in line with human rights instruments. A score of at least 3 was achieved by 78 countries (80% of responding countries), and 68 countries (69% of responding countries) scored at least 5, indicating partial compliance (Fig. 14). All seven standards were endorsed by 42 countries (43% of those that responded), corresponding to full compliance.

Figure 14. Mental health legislation and human rights: checklist scores (percentage of responding countries), by WHO region



Longitudinal analysis for the period 2017–2024, which assesses cumulative progress towards the global target of 80% of all WHO Member States, shows that the extent of compliance of mental health legislation with human rights instruments across the five overall standards has not notably improved since the last survey in 2020 (Fig. 15). Between 68-74% of Member States report meeting the first four standards, while just less than half (48%) continue to meet all five standards. These latest data include instances from countries where standards that were reported to be complied with in earlier Atlas surveys are no longer endorsed, which may represent actual regression in meeting the standards but could also reflect differences in rating compliance by successive focal points completing the checklist.

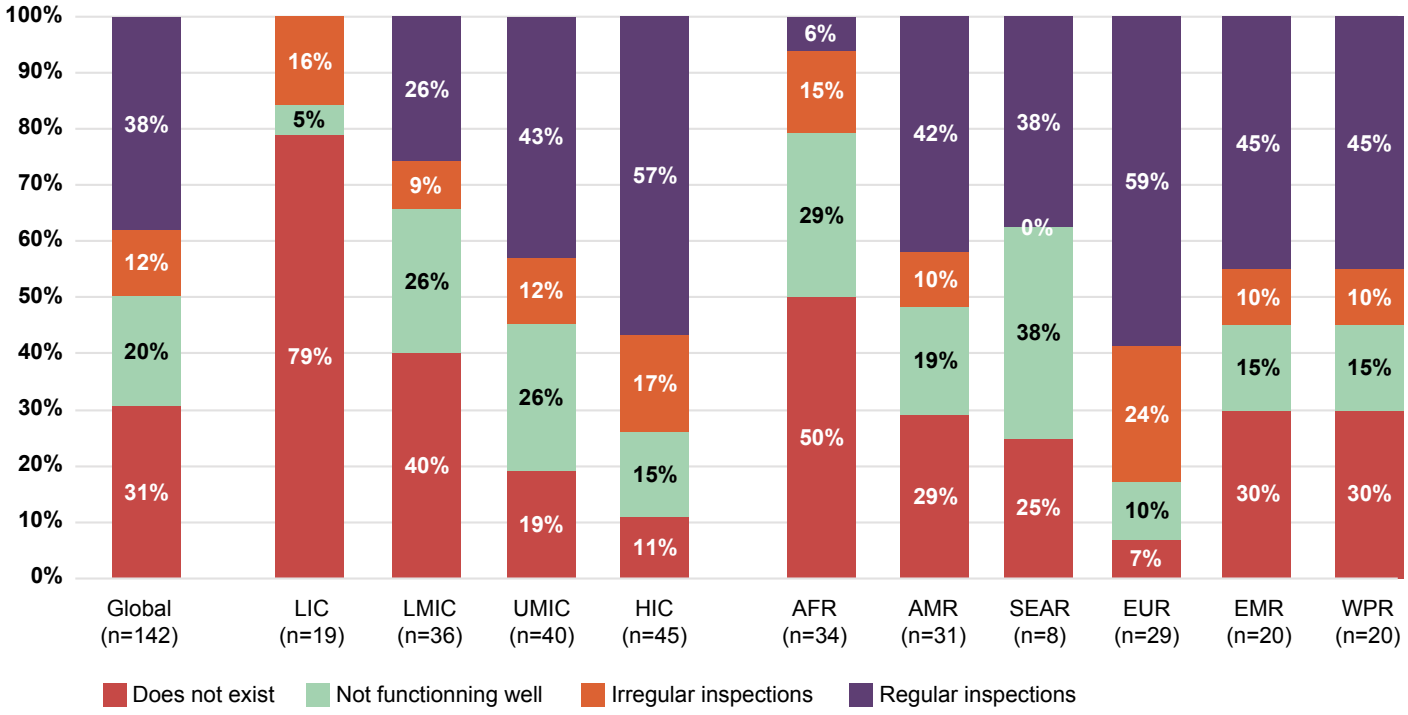
Figure 15. Compliance of mental health legislation with human rights instruments across 194 WHO Member States (2017, 2020 and 2024)



Existence of an independent monitoring authority

Close to one-third of responding countries globally (32%) reported that a dedicated authority or independent authority for assessing the compliance of mental health legislation with international human rights instruments did not exist (similar to what was found in 2020. The proportion was 79% in LIC and 50% in the AFR (Fig. 16). Regular inspections by a dedicated or independent authority were conducted in 27% of countries globally and by > 40% of UMIC and HIC.

Figure 16. Countries with a dedicated authority or independent body for assessing the compliance of their mental health legislation with international human right instrument, by WHO region



2.3 Stakeholder collaboration

Implementation of mental health policies and plans and laws requires collaboration among many sectors, including a country's ministry of health, to develop a people-centred system, improve the coordination of services and implementation of programmes and strengthen mental health care. Stakeholder collaboration requires strong leadership and intersectoral engagement with bodies including service users and family and carer advocacy groups and areas such as social affairs, social welfare, housing, employment, justice, education, governmental and nongovernment agencies, the media, academia, professional associations, faith-based organizations and institutions and traditional and indigenous healers.

The Comprehensive mental health action plan identifies multisectoral collaboration as one of its six cross-cutting principles and approaches. It encourages Member States to motivate and engage with stakeholders in all relevant sectors and backgrounds, including engagement with and the involvement of people 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, coordinated structures and mechanisms to ensure effective, sustainable collaboration and effective results. Countries were asked to identify any national collaboration between government mental health services and other ministries, services and sectors. They were also asked to identify the number and type of groups that collaborated with government mental health services in planning and/or delivering mental health promotion, prevention, treatment and rehabilitation services.

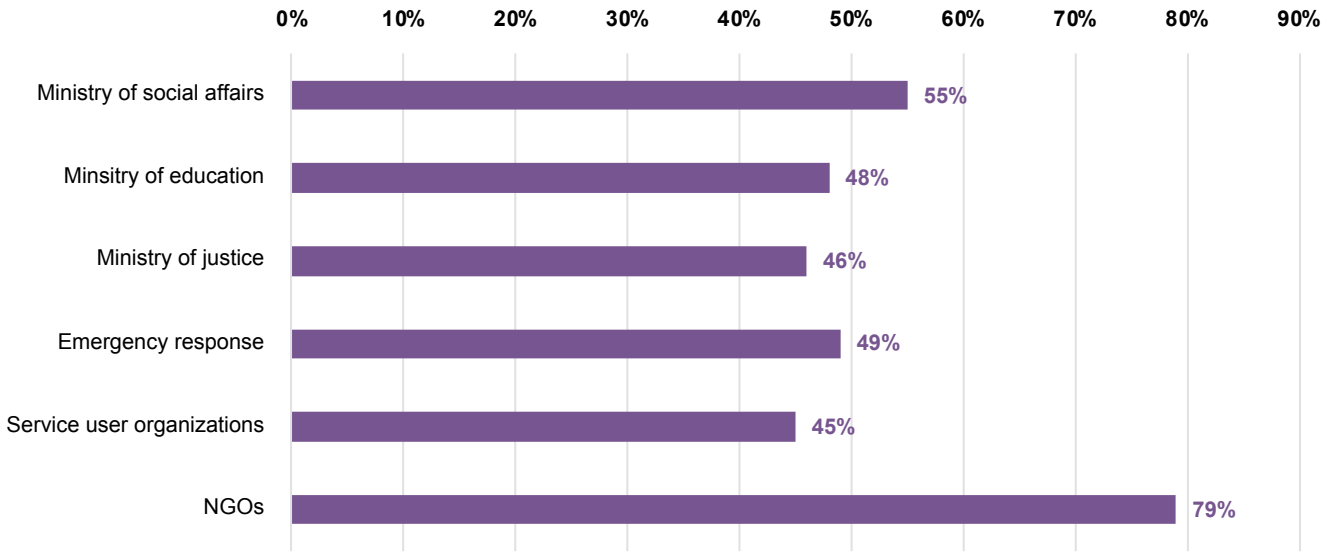
Table 16 shows the numbers of countries that reported stakeholder collaboration. Of the 143 countries that answered this question, 136 reported collaboration with at least one partner (95% of responding countries). More than 70% of countries met annually with the ministry of social affair and welfare, the ministry of education, the ministry of justice, service users or NGOs.

Table 16. Proportions of countries that collaborate with a formalized structure and/or mechanism, by WHO region and World Bank income group (% of responding countries)

	Ministry of social affairs (%)	Ministry of education (%)	Ministry of justice (%)	Emergency response (%)	Service users (%)	NGOs (%)
Globally (n= 143)	90	86	82	77	79	96
By World Bank income group						
LIC (n=19)	74	68	63	74	63	95
LMIC (n=36)	86	83	75	64	69	94
UMIC (n=43)	98	90	81	80	80	95
HIC (n=46)	91	89	89	80	89	96
By WHO region						
AFR (n=33)	79	76	73	70	72	94
AMR (n=31)	87	81	77	83	80	97
SEAR (n=9)	100	90	89	78	78	100
EUR (n=29)	97	97	93	75	86	100
EMR (n=20)	90	90	80	80	90	65
WPR (n=20)	100	89	84	79	72	95

Stakeholder collaborations were considered to be "functioning" when at least two of the three following items applied: 1) existence of a formal agreement or joint plan with the partner; 2) dedicated funding from or by the partner; and 3) regular meetings with the partner (at least once a year). Fig. 17 shows the proportions of countries that reported that they had formal collaboration with at least one partner. Most of the partners were local or international NGOs (79% of responding countries), ministries of social affairs or social welfare (55%) and ministries of education (48%). A small proportion collaborated with service users and family or caregiver advocacy groups (45% of countries). The proportion of countries that collaborated with service users and family and advocacy groups was lower than in 2020 in all regions (data not shown).

Figure 17. Functioning collaborations with stakeholders (% of responding countries)



3 Mental health financing and workforce

3.1 Public financing

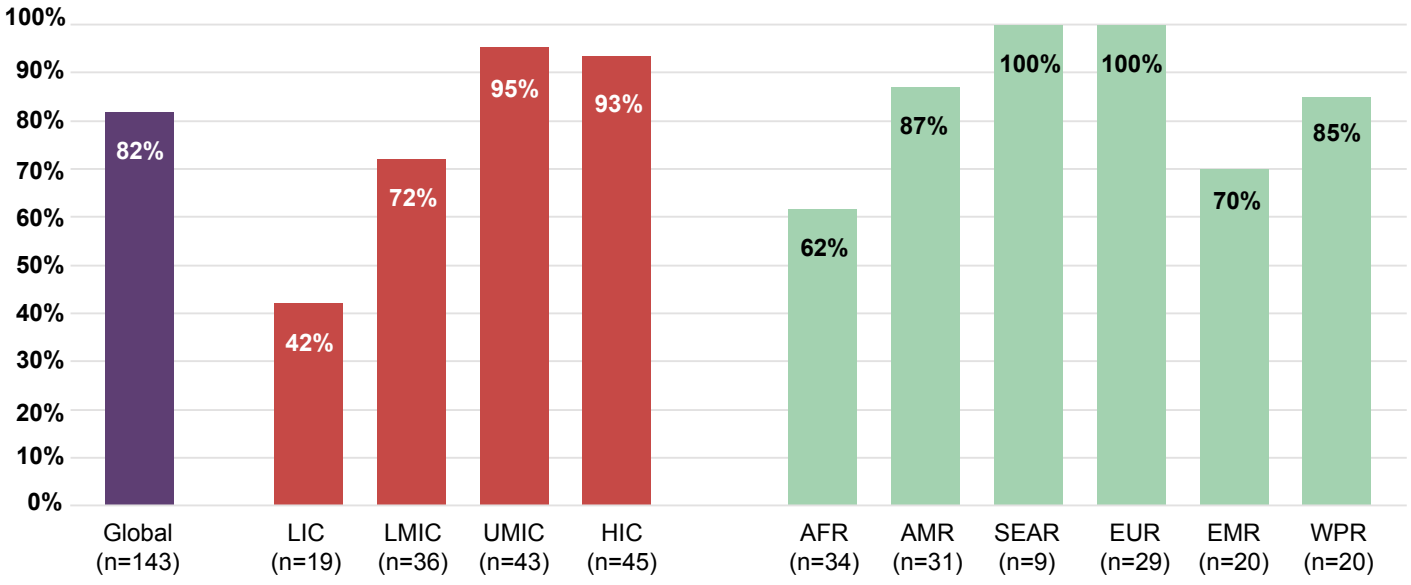
Generation, pooling and allocation of financial resources are intrinsic components of effective health planning and delivery. The Mental Health Atlas 2024 survey included two aspects of public financing for mental health: the availability and extent of publicly-funded financial protection for people affected by mental health conditions and the level and distribution of government spending on mental health. These two aspects address the overall level of investment in mental health systems and services and the fairness or equity of current payment arrangements.

Publicly funded financial protection for mental health

As direct, out-of-pocket expenditure on health services and products can lead to financial hardship for affected individuals and households, particularly in more disadvantaged socioeconomic groups, it is a key concern underlying the drive towards universal health coverage. Pre-payment mechanisms achieved through public spending on health helps to safeguard at-risk populations from the financial consequences of ill-health. Accordingly, it is important to monitor ongoing efforts by countries to move toward universal health coverage by assessing the extent to which people with mental health conditions are entitled to publicly financed health care and their expected contribution to the costs of treatment and care.

Responses to this Atlas survey item were provided by 143 or 74% of WHO Member States, of which 82% reported that health care and treatment for mental health conditions were included in a publicly-funded health or financial protection scheme. As shown in Fig. 18, the responses differed by income group, from 42% in LIC to more than 90% in UMIC and HIC. When disaggregated by WHO region, the percentage ranged from 62% in the AFR to 100% in the SEAR and the EUR. The values were similar to those

Figure 18. Inclusion of mental health care and treatment in a publicly funded health or financial protection scheme, by World Bank income group and WHO region



reported in the Atlas 2020 survey, except in LIC, where an increase was reported.

Member States were requested to report the extent to which most people with mental health conditions contributed towards the costs of their care. As shown in Fig. 19, in at least 50% of responding countries, service users paid little or nothing (≤ 5%) towards the cost of inpatient care, outpatient care and psychotropic medication and less than a half (47%) for psychological therapy. In some countries, however, people with mental health conditions contributed most or all financing (≥ 50%), from 14% for mental health inpatient care to 28% of responding countries for psychological therapy. In the remaining 20–25% of responding countries, most people with mental health conditions paid moderate (6–20%) or significant (21–50%) sums towards the costs of mental health services or products.

Figure 19. Contributions by people with mental health conditions towards the costs of care and treatment (% of responding countries globally)

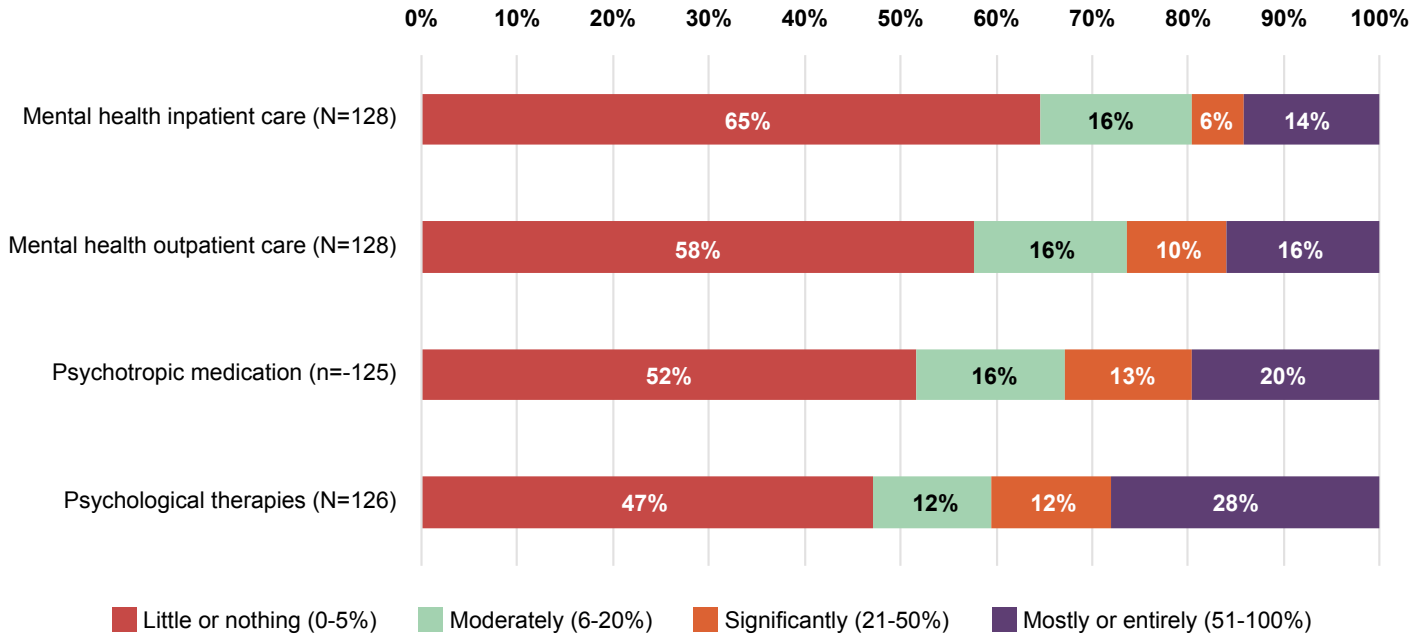


Table 17 shows that the proportion of responding countries in which people with mental health conditions pay a moderate or small amount or nothing towards the cost of care (≤ 20%) ranged from a high of 73% for mental health inpatient care to 50% for psychological therapy. In LIC, these rates fall to 32% and 21%, respectively. In nearly 50% of responding LMIC, most people with mental health conditions pay at least 20% towards the cost of these services. There is therefore a significant gap in financial protection against the costs of mental health care and treatment in those countries.

Table 17. Proportions of countries in which people with mental health conditions pay ≤ 20% towards the cost of care, by World Bank income group and WHO region

	Inpatient care (%)	Outpatient care (%)	Psychotropic medication (%)	Psychological therapy (%)
Globally (n=105)	73	64	58	50
By World Bank income group				
LIC (n=6)	32	21	21	21
LMIC (n=23)	61	50	42	44
UMIC (n=38)	84	84	74	60
HIC (n=38)	83	74	70	57
By WHO region				
AFR (n=17)	50	44	44	44
AMR (n=26)	78	69	63	53
SEAR (n=6)	56	56	33	44
EUR (n=26)	86	76	66	45
EMR (n=14)	70	70	55	45
WPR (n=16)	80	70	75	70

Government expenditure on mental health

Overall government health spending is reported and monitored in an internationally agreed system of health accounting; however, there are few disease-specific sub-accounts for mental health. Therefore, Atlas focal points were requested to provide estimates of mental health spending, both as a total monetary amount and as a percentage of government health expenditure. Countries were also asked to report whether there was a dedicated government budget line for mental health. Of 142 countries that responded to this question, 63% indicated that there was a budget line, the rates differing modestly by country income (from 44% in LIC to 70% in HIC).

Accurate reporting of mental health expenditure is difficult, as it is not always clear what it includes, especially with reference to social care and support services, and there are few good-quality data from non-specialized settings into which mental health services have been integrated, such as primary care. This is reflected in the relatively small number of countries (75 of 144) that provided financial data. This low response rate limits the completeness and representativeness of the conclusions.

Globally, after conversion of all national spending into a common comparable currency, median reported expenditure on mental health was US$ 2.69, which is similar to that estimated for the Atlas survey in 2017 (US$ 2.50) but appreciably lower than that reported in the 2020 survey (US$ 7.49). This is probably due to the lower representation of relatively high-spending countries in the EUR in the current survey. As in earlier Atlas surveys, public spending differed dramatically according to income group, from < US$ 1 in LIC (US$ 0.04 per capita) and LMIC (US$ 0.34 per capita) to US$ 65.89 in HIC (Table 18). Similarly, median per capita spending varied from US$ 0.07 in the AFR to US$ 51.76 in the EUR.

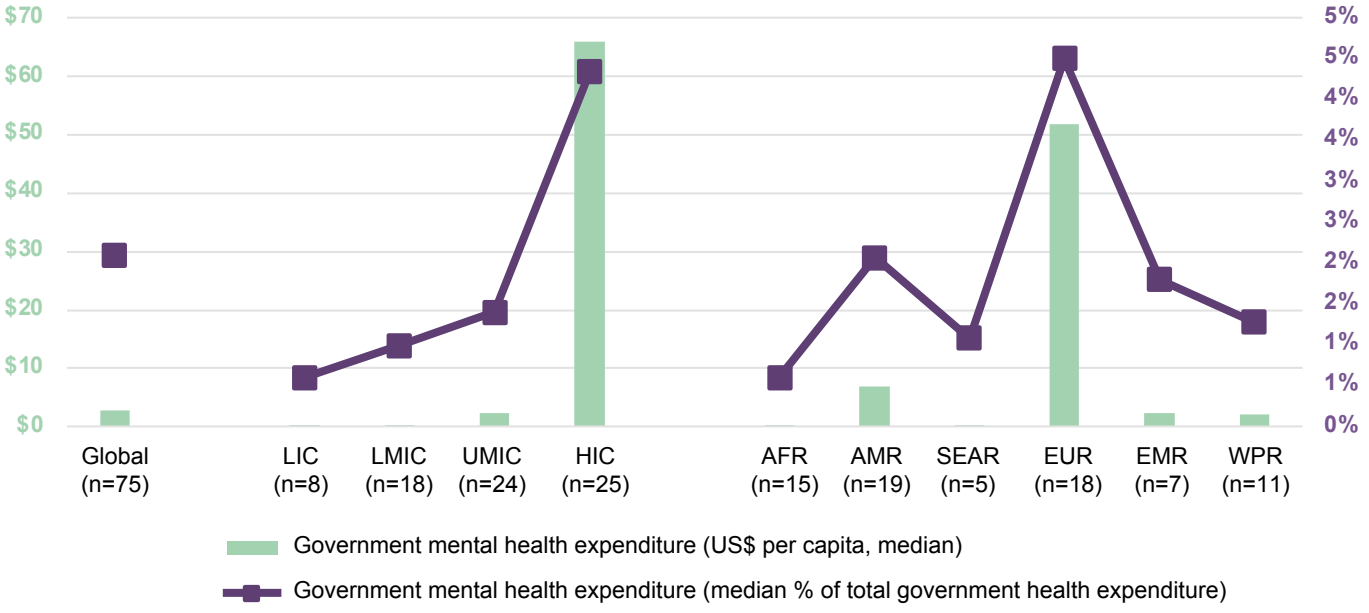
The global median percentage allocated to mental health, as a proportion of total government health expenditure, was 2.1%, as in both in 2017 and 2020. By country income group, the proportion ranged from ≤ 1.5% in LMIC to 4.3% in HIC.

Fig. 20 shows the relation between expenditure (left axis) and the proportion of overall health spending on mental health (right axis).

Table 18. Government expenditure on mental health (US$ per capita and as percentage of total government health expenditure), by World Bank income group and WHO region

No. of responding countries)	Government mental health expenditure per capita, median ((US$)	Government mental health expenditure (median of total government health expenditure) (%)
Globally (n=75)	2.69	2.1
By World Bank income group		
LIC (n=8)	0.04	0.6
LMIC (n=18)	0.34	1.0
UMIC (n=24)	2.35	1.4
HIC (n=25)	65.89	4.3
By WHO region		
AFR (n=15)	0.07	0.6
AMR (n=19)	6.86	2.1
SEAR (n=5)	0.30	1.1
EUR (n=18)	51.76	4.5
EMR (n=7)	2.41	1.8
WPR (n=11)	2.20	1.3

Figure 20. Government mental health expenditure, by World Bank income group and WHO region



Of the 75 countries that provided data on mental health expenditure, 49 reported on its distribution to seven mental health programme areas (see Fig. 21). As in previous Atlas surveys, the largest category of expenditure was for psychiatric hospitals (47%). This figure is, however, appreciably lower than the two thirds reported in 2020, perhaps indicating a move towards community-based models of service delivery, although it could be due to the different combination of responding countries and the revised formulation of questions for Atlas 2024. The next largest category of expenditure globally was services delivered in non-specialist general health-care settings, including district hospitals (15%) and primary care facilities (10%). Community mental health services accounted for 11%, while mental health prevention and promotion and MHPSS each received only 4% of the expenditure allocated to mental health.

The distribution of government mental health expenditure by World Bank country income group (Fig. 21) and WHO region (Fig. 22) shows that the highest proportion of spending is still for specialized psychiatric hospitals in many countries or regions, such as 69% of spending in countries in the AFR and in 62% in UMIC that responded to this survey question. In HIC, the proportion of the budget for psychiatric hospitals is lower (25%), and over half of total expenditure is allocated to mental health delivered in general hospitals (28.4%) and community mental health services (26%), with a further 14% to mental health delivery in primary health care.

Figure 21. Distribution of government mental health expenditure, globally and by World Bank income group

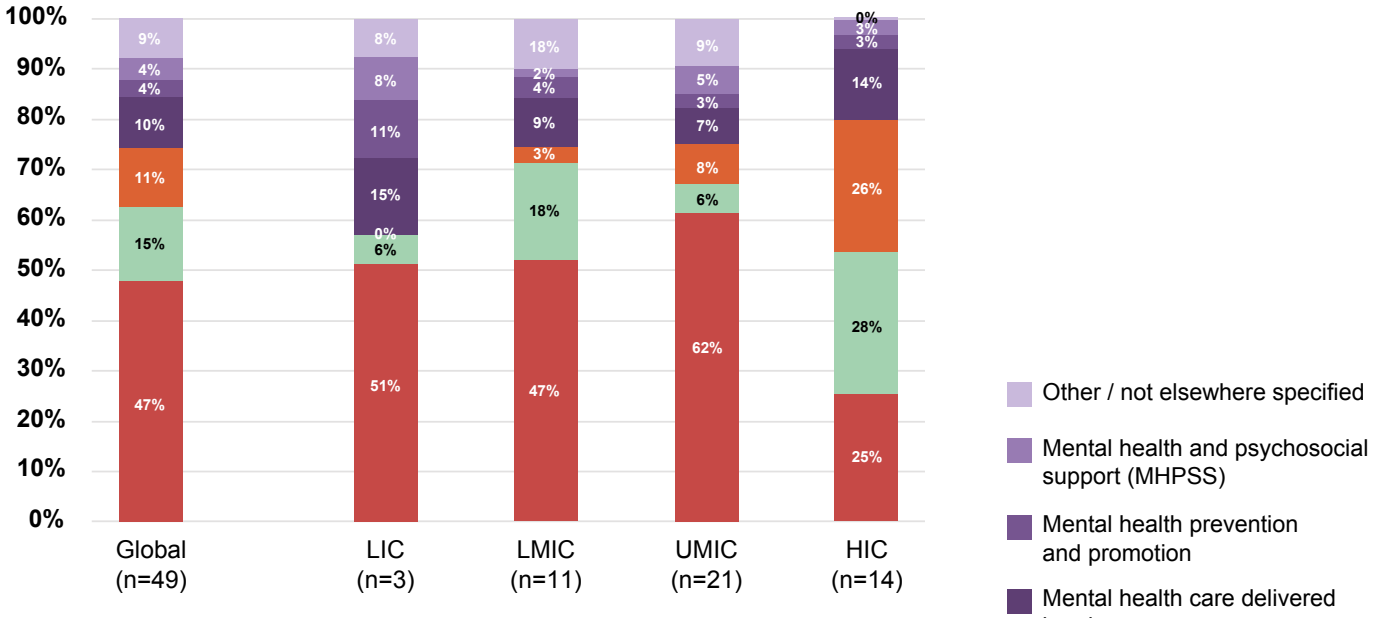
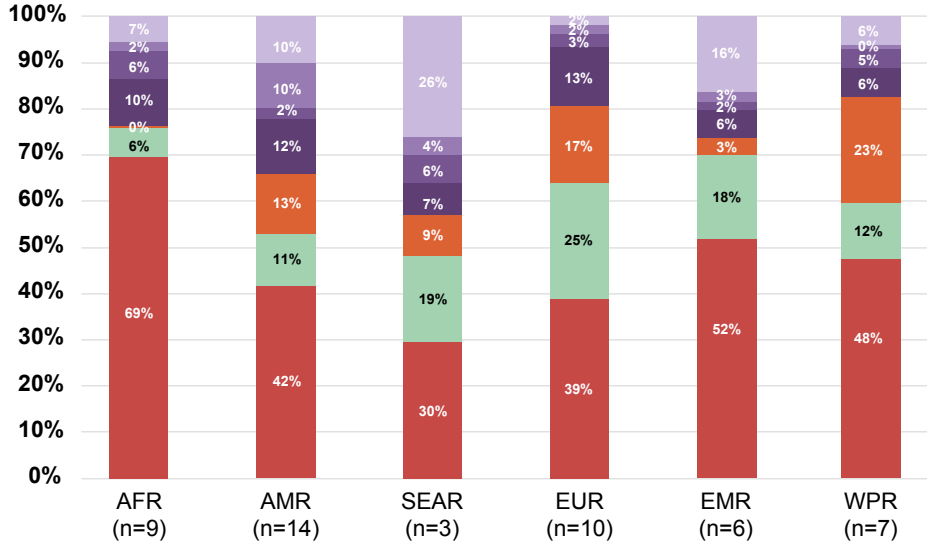


Figure 22. Distribution of government mental health expenditure, by WHO region



3.2 Workforce

A skilled, capable, motivated workforce is vital for effective operation of any mental health system and to meet both population and individual mental health needs. Yet, human resources for mental health are often insufficient and are distributed inequitably. For Atlas 2024, Member States were asked to provide information on the availability of mental health workers and their distribution among defined occupational categories, both for the adult population and for children and adolescents. Information was sought only on specialized mental health workers working partly or fully in general and specialist health-care settings; non-specialized health workers, such as those working in primary care, were not included. Information was solicited on specialized mental health workers in both the government and nongovernment sectors; however, difficulty in measurement and lack of data on nongovernment or private sector workers may have resulted in under-counting. To avoid double-counting of individuals who work in more than one setting (e.g. both nongovernment services and government hospitals), respondents were asked to allocate workers to the care setting in which they spent most time.

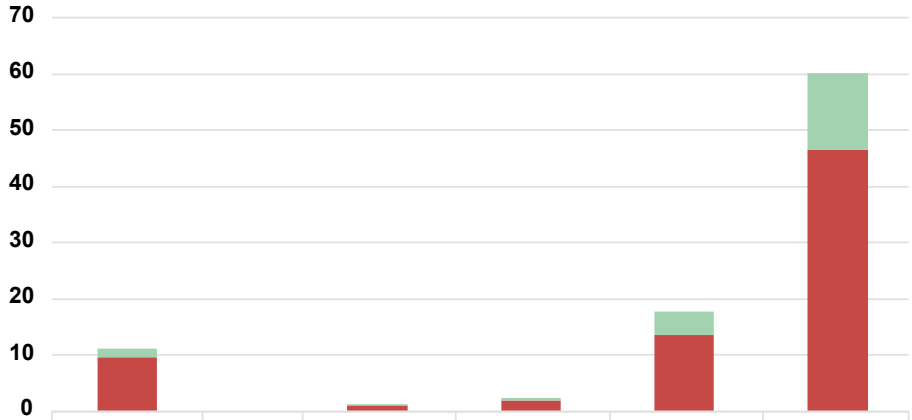
Availability and composition of mental health workers for treatment of adults

Data from the 132 Member States that responded to these questions in the Atlas survey show that the global median number of specialized mental health workers was 13.5 per 100 000 population (Table 19). Despite the afore-mentioned limitation of some expected under-estimation in the nongovernment sector, most mental health workers were estimated to be working in the public sector (9.6 per 100 000 population). As found for financial resources, large disparities were found in human resources for mental health care among countries at different levels of income, from a median of 1.1–2.4 in LIC and LMIC to 67.2 in HIC (Fig. 23). In LIC, there was usually < 1 specialized government mental health worker per 100 000 population. The range was also wide among WHO regions, from a median of 2.2 mental health workers in the AFR to 80.4 in the EUR.

Table 19. Availability of mental health workers, globally, by World Bank income group and by WHO region (median number per 100 000 population)

No. of specialized mental health workers for adults (per 100 000 population)	Government mental health workers	Nongovernment mental health workers	All mental health workers
Globally (n=132)	9.6	1.5	13.5
By World Bank income group			
LIC (n=18)	0.9	0.3	1.1
LMIC (n=35)	1.9	0.4	2.4
UMIC (n=38)	13.6	4.0	19.3
HIC (n=41)	46.6	13.7	67.2
By WHO region			
AFR (n=33)	1.9	0.3	2.2
AMR (n=28)	13.4	8.7	22.2
SEAR (n=7)	2.3	1.6	4.0
EUR (n=27)	52.0	11.3	80.4
EMR (n=19)	3.7	1.9	4.7
WPR (n=18)	12.8	3.9	14.1

Figure 23. Numbers of mental health workers for adults (median per 100 000 population), by World Bank income group



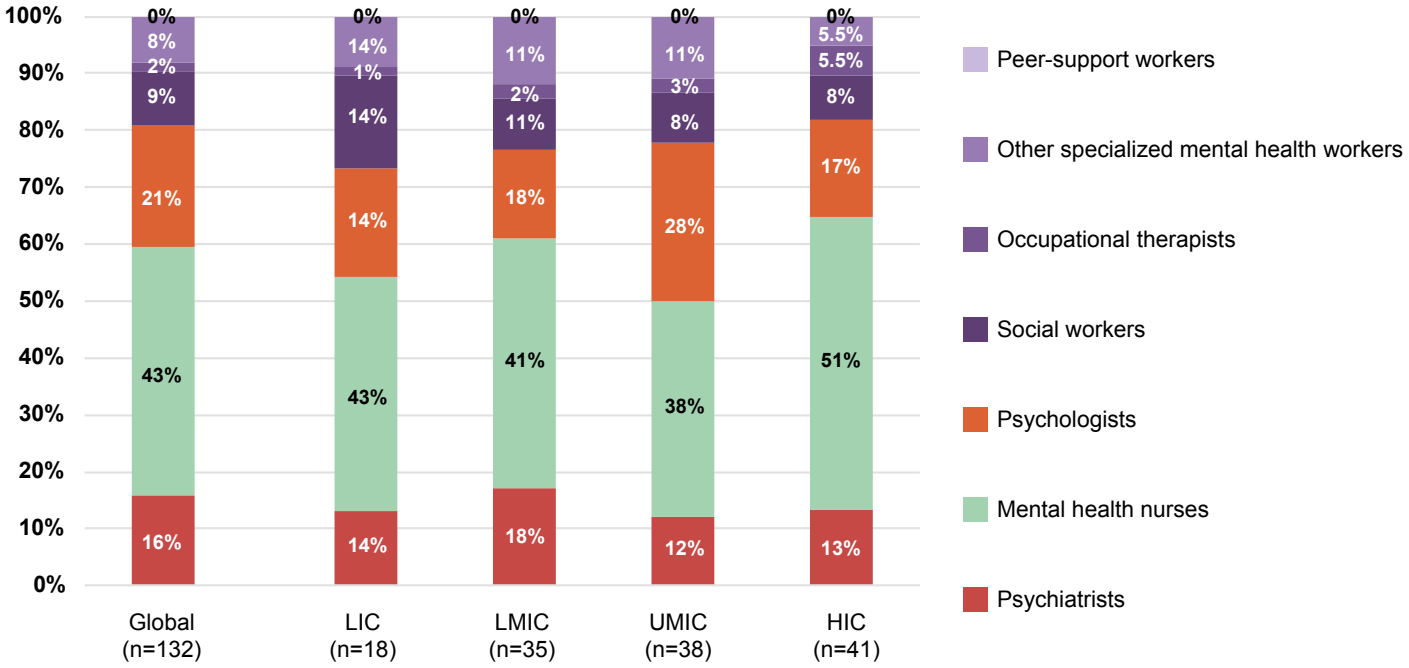
	Global (n=132)		LIC (n=18)	LMIC (n=35)	UMIC (n=38)	HIC (n=41)
Non-government mental health workers (median per 100,000 population)	1.5		0.3	0.4	4	13.7
Government mental health workers (median per 100,000 population)	9.6		0.9	1.9	13.7	46.6

The distribution of the government and nongovernment mental health workforce is illustrated in Table 20 and Fig. 24. Mental health nurses make up the single largest proportion of the specialized mental health workforce globally (43% of the total), followed by psychologists (22%) and psychiatrists (16%). The proportions are relatively stable among countries at different levels of income and are also similar to those in Atlas 2000, although the absolute numbers of workers in each category differs considerably. For example, there is a median of just 0.1 psychiatrist per 100 000 population (one per million people) in LIC and 7 per 100 000 in HIC.

Table 20. Numbers of mental health workers globally, by occupational category, World Bank income group and WHO region (median per 100 000 population)

	Psychiatrists	Mental health nurses	Psychologists	Social workers	Occupational therapists	Other specialized mental health workers	Peer-support workers
Globally (n=132)	1.5	4.1	2.0	0.9	0.2	0.8	0.0
By World Bank income group							
LIC (n=18)	0.1	0.3	0.1	0.1	0.0	0.1	0.0
LMIC (n=35)	0.3	0.7	0.3	0.2	0.0	0.2	0.0
UMIC (n=38)	1.7	5.4	4.0	1.2	0.4	1.5	0.0
HIC (n=41)	7.0	27.0	9.0	4.1	2.8	2.7	0.0
By WHO region							
AFR (n=33)	0.1	0.6	0.2	0.1	0.0	0.1	0.0
AMR (n=28)	1.7	3.6	6.4	1.7	0.2	1.5	0.0
SEAR (n=7)	0.5	0.4	0.2	0.3	0.3	0.2	2.6
EUR (n=27)	9.9	28.4	9.3	3.6	4.4	1.9	0.4
EMR (n=19)	1.3	3.2	1.0	0.4	0.1	0.2	0.1
WPR (n=18)	2.2	12.9	0.4	0.2	0.0	1.9	0.0

Figure 24. Distribution of specialized mental health workers for adults (median number per 100 000 total population), globally and by World Bank income group



When the composition of the workforce is disaggregated by WHO region, greater fluctuation is seen; for example, psychologists make up a larger proportion of the mental health workforce in the AMR (Fig. 25), and a large number of peer-support workers were reported for the SEAR (a median of 2.6 per 100 000 population). The latter is, however, an artificially inflated measure, as only two countries in this region reported data for this category. In this and other regions, in fact, very few peer-support workers were reported as contributing to the mental health workforce. It should be noted, however, that the Mental Health Atlas 2024 survey was the first in which this category of worker was included, and the data may not have been available or there were few such workers.

Figure 25. Distribution of specialized mental health workers for adults (median per 100 000 total population), by WHO region

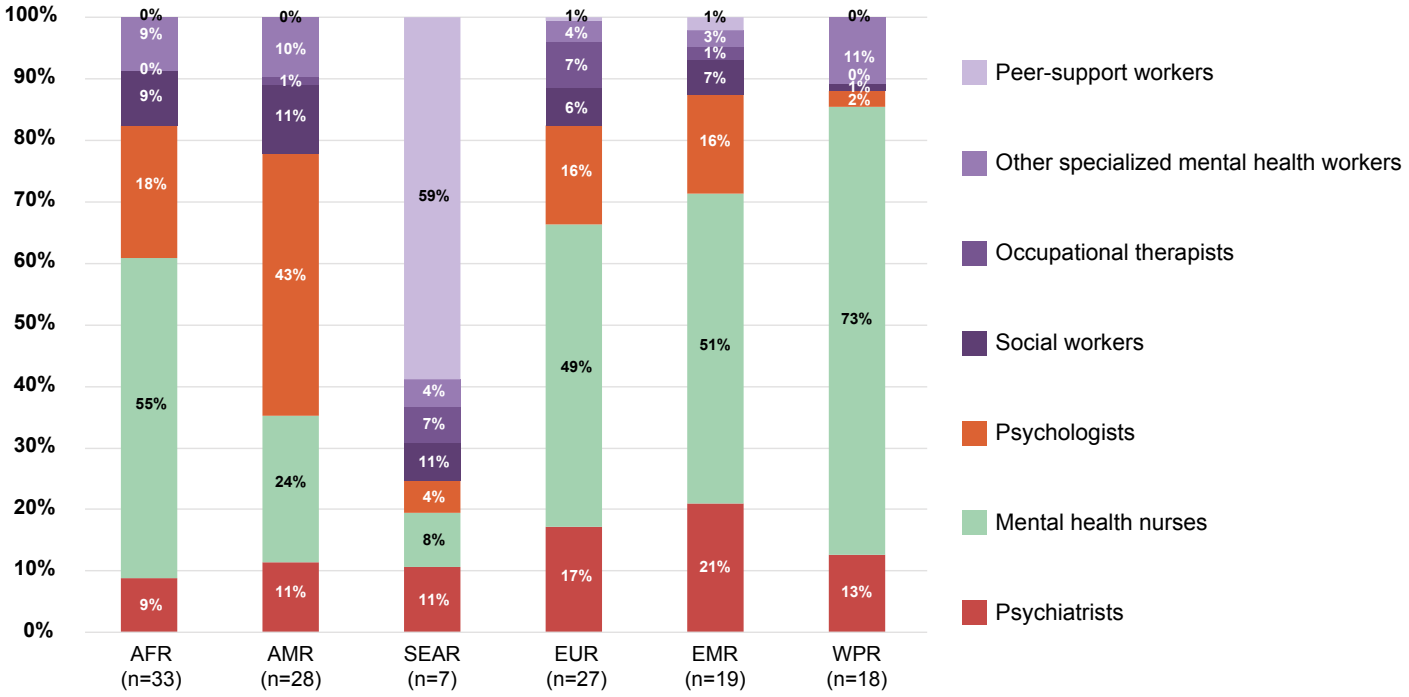
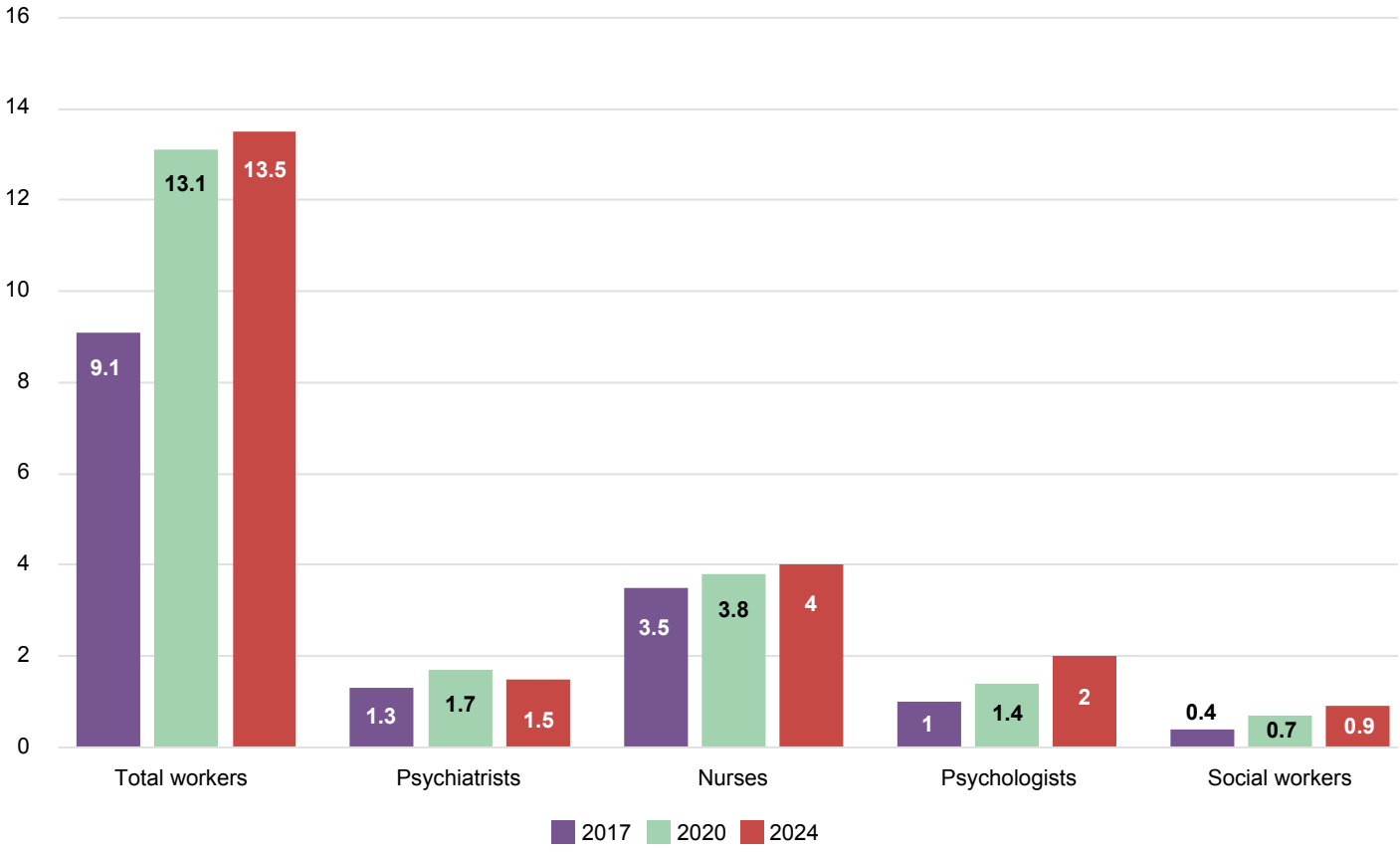


Fig. 26 shows the median numbers of specialized mental health workers in 2017–2024, indicating a gradual increase in the availability of most categories of worker. The slight decrease in the median number of psychiatrists per 100 000 population is due to reporting of a lower rate in HIC (from 8.6 in 2020 to 7 in 2024).

Figure 26. Mental health workforce, 2017–2024 (median number per 100 000 population)



Availability and composition of the mental health workforce for children and adolescents

Member States were requested to provide information on the availability of specialized mental health workers for children and adolescents. The results are summarized in Table 21, which shows a global median of 1.5 such workers per 100 000 total population (or 4.5 per 100 000 population under 19 years of age, as this group accounts for one third of the total global population). As for the adult population, most work in the government sector; however, for example, approximately one third of child and adolescent mental health workers were reported to work in the nongovernmental sector. Results disaggregated by income and geographical region show disparities in availability similar to those reported for the adult population, from 0.05 child and adolescent mental health worker per 100 000 population in LIC to 4.5 in HIC. The absolute availability of such workers is, however, much lower, with ≥ 10 adult mental health workers for every child and adolescent mental health worker in UMIC and HIC.

Table 21. Availability of child and adolescent mental health workers, globally, by World Bank income group and WHO region (median number per 100 000 total population)

	Government child and adolescent mental health workers	Nongovernment child and adolescent mental health workers	Total child and adolescent mental health workers
Globally (n=112)	1.06	0.38	1.51
By World Bank income group			
LIC (n=15)	0.04	0.04	0.05
LMIC (n=33)	0.09	0.04	0.12
UMIC (n=32)	1.49	0.49	2.14
HIC (n=32)	3.76	1.68	4.56
By WHO region			
AFR (n=27)	0.08	0.01	0.09
AMR (n=25)	1.11	3.16	1.89
SEAR (n=7)	0.08	0.01	0.09
EUR (n=22)	3.51	1.49	4.07
EMR (n=18)	0.56	0.38	0.96
WPR (n=13)	2.07	0.02	2.52

The composition of the specialized child and adolescent mental health workforce is shown in Table 22, which further illustrates the very low or even barely detectable level of dedicated human resources available for this segment of the population, especially in LIC and LMIC. Only in HIC is there more than one psychiatrist, psycholgist or mental health nurse available per 100 000 children and adolescents. The few specialized child and adolescent mental health workers globally indicates a substantial unmet need for dedicated care and support. In countries and settings in which they are not available, affected individuals and households may seek or attend adult mental health services instead, although this was not assessed in the survey.

Table 22. Availability of child and adolescent mental health workers, globally, by World Bank income group and by WHO region (median number per 100 000 total population)

	Psychiatrists	Mental health nurses	Psychologists	Social workers	Occupational therapists	Other specialized mental health workers	Peer-support workers
Global (n=112)	0.28	0.75	0.37	0.20	0.24	0.24	0.22
By World Bank income group							
LIC (n=15)	0.00	0.01	0.01	0.00	0.00	0.00	0.00
LMIC (n=33)	0.03	0.01	0.02	0.00	0.00	0.00	0.00
UMIC (n=32)	0.31	0.56	0.36	0.10	0.16	0.04	0.07
HIC (n=32)	1.26	2.06	1.49	0.73	0.32	0.45	0.35
By WHO region							
AFR (n=27)	0.01	0.02	0.01	0.00	0.00	0.00	0.00
AMR (n=25)	0.24	0.11	0.80	0.25	0.16	0.05	0.05
SEAR (n=7)	0.04	0.54	0.02	0.01	0.13	0.25	0.09
EUR (n=22)	1.32	1.66	1.49	0.33	0.38	0.53	0.99
EMR (n=18)	0.17	0.14	0.13	0.03	0.09	0.02	0.09
WPR (n=13)	0.11	1.25	0.01	0.04	0.01	0.00	0.20

4 Mental health services

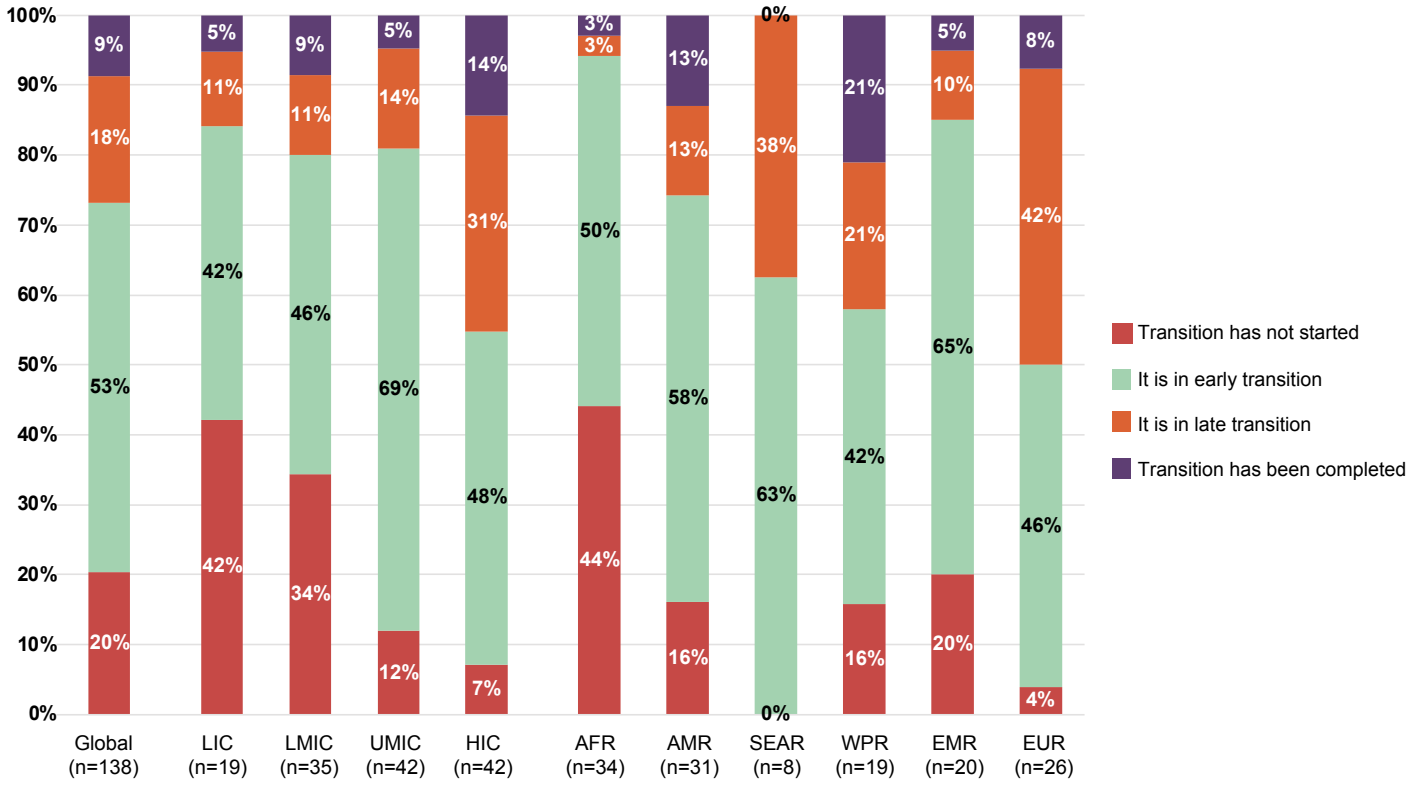
4.1 Service development and integration

Transition to community-based mental health services

The Mental Health Atlas 2024 survey also assessed the status of transition from hospital-based to community-based mental health care. Transition was considered not to have been started when there were no beds or inpatient or outpatient services for mental health in general hospitals or community facilities. Service reform was defined as early transition when there were more beds and inpatient/outpatient services in psychiatric hospitals than in general hospitals and community facilities, and late transition when countries reported more beds and inpatient and outpatient services in general hospitals and community facilities than in psychiatric hospitals. The transition was considered complete when countries reported that there were no more psychiatric hospitals.

Globally, mental health service reform is progressing slowly; only 9% of countries had fully completed the transition from psychiatric hospitals to community care (Fig. 27). A majority (53%) remained in the early stages of transition, with more beds and services still concentrated in psychiatric hospitals. The AFR showed the least progress, with 44% of countries yet to initiate any transition. The WPR led, 21% of countries having completed the transition. HIC were more advanced (14% completed), and LIC and LMIC were behind, with over one third yet to start reform.

Figure 27. Status of service reform, percentage of responding countries, by WHO region and World Bank income group



Integration of mental health into primary health care

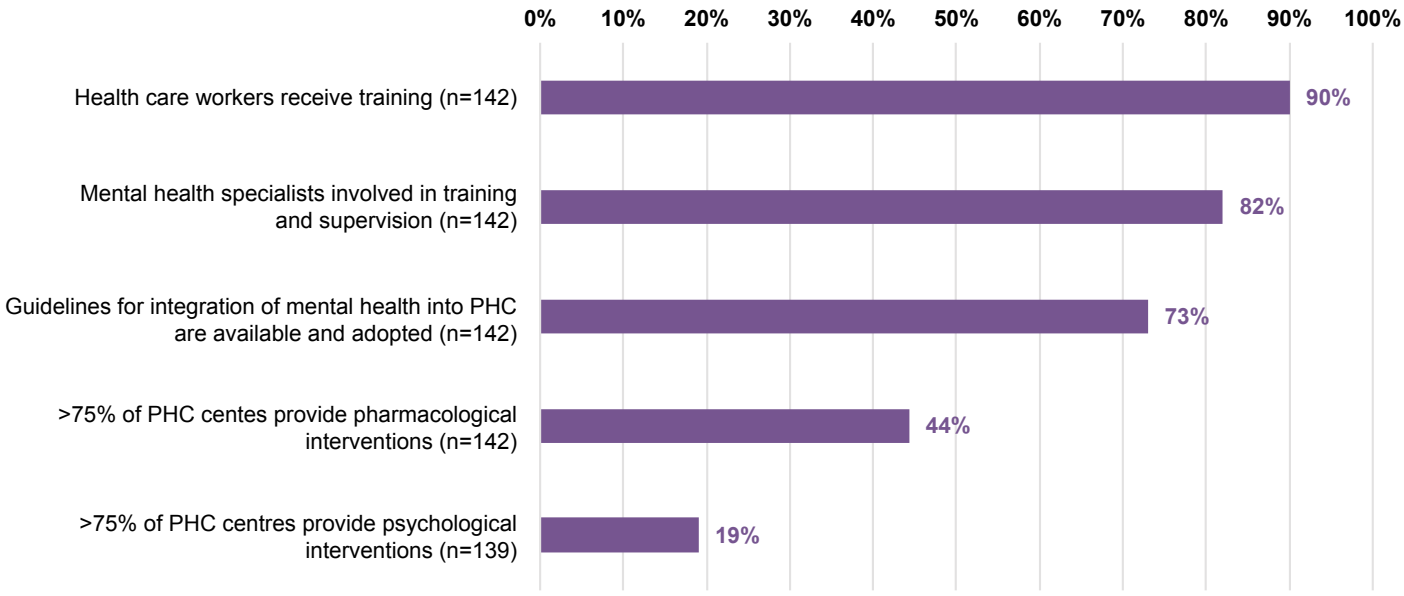
Prioritization of investment in strong primary health care, including mental health prevention, promotion, treatment and rehabilitation, is vital to improve the efficiency of health management and to achieve universal health coverage. The Comprehensive mental health action plan also stresses the importance of decentralizing care from long-stay mental hospitals to primary care settings. The Action Plan promotes use of evidence-based interventions and principles of stepped care, which offers an integrated approach to mental and physical health care. Effective implementation requires training of non-specialized health workers to identify people with mental health conditions, deliver appropriate treatment and support and refer patients to other levels of care when necessary. 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 2024, "primary health care" refers to the provision of mental health care by non-specialized services and workers, including health-care services provided by governments, NGOs and private (for-profit) health facilities and services. Integration of mental health into primary health care is considered to be functional if at least four of the following five criteria are fulfilled:

- guidelines for mental health integrated into primary health care available and adopted nationally;
- pharmacological interventions for mental health conditions available and provided in primary care;
- psychosocial interventions available and provided at primary care level;
- health workers in primary care trained in management of mental health conditions; and
- mental health specialists involved in training and supervising primary care professionals.

The criterion most frequently fulfilled was the availability of training for health-care workers (90% of responding countries), primarily by in-service training. In 82% of responding countries, mental health specialists were involved in training, and 37% of countries declared that people with lived experience were involved in training. The least commonly met criterion was provision of psychosocial interventions in at least 75% of primary care centres (19% of responding countries) (Fig. 28).

Figure 28. Fulfilment of criteria for integration of mental health into primary health care



Out of 138 responding countries, only 12% met all five criteria for integration of mental health into primary care (Table 23); 47 countries (34% of responding countries) met at least four of five criteria, which is the indicator for meeting global target 2.3 of the Global Mental Health Action Plan. Longitudinal comparisons of 2020 and 2024 show a slight increase in the proportion of responding countries that fulfilled four of the five criteria. Most countries met at least three of the five criteria. Integration of mental health into primary care was strongly influenced by countries' income level, with two to four times more countries with functional integration of mental health into primary health care in UMIC and HIC than in LMIC and LIC, where 22% and 8% of responding countries, respectively, fulfilled at least four of the five indicators (Fig. 29).

Table 23. Functional integration of mental health into primary health care: fulfilment of criteria (% of responding countries, 2020 and 2024)

No. of criteria fulfilled	No. of responding countries (%)	
	2020	2024
0/5	9 (6)	7 (5)
1/5	11 (7)	5 (4)
2/5	22 (14)	24 (17)
3/5	69 (43)	55 (40)
4/5	25 (16)	30 (22)
5/5	24 (15)	17 (12)

Figure 29. Functional integration of mental health into primary health care: fulfilment of at least four of five criteria

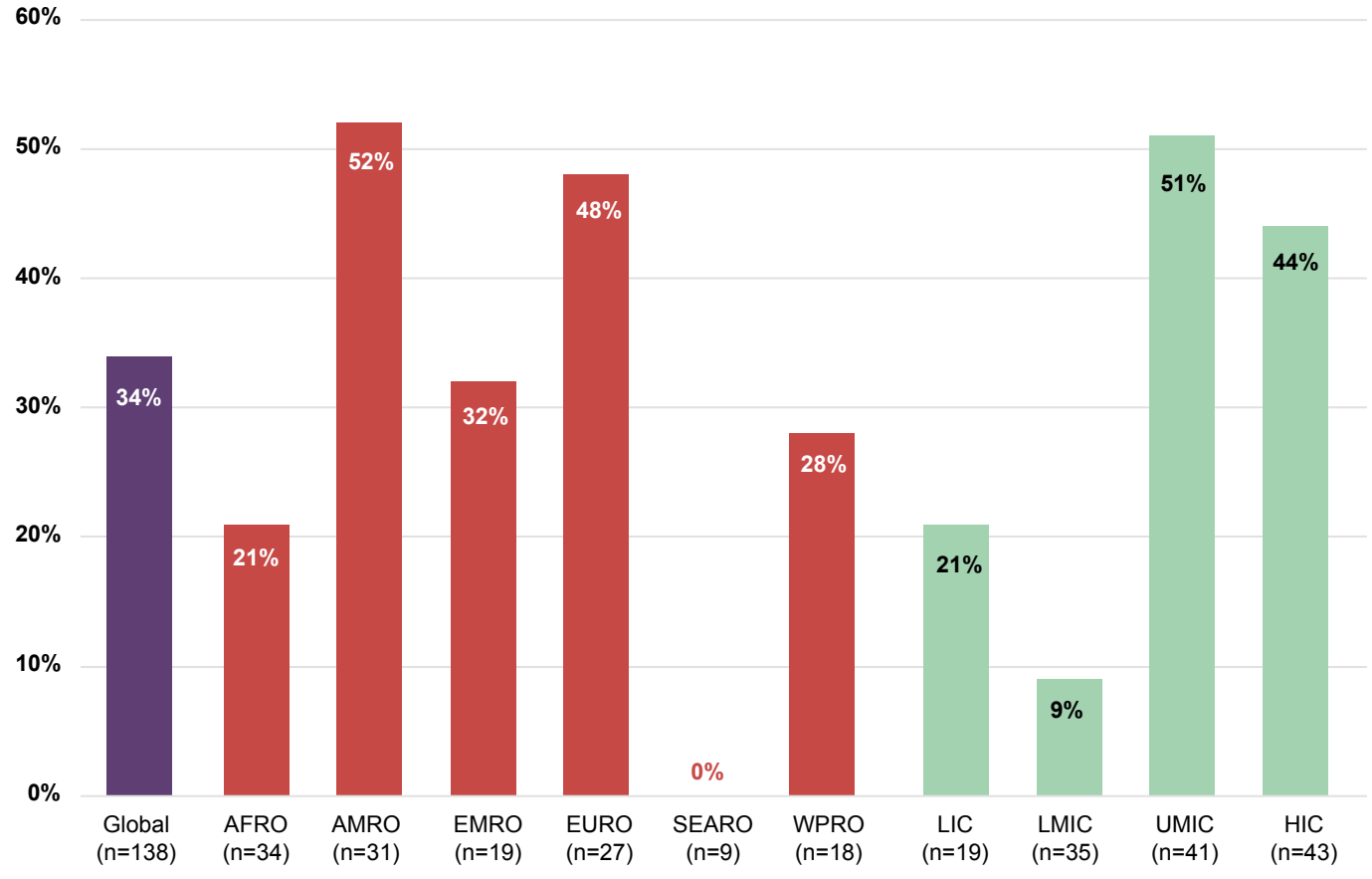


Table 24 summarizes the extent to which responding countries had implemented different elements of integration of mental health into primary health care. More than a half of responding countries in all WHO regions and 73% of responding countries globally reported the availability and adoption of guidelines for integration of mental health into primary health care .

In 90% of all responding countries and in at least 75% of each regional or income country grouping, primary health care workers were reported to receive training in the management of mental health conditions. Of these, 82% reported that mental health specialists were involved in training and supervision of primary care professionals.

Less than 20% of responding countries reported ensuring both pharmacological and psychosocial interventions in at least 75% of primary care centres. Pharmacological interventions were more widely available than psychosocial interventions. The gap between pharmacological and psychosocial interventions was particularly evident in HIC, where the availability and provision of pharmacological treatment in primary care was high (80%), while only 30% of responding countries reported that psychosocial interventions were available. In LIC, psychosocial interventions were available and provided in 5% of responding countries and pharmacological interventions in 16% of countries.

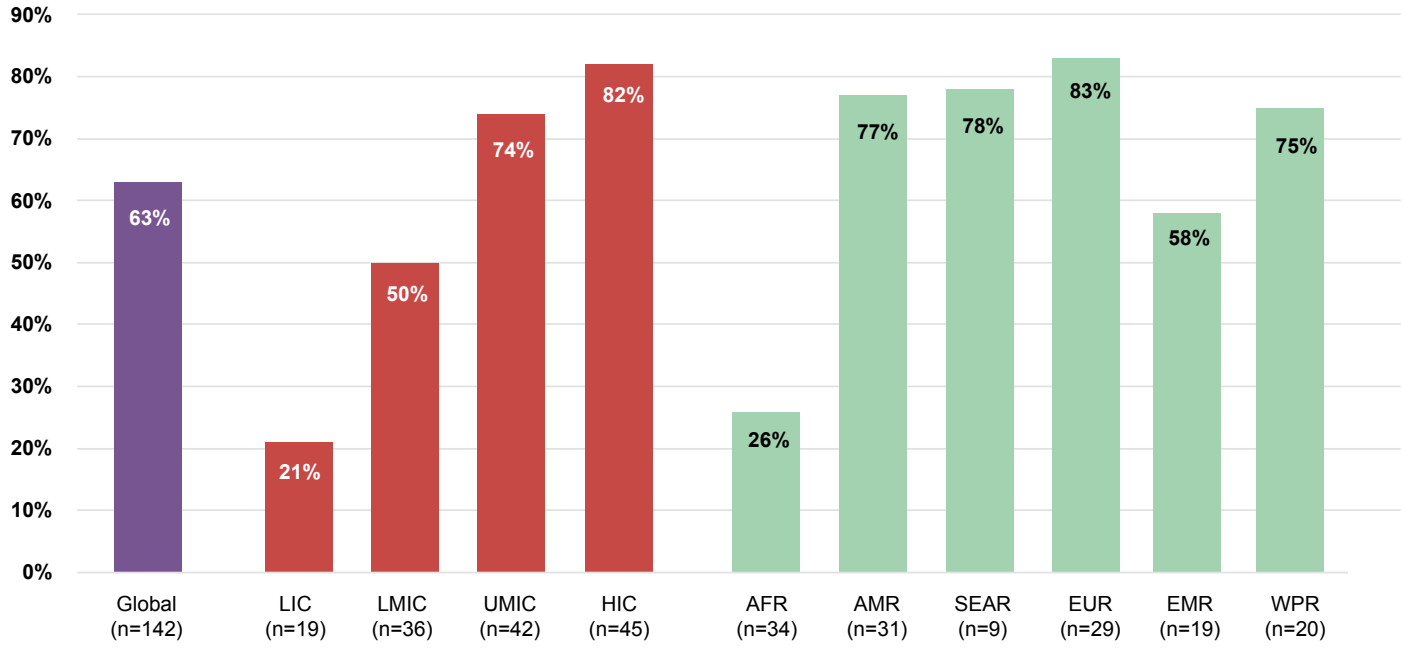
Table 24. Proportions of countries that have integrated elements of mental health into primary health care

No. of responding countries	Guidelines for integration of mental health into primary health care available and adopted (%)	Health-care workers receive training (%)	Mental health specialists involved in training and supervision (%)	> 75% of primary care centres provide pharmacological interventions (%)	> 75% of primary care centres provide psychological interventions (%)
Globally (n=142)	73	90	82	45	19
By World Bank income group					
LIC (n=19)	74	79	68	16	5
LMIC (n=36)	78	89	86	11	0
UMIC (n=42)	81	100	95	47	31
HIC (n=45)	62	87	71	80	30
By WHO region					
AFR (n=34)	65	76	71	29	9
AMR (n=31)	81	100	97	48	32
SEAR (n=9)	89	100	100	0	0
EUR (n=28)	71	90	68	83	29
EMR (n=20)	90	95	85	35	15
WPR (n=20)	55	90	85	32	17

Telehealth services

For the first time, the Mental Health Atlas 2024 questionnaire included a sub-section on telehealth services. Tele-mental health services consist of the delivery of services by health-care professionals with information and communication technology for exchanging valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation and continuing education of health-care workers. These services are particularly useful when distance is a critical factor. Ninety countries (63% of responding countries) reported that telehealth services were available and being used in their country. The AFR reported the least availability, with only 26% of responding countries and 19% of all Member States reporting provision of telehealth services. The EUR and the SEAR reported the highest proportions, at 83% and 78% of responding countries, respectively. Disparities were even more pronounced by income: only 21% of responding LIC and 82% of HIC reported their availability (Fig. 30). In countries in which telehealth services were available and used, they were usually organized by the public and private sectors (82% of responding countries). These trends reflect notable digital and infrastructural divides, limiting the potential of telehealth to extend equitable mental health service coverage.

Figure 30. Availability of telehealth services by WHO region and World Bank income group (percentage of responding countries)

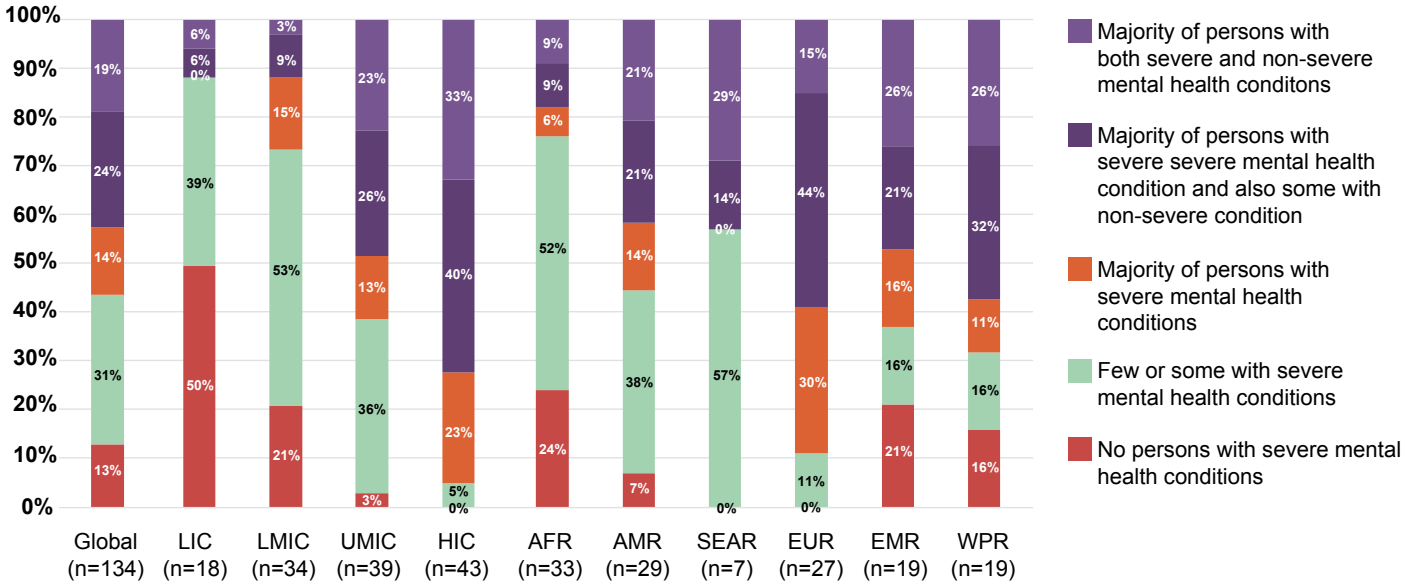


Social support

Social support refers to monetary or non-monetary benefits from public funds that are provided, as a legal right, to people with health conditions that reduce their ability to function. For the Mental Health Atlas 2024, as for previous editions, Member States were asked to report the availability of government social support for people with mental health conditions and to specify those officially recognized as receiving government support (e.g. disability payments or income support) but excluding those with a mental health condition who received monetary or non-monetary support from family members, local charities or another NGO. Social support can consist of income, housing, employment, education, social care or legal support.

Globally, 88% of responding countries reported that people with mental health conditions benefited, to some extent, from social support, and over half (59%) reported that most people with a severe mental health condition received such support. The availability of support varied widely, however, among regions and was strongly influenced by income level (Fig. 31). All the responding countries in the HIC group and only 8% in LIC reported that most people with severe mental health conditions benefited from social support.

Figure 31. Availability of social support for people with mental health conditions (% of responding countries, by WHO region and World Bank income group)



Mental health focal points were also asked about the main forms of social support provided by their country's government to people with mental health conditions. As in 2020, the main types of government social support were for social care (72%) and income (52%), while housing, employment, education and legal support were reported in < 50% of responses (Table 25). Only 23% of the 145 responding countries provided all six forms of social support. Wide discrepancies were seen by income group. For example, income support was reported by 87% of responding HIC and only 11% of LIC. The differences with respect to housing and employment support were even more significant, being provided by 74% of HIC but by only 11% LIC. Housing was the least reported form of social support globally, while social care support was that most frequently reported.

Table 25. Types of social support provided (% of responding countries)

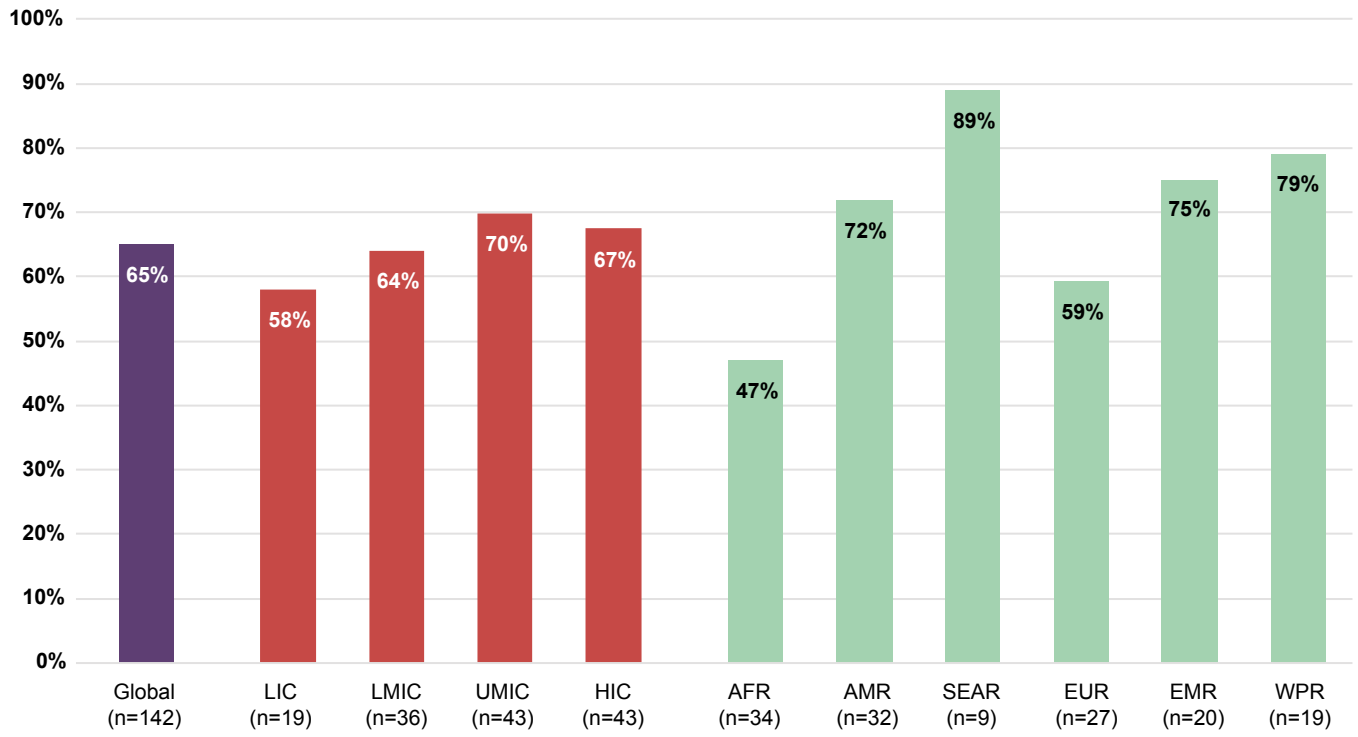
	Income (%)	Social care (%)	Housing (%)	Legal (%)	Employment (%)	Education (%)
Global (n=144)	52	72	39	43	40	48
By World Bank income group						
LIC (n=19)	11	44	11	11	17	11
LMIC (n=36)	22	51	5	27	16	32
UMIC (n=43)	57	81	40	48	38	52
HIC (n=46)	87	89	74	64	70	70
By WHO region						
AFR (n=34)	21	59	12	18	21	26
AMR (n=32)	56	78	44	38	34	53
SEAR (n=9)	33	67	11	56	22	33
EUR (n=29)	83	90	76	66	76	66
EMR (n=20)	48	62	38	57	33	52
WPR (n=20)	65	70	35	40	45	50

Mental health and psychosocial support

The term "mental health and psychosocial support" (MHPSS) is used in the global humanitarian community for a wide range of actors responding to emergencies such as the COVID-19 pandemic, including those who use biological and sociocultural approaches in health, social, education and community settings. In alignment with a recent World Health Assembly resolution on strengthening mental health care and psychosocial support (WHA 77.3)[9], the Mental Health Altas 2024 included a section on MHPSS. This section provides data on services and coordination mechanisms related to MHPSS for global monitoring of integration of MHPSS into national crisis preparedness and responses.

Two thirds (65%) of responding countries reported having a system for MHPSS for emergency preparedness and/or disaster risk management (Fig. 32). This represents a major increase over that reported for the 2020 edition (45% of responding countries). In all country income groups, 60–70% of responding countries reported such a system. Wider differences were seen by WHO region, from 47% in the AFR to 89% in the SEAR. This is consistent with the findings of a WHO assessment of the impact of COVID-19 on mental, neurological and substance use services and a subsequent survey that showed > 90% of Member States reporting integration of MHPSS into their public health emergency response during COVID-19.[10] Out of 59 responding countries experiencinged a level 2 or 3 emergency, 85% overall and over 75% in all WHO regions reported that mental health and psychosocial support had been provided in the emergency response.

Figure 32. MHPSS preparedness and response system as part of emergency response and/or disaster risk management, by WHO region and World Bank income group



9. Resolution WHA77.3. Strengthening mental health and psychosocial support before, during and after armed conflicts, natural and human-caused disasters and health and other emergencies. Geneva: World Health Organization; 2024 (https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_R3-en.pdf).
10. Fourth round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November 2022–January 2023: interim report. Geneva: World Health Organization; 2023. https://iris.who.int/handle/10665/367352. License: CC BY-NC-SA 3.0 IGO.

Countries with an MHPSS system answered additional questions on the extent of readiness and preparation. Table 26 shows the availability of dedicated resources for MHPSS, a plan or strategy for MHPSS components of emergency preparedness and response and documented evidence on the progress or impact of MHPSS. Of the 92 responding countries, 75% had a defined plan or strategy, 65% had dedicated resources for MHPSS, and 44% reported having documented evidence of progress or impact. Marked differences were observed, such as between LIC and LMIC.

Table 26. MHPSS resources, plans and monitoring

No. of responding countries	Dedicated resources (%)	Defined plan or strategy for MHPSS (%)	Documented progress or impact (%)
Globally (n=92)	65	75	44
By World Bank income group			
LIC (n=11)	82	91	64
LMIC (n=23)	35	45	14
UMIC (n=30)	70	79	59
HIC (n=28)	79	89	43
By WHO region			
AFR (n=16)	63	63	44
AMR (n=23)	61	77	41
SEAR (n=8)	75	43	67
EUR (n=15)	80	80	47
EMR (n=15)	47	93	40
WPR (n=15)	73	79	40

Of the responding countries listed as having experienced a level 2 or 3 emergency and that reported provision of mental health and psychosocial support as part of the emergency response (51 countries), 71% had established a multisectoral mental health and psychosocial support coordination group or platform, and 85% had adopted the Inter-Agency Standing Committee's MHPSS Minimum Service Package to guide the emergency response (Table 27).

Table 27. Activation of MHPSS implementation (% of responding countries)

	Coordination group established (%)	Minimum service package adopted (%)
Globally (n=51)	71	58
By World Bank income group		
LIC (n=14)	93	85
LMIC (n=15)	87	60
UMIC (n=16)	69	73
HIC (n=6)	83	50
By WHO region		
AFR (n=17)	76	69
AMR (n=10)	60	60
SEAR (n=4)	100	100
EUR (n=6)	83	67
EMR (n=10)	100	67
WPR (n=4)	100	75

4.2 Outpatient services

Availability and use of mental health outpatient services by the adult population

Member States were requested to provide information on the availability and use of outpatient mental health care organized by both government and nongovernmental (profit or not-for-profit) providers.

Of the 138 Member States that provided information on different types of mental health outpatient services (Fig. 33 and Fig. 34), at least 75% reported that they operated mental health outpatient facilities in psychiatric hospitals and in general hospitals; the exception was the WPR, where only 50% of responding countries reported outpatient services at psychiatric hospitals. The proportions that offered community outpatient services varied more widely, from 25% in LIC and 50% in LMIC to 76–80% in UMIC and HIC. By WHO region, the range was from less than half (42%) in AFR to> 90% in the EUR.

Figure 33. Availability of mental health outpatient services for adults, globally and by World Bank income group

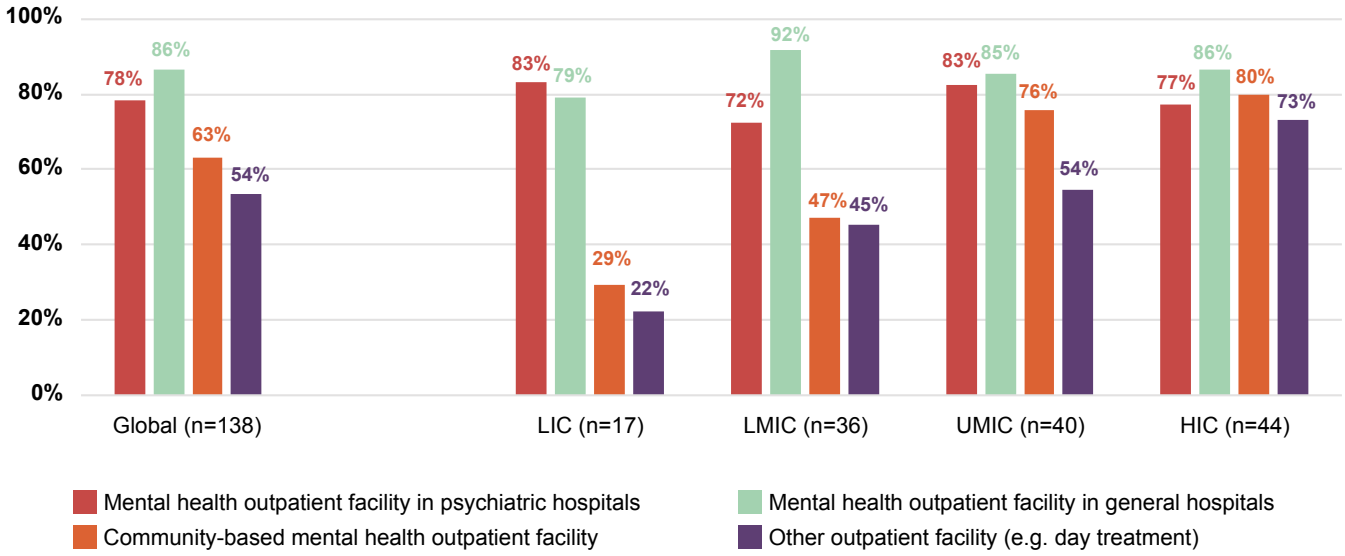


Figure 34. Availability of mental health outpatient services for adults, by WHO region

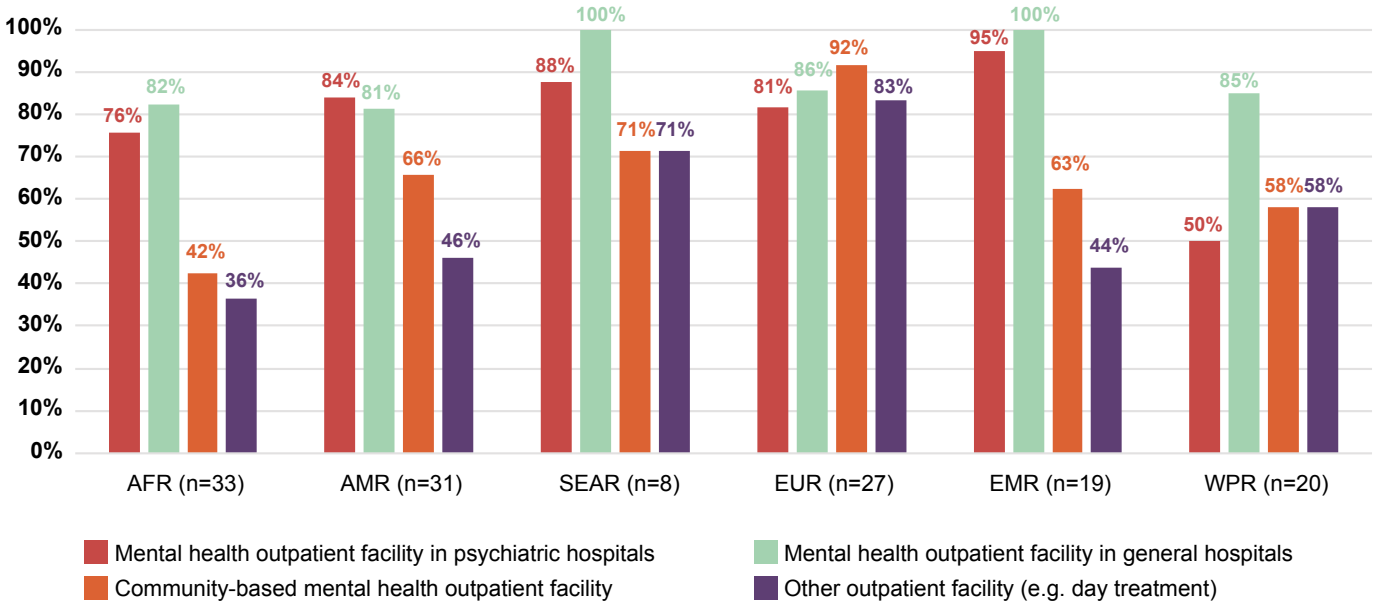
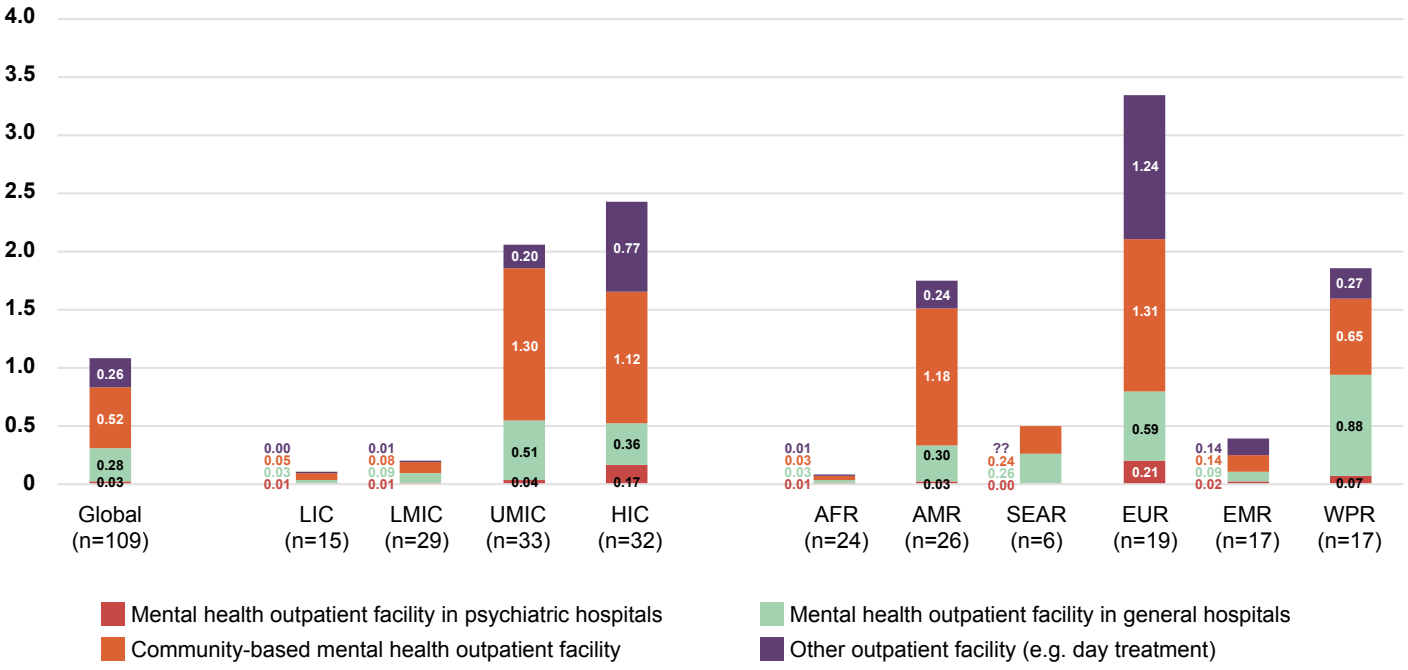


Fig. 35, based on data from 109 countries, provides additional information on the availability of and access to outpatient services as the median number of facilities per 100 000 population. Considerable variation is seen around the global median of 0.45 facilities per 100 000 population, from > 1 in UMIC and > 2 in HIC to< 0.1 in LIC and LMIC. The latter values correspond to > 1 million people per outpatient facility in LIC. The median number of outpatient facilities ranged from nearly 0.1 in the AFR and the SEAR to 1.8–1.9 in the EUR and the WPR. Most outpatient facilities were community mental health centres and facilities such as day hospitals and drop-in centres.

Figure 35. Availability of mental health outpatient facilities for adults (median rate per 100 000 population)



Another measure of the provision and uptake of mental health outpatient care services was the number of visits they received (Table 28). Data from the small number of responding countries (87) showed that the median number of visits to any type of outpatient facility was close to 2000 per 100 000 population, most visits being made to community mental health facilities. There were considerable differences among countries by region and income level, due partly to the relatively few data points.

Table 28. Use of mental health outpatient services (median number of visits per 100 000 population)

Median number of visits per 100 000 population	Outpatient services in psychiatric hospitals	Mental health outpatient service in general hospitals	Community-based mental health outpatient services	Other mental health outpatient services (e.g. day treatment)	All mental health outpatient services
Globally (n=86)	360	774	1832	812	2029
By World Bank income group					
LIC (n=12)	116	78	8	5	113
LMIC (n=21)	103	462	391	38	541
UMIC (n=23)	432	972	1661	459	2738
HIC (n=31)	1579	1809	2314	2326	4227
By WHO region					
AFR (n=16)	108	78	8	5	125
AMR (n=20)	535	867	1699	459	2588
SEAR (n=4)	78	4333	3426	–	1762
EUR (n=20)	1105	972	2776	1937	3521
EMR (n=14)	392	427	364	644	1355
WPR (n=13)	1689	1651	1544	8676	4227

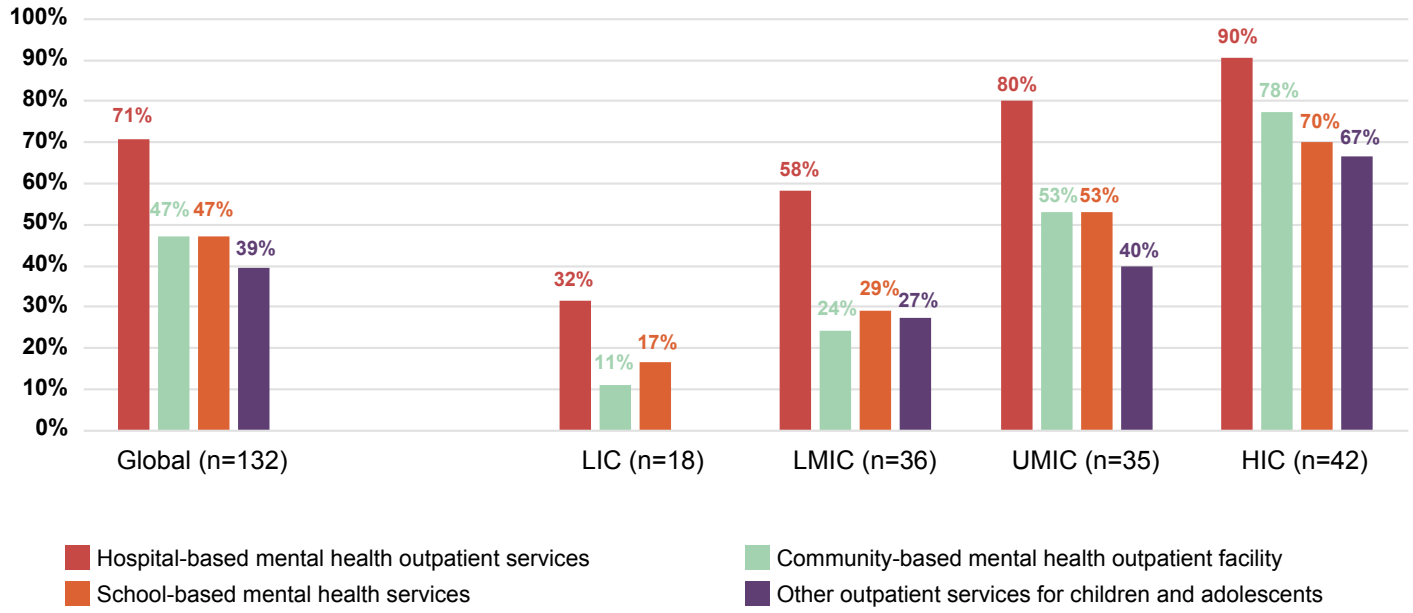
Availability of mental health outpatient services for children and adolescents

The 2024 Atlas survey included questions not only on the availability of a policy and of a dedicated workforce for child and adolescent mental health but also on the extent of outpatient mental health services for this group. Respondents were asked to include only facilities in which children and adolescents are the only users.

Fig. 36 shows that, of 132 responding countries, 70% operate hospital-based mental health outpatient services.

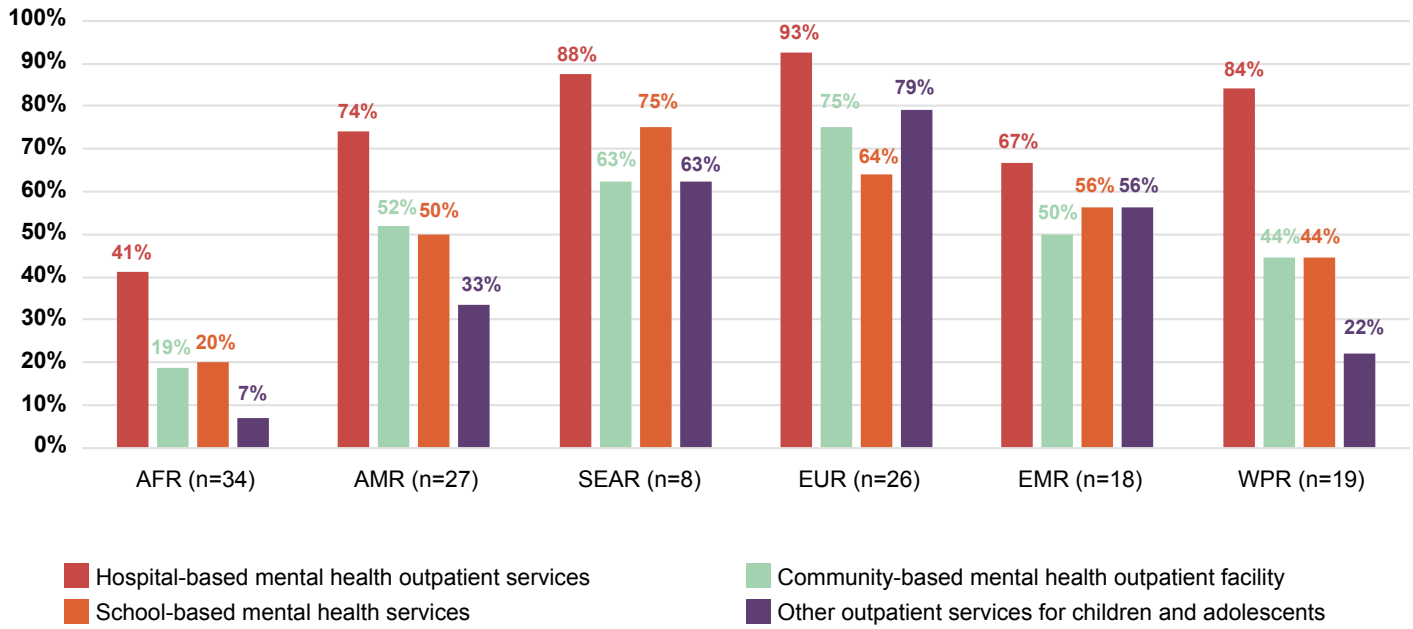
A linear gradient was seen for countries at different income levels, from 30% of LIC to 90% of HIC. Fewer than half of responding countries provided community-based, school-based or other mental health services for this population group, and a similar gradient was seen by income group. For example, community mental health outpatient facilities were available in less than 25% of LIC and LMIC, in 50% of UMIC and 75% of HIC. A similar pattern was observed for school-based mental health services.

Figure 36. Availability of mental health outpatient services for children and adolescents, globally and by World Bank income group



When data were disaggregated by WHO region (Fig. 37), the availability of community- and school-based mental health outpatient services ranged from 20% to 75%, while the range for hospital-based mental health outpatient services was 40–90%. In both cases, services were least available in the AFR and most available in countries in the EUR and the SEAR.

Figure 37. Availability of mental health outpatient services for children and adolescents, by WHO region



Data on the number of such facilities per 100 000 population are not reported because of low response rates (fewer than 30 data points reported). Data from 60 countries on hospital-based mental health outpatient services for children and adolescents indicate that the global median is < 0.1 per 100 000 population.

Data submitted by 49 countries provide estimates of the median number of visits to hospital, community and other mental health outpatient facilities specifically for children and adolescents (Table 29). Data on school outpatient services are omitted because of the low level of reporting. Globally, a median of 232 visits per 100 000 population was made to these facilities per year. The difference in median values by country income group and region was extremely wide (two orders of magnitude, from < 10 to nearly 1000), reflecting the low response rate and consequent instability of estimates. These results should therefore be considered tentative rather than definitive.

Table 29. Use of mental health outpatient services for children and adolescents, globally, by World Bank income group and WHO region

Median number of visits per 100 000 population	Median number of visits per 100 000 population
Globally (n=49)	232
By World Bank income group	
LIC (n=1)	4
LMIC (n=11)	38
UMIC (n=15)	70
HIC (n=22)	974
By WHO region	
AFR (n=2)	3
AMR (n=10)	164
SEAR (n=3)	83
EUR (n=15)	925
EMR (n=10)	113
WPR (n=9)	62

4.3 Inpatient services

Member States were requested to provide information on the availability and use of inpatient and residential mental health services, including those run by government and nongovernmental (profit or not-for-profit) providers. Separate questions were asked about inpatient services for adults and for children and adolescents. Inpatient and residential care facilities include psychiatric hospitals, psychiatric wards in general hospitals and community residential facilities.

Availability and use of mental health inpatient services for adults

Information on the availability of mental health inpatient services were provided by 143 Member States i (Fig. 38 and Fig. 39). Globally and in almost all country income groups and WHO regions, at least 75% of responding countries reported mental health inpatient facilities in psychiatric hospitals and in general hospitals; the exception was the WPR, where only 65% of responding countries reported inpatient services in psychiatric hospitals. The proportion of responding countries with community mental health residential facilities varied more widely, from 22–45% in LMIC to 80% in HIC. By WHO region (Fig. 39), the range of values for this category of residential care was similar, from 22% in the AFR to 85% in the EUR.

Figure 38. Availability of mental health inpatient services for adults, globally and by World Bank income group

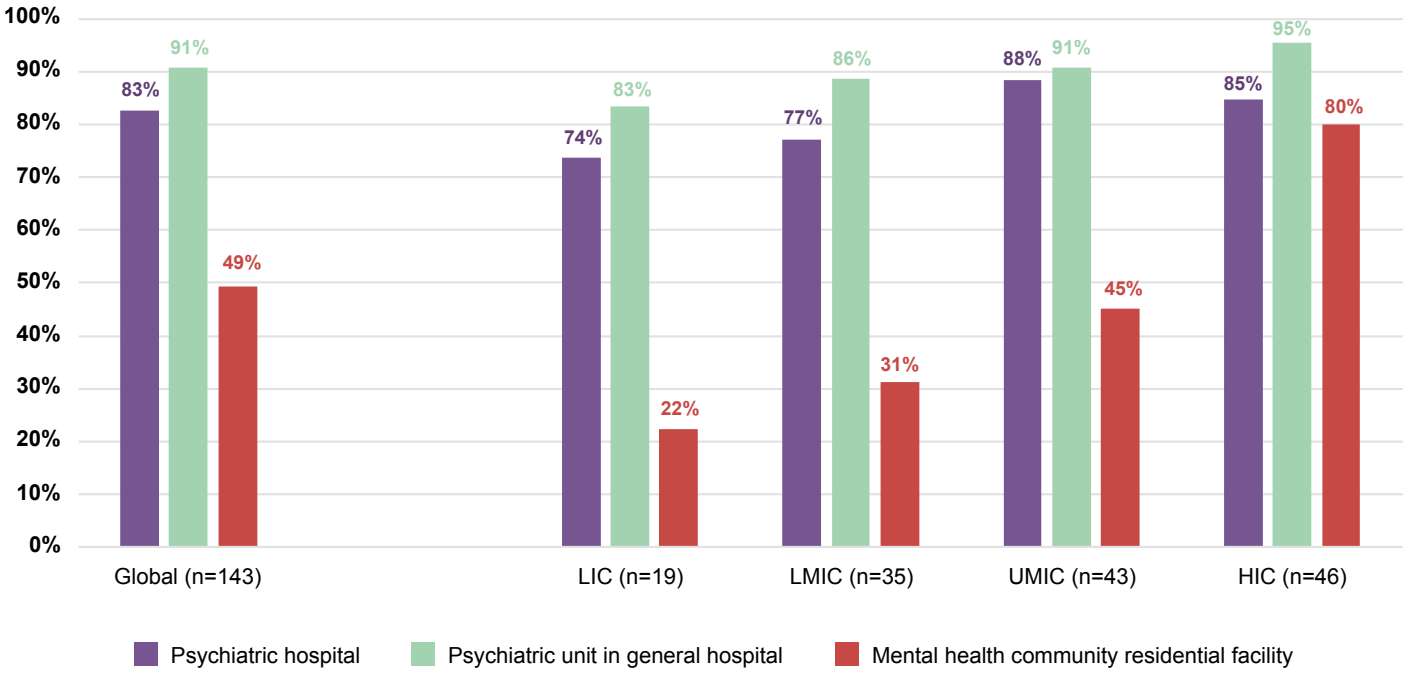
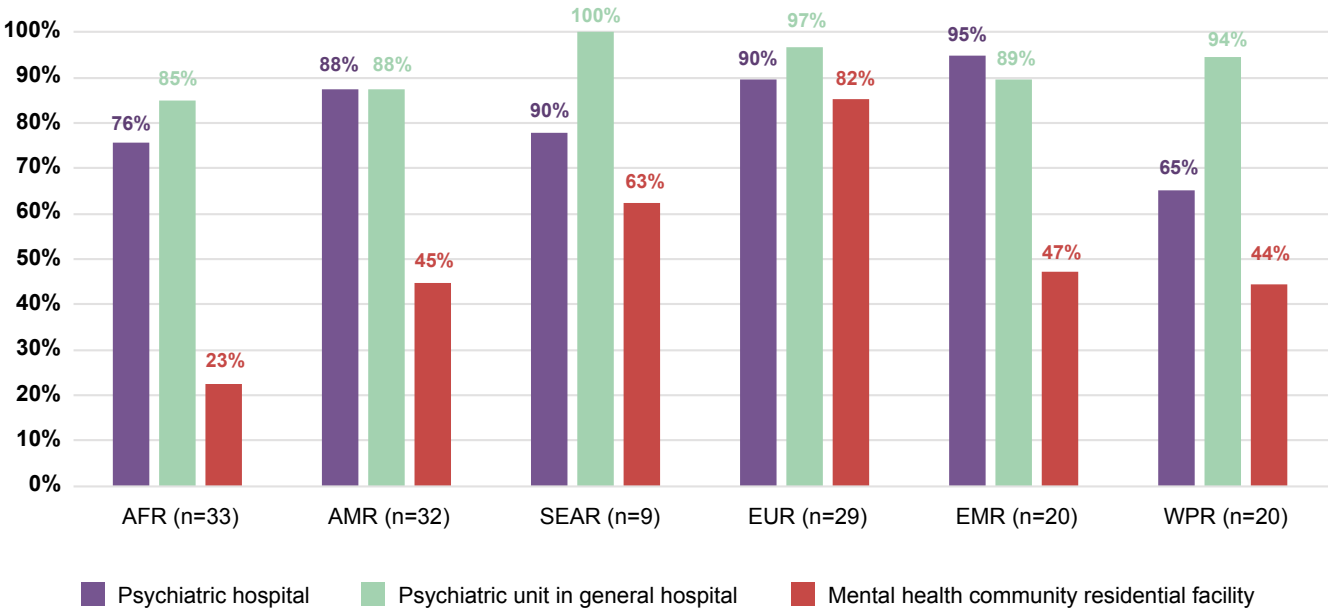


Figure 39. Availability of mental health inpatient services for adults, by WHO region



Tables 30 and 31 provide data on separate but related aspects of mental health inpatient care: the number of inpatient beds and the number of admissions. In both cases, the data shown are median rates per 100 000 population, broken down by type of inpatient facility, country income group and WHO region.

In terms of the availability of inpatient and residential care beds, data from 123 countries indicate a global median of 10 per 100 000 population, equivalent to one bed per 10 000 population (Table 30). By income group, the median rate per 100 000 population ranged from < 5 in LMIC to > 40 in HIC, and, by WHO region, from 3 in the AFR to 67 in the EUR. Beds were located mainly in psychiatric hospitals, indicating that relatively large institutions have many beds. Globally, there was a median of 6.2 inpatient beds in psychiatric hospitals, 2.9 in psychiatric units of general hospitals and 4.1 in community residential facilities.

Table 30. Numbers of mental health inpatient beds for adults (median rate per 100 000 population)

Median number of inpatient beds per 100 000 population	Psychiatric hospital	Psychiatric unit in general hospital	Mental health community residential facility	All inpatient facilities
Globally (n=123)	6.2	2.9	4.1	10.0
By World Bank income group				
LIC (n=17)	1.1	0.7	0.5	1.7
LMIC (n=31)	2.9	1.2	0.1	3.1
UMIC (n=35)	9.2	3.4	3.5	13.2
HIC (n=40)	23.4	11.0	9.5	44.1
By WHO region				
AFR (n=29)	1.9	1.0	0.4	3.0
AMR (n=28)	6.5	2.9	2.5	10.2
SEAR (n=6)	2.9	2.3	1.8	7.4
EUR (n=23)	43.5	14.8	48.0	67.5
EMR (n=19)	3.8	0.8	1.5	5.8
WPR (n=18)	10.3	8.7	9.5	15.3

Admission rates to these different categories of inpatient and residential care facility are summarized in Table 31. Globally and in most regional and country income groupings, the median rates of admission per 100 000 population were similar for psychiatric hospitals and psychiatric units of general hospitals (for example, 66.5 and 56.6 at global level). The rates of admission to community residential facilities tended to be lower than to hospital facilities, but not in all contexts, as in the AFR and the WPR. Response rates for this item were, however, lower than for hospital-based admissions, influencing the stability and therefore the reliability of the median estimates.

Table 31. Numbers of adults admitted as mental health inpatients (median rate per 100 000 population)

Inpatient admissions per 100 000 population (median)	To a psychiatric hospital	To a psychiatric unit in a general hospital	To a mental health community residential facility	To all inpatient facilities (per 100 000 population)
Globally (n=118)	66.5	56.6	11.1	115.6
By World Bank income group				
LIC (n=16)	6.5	13.5	0.0	21.0
LMIC (n=25)	18.4	18.5	16.5	38.1
UMIC (n=38)	97.7	74.9	5.6	139.9
HIC (n=39)	104.7	140.9	8.2	300.8
By WHO region				
AFR (n=24)	17.0	13.5	0.0	46.1
AMR (n=27)	46.6	56.9	0.3	97.5
SEAR (n=6)	24.6	118.1	14.5	66.1
EUR (n=25)	260.3	244.7	49.8	504.1
EMR (n=19)	46.6	25.8	7.5	61.3
WPR (n=17)	98.3	57.4	105.6	121.0

Two further aspects of inpatient care were assessed for the Mental Health Atlas 2024: the rate of involuntary admissions and the average length of stay. Data from only 45 responding countries indicated that 49% of all psychiatric hospital admissions globally were involuntary, with marginally lower rates in UMIC (33%) and HIC (30%) (Fig. 40). . Regionally, the AMR and the WPR had the highest proportions of reported involuntary admissions (> 50%), while the EUR reported the lowest (23%). These finding show both significant variation and continuing high levels of involuntary treatment in mental health care services and systems around the world.

Figure 40. Involuntary admissions to hospital-based mental health inpatient facilities by income level and WHO region

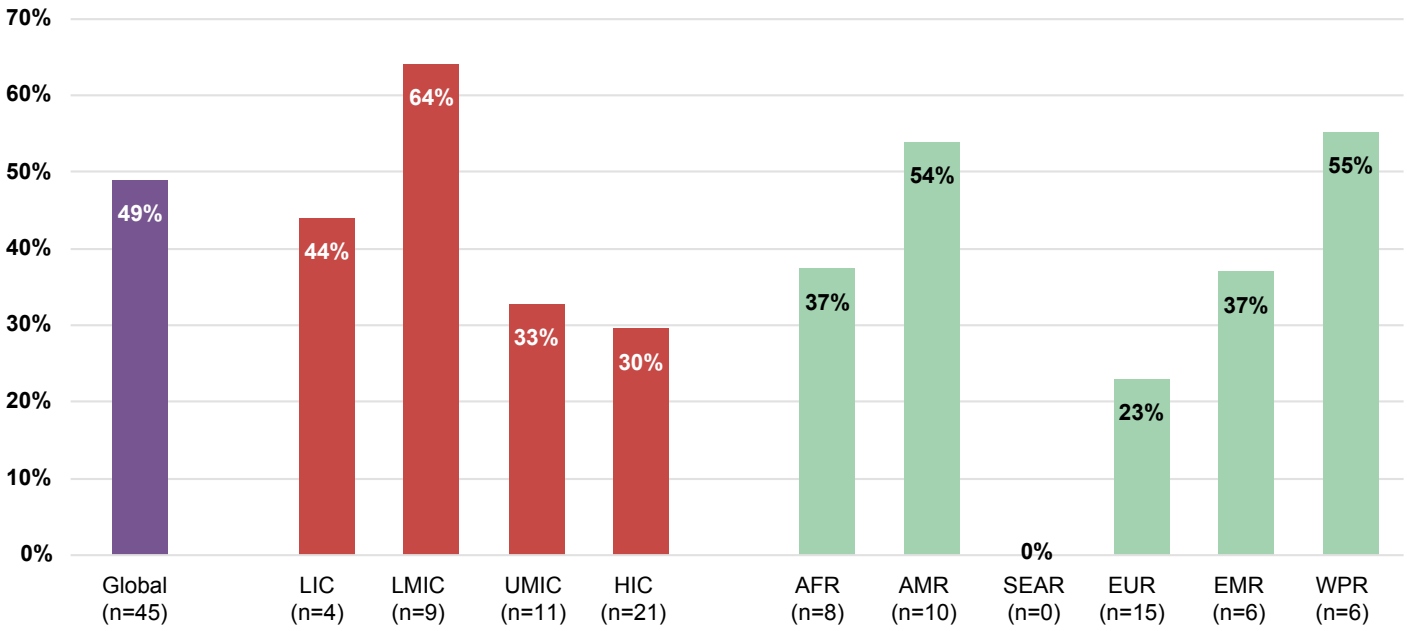


Table 32 provides a breakdown of data submitted by 63 countries on the length of stay of psychiatric hospital inpatients (from < 6 months to > 5 years). Most inpatients (72% globally) were reported to stay for < 6 months. The global percentages of inpatients reported to have stayed in a psychiatric hospital for > 1 and > 5 years were 7% and 16%, respectively, indicating that more than one in five inpatients stays in such facilities for > 1 year. As shown by the standard deviation values, however, marked differences were see among countries in longer stays. The rates by WHO region are not shown because of low reporting from some regions (e.g. only three countries in the SEAR). When the data are disaggregated by level of income, only modest differences were found in stays of < 6 months and > 5 years, but > 10% of inpatients in LIC stayed for 6–12 months or 1–5 years as compared with 1.4% and 5.3%, respectively, in UMIC.

Table 32. Average length of stay after an inpatient admission to a psychiatric hospital

No. of responding countries	Length of stay in a psychiatric hospital (%)			
	< 6 months	6–12 months	1–5 years	> 5 years
Globally ± standard deviation (n=63)	72 ± 33	6 ± 9	7 ± 11	16 ± 27
LIC (n=8)	64	12	11	13
LMIC (n=16)	73	9	4	15
UMIC (n=20)	76	1	5	18
HIC (n=19)	69	6	9	16

Availability of mental health inpatient services for children and adolescents

Fig. 41 shows that, of 141 responding countries, less than half (45%) had dedicated hospital-based inpatient facilities (either in psychiatric hospitals or in psychiatric units of general hospitals) for children and adolescents, and less than 20% had community residential facilities for this population group. None of the 19 LIC that submitted data for this question reported community facilities, and only one in five reported hospital-based facilities. Community residential facilities were available in 31% of UMIC and 50% of HIC and hospital-based inpatient services in 63% and 87%, respectively. At WHO regional level (Fig. 42), 35–100% had hospital-based services, and 10–63% had community residential facilities.

Figure 41. Availability of mental health inpatient services for children and adolescents, globally and by World Bank income group

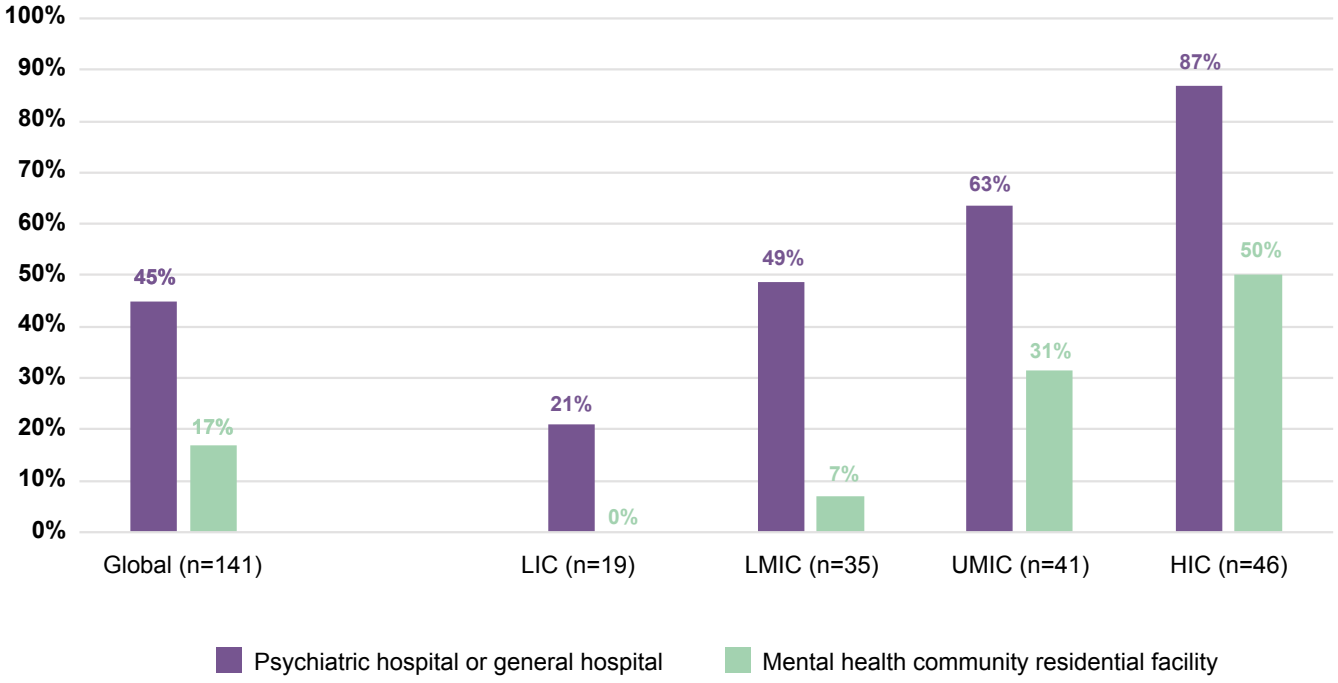
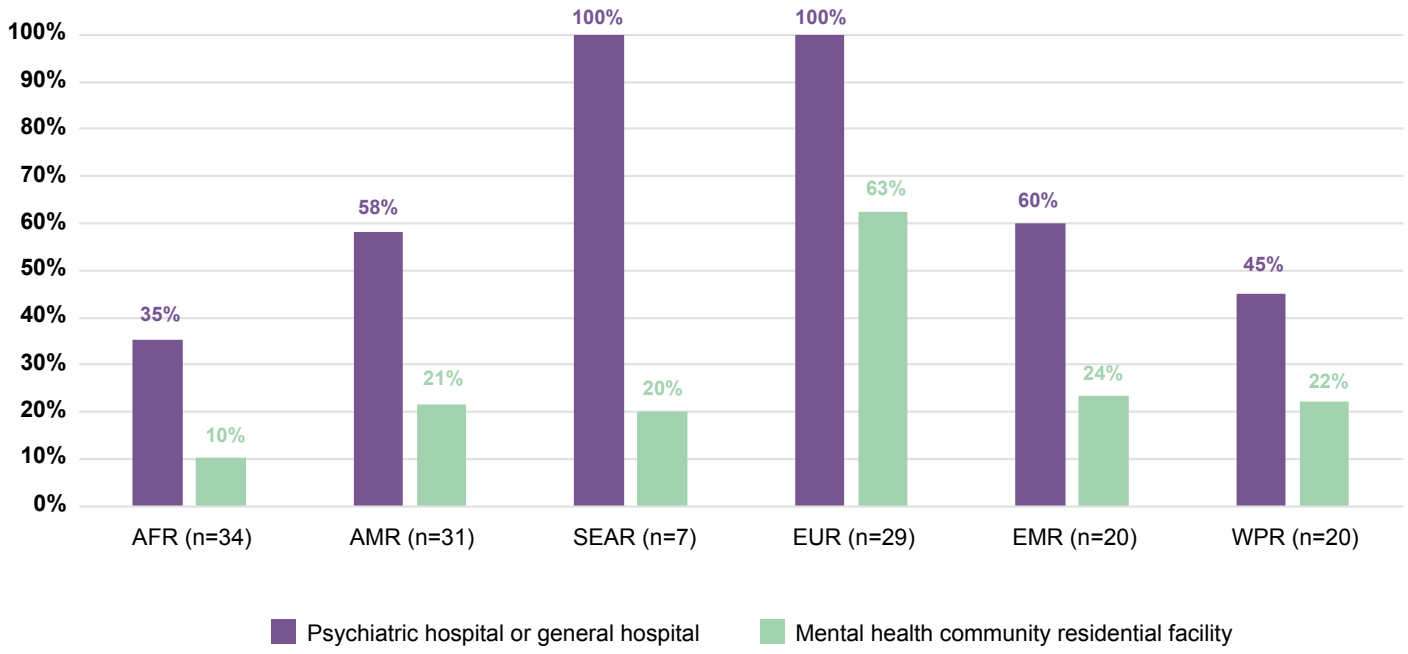


Figure 42. Availability of mental health inpatient services for children and adolescents, by WHO region



The median rates of service availability, beds and admissions per 100 000 population can be presented only for hospital-based inpatient care for children and adolescents (Table 34), as the data for community residential facilities were too sparse for meaningful analysis. Data provided by 60 countries indicate that, globally, there is a very little availability, with a median rate of 0.04 facilities, 0.6 beds and eight admissions per 100 000 population. The median number of beds did not exceed two per 100 000 population in any geographical or country income grouping.

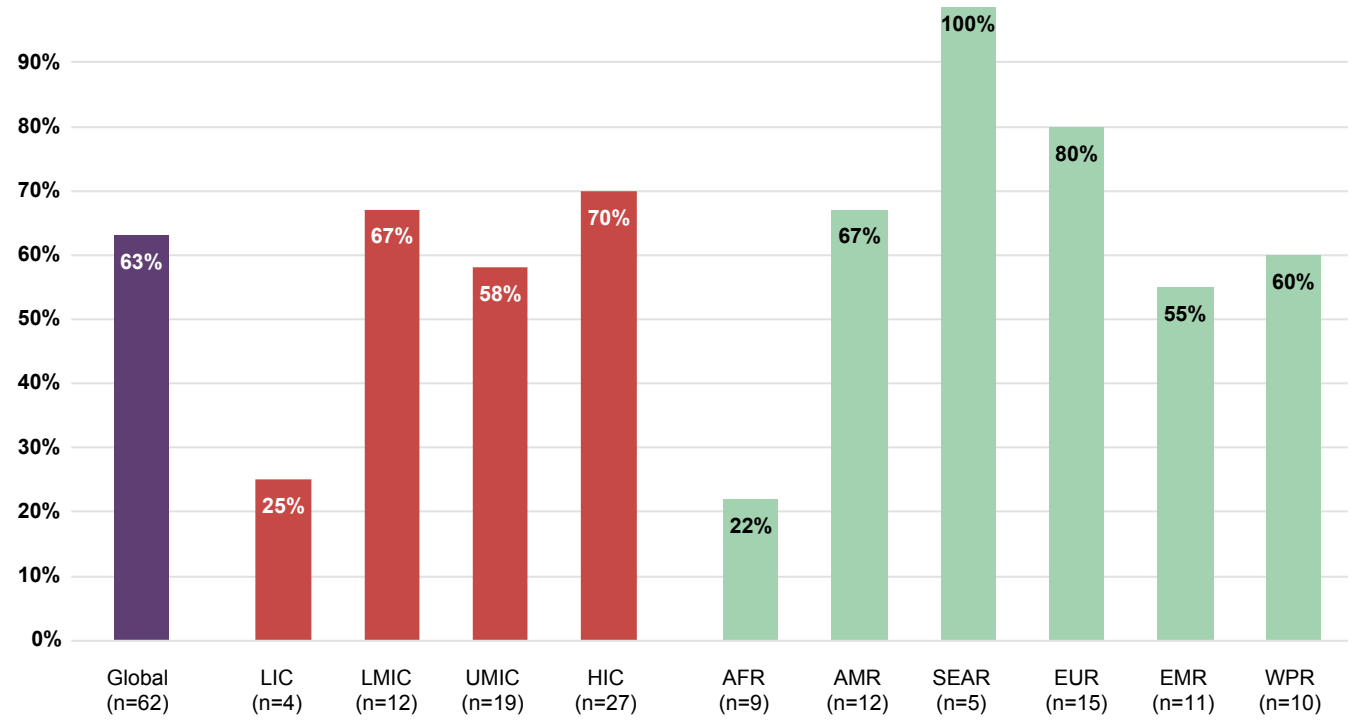
Table 33. Use of mental health inpatient services for children and adolescents (median number of visits per 100 000 population) by income grouping and WHO region

	Mental health inpatient care in psychiatric and general hospitals (median rate per 100 000 population)		
	Facilities	Beds	Admissions
Globally (n=60)	0.04	0.59	8.02
By World Bank income group			
LIC (n=4)	0.00	0.06	0.55
LMIC (n=12)	0.01	0.11	1.17
UMIC (n=15)	0.04	0.58	5.32
HIC (n=29)	0.11	1.42	22.70
By WHO region			
AFR (n=8)	0.01	0.30	1.27
AMR (n=11)	0.04	1.03	6.52
SEAR (n=6)	0.01	0.24	10.43
EUR (n=19)	0.11	1.97	36.76
EMR (n=12)	0.02	0.14	1.44
WPR (n=4)	0.02	0.56	10.12

Availability of a registry for recording use of seclusion or restraint in mental health services

Maintenance of a register of use of seclusion or restraint in a mental health care service is essential to ensure transparency, accountability and the protection of human rights to safeguard the protection of service users' rights. Accurate, systematic documentation can be used for setting policy and helps to prevent misuse or overuse of such interventions. Just under half (49%) of the 133 countries that submitted data declared that there was a registry of incidents of seclusion or restraint (Fig. 43). Only 25% of countries in the AMR and the SEAR had such registries as compared with 75% in the EUR. Registries were most common in HIC (61%), indicating that there is a substantial gap in recording use of seclusion and restraint even in the most well-resourced health systems. It should be noted that no operational criteria were used to establish the quality of such registries.

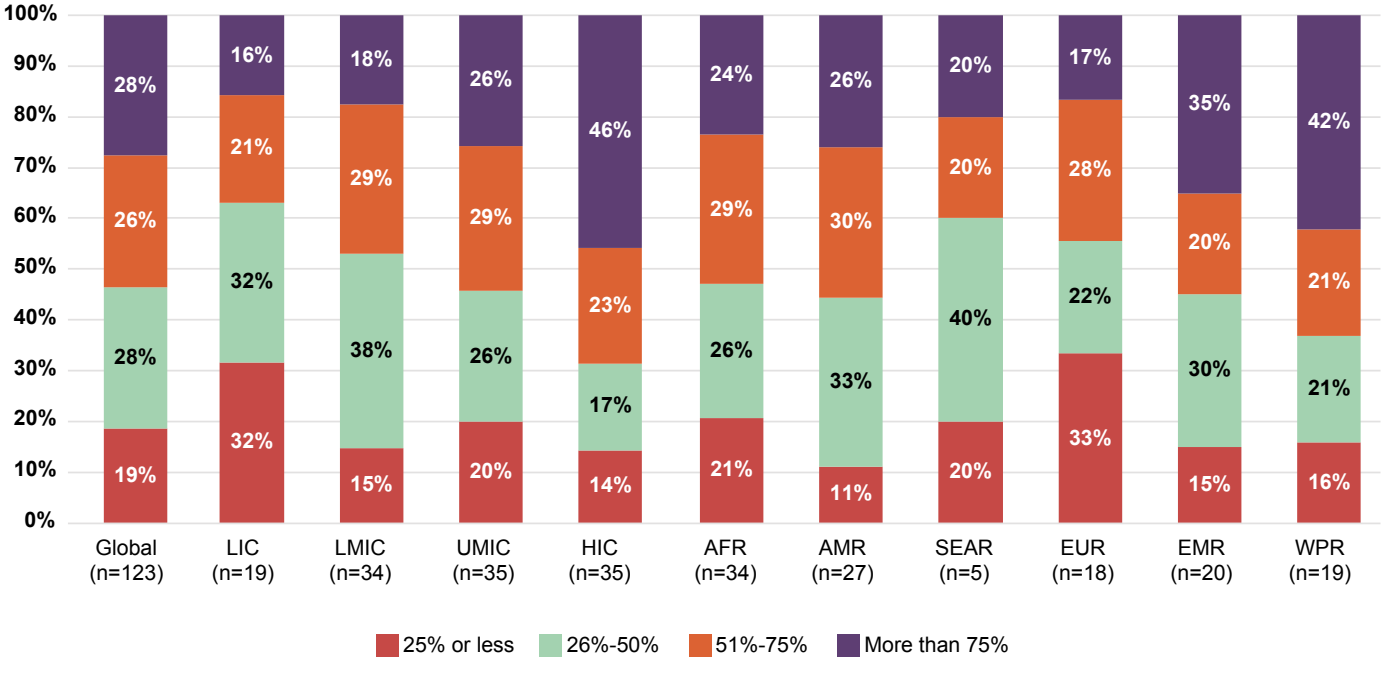
Figure 43. Maintenance of a registry of use of seclusion and restraint by World Bank income group and WHO region



Follow-up of inpatients

Follow-up within 1 month of discharge is a key indicator of the continuity of care. Only 28% of responding countries reported that more than 75% of discharged patients received a follow-up outpatient visit within 1 month. HIC perform best (46%), while LIC and LMIC had much lower rates (< 20%). Wide regional disparities were seen: the WPR (42% of responding states) and the EMR (35%) had better rates than the other regions (17–26%) (Fig. 44).

Figure 44. Follow-up of discharged inpatients within 1 month, by WHO region and World Bank income group (% of responding countries)



4.4 Service coverage

A key measure of health service output and a core dimension of the concept and goal of universal health coverage is service coverage. One of the targets of the WHO Comprehensive mental health action plan 2013–2030 is to increase service coverage for people with mental health conditions, with specific indicators for psychosis and depression. Service coverage is defined as the proportion of people with a mental health condition who used services in the past year. Estimates of treatment prevalence and service coverage can be obtained periodically by administering a population-based survey. As noted in the introduction, one third of responding countries reported that they had conducted a national mental health survey in the previous 10 years, of which > 80% included a section on service use. For more regular monitoring and reporting of service coverage and for countries that did not recently conduct a national mental health study, routine health information collected in health facilities and recorded in registries or other administrative records can be used.

To assess service uptake and coverage rates, the Mental Health Atlas 2024 survey included questions on the use of inpatient and outpatient services by people with psychosis within the past year. The submitted data were rigorously checked, and estimates were made by a method developed for the Mental Health Atlas 2017 by Jaeschke et al.[11] For example, data were excluded if they did not include use of both inpatient and outpatient services, if there had been fewer than one visit per individual with the condition, or if the reported number of people with psychosis who used the used services exceeded the total estimated prevalence of the condition in the country.

Of 86 countries that submitted data, 35 were excluded because they did not provide information on both inpatients and outpatients, and a further 29 were excluded as they did not meet the defined inclusion criteria. This high exclusion rate (74% of submitted data) significantly limits the representativeness and reliability of estimates of service coverage. Based on the remaining sample of data from 22 countries, results are presented in Table 34, both globally and by country income group. The rate of service uptake or treated prevalence per 100 000 population for psychosis ranged from < 50 in LIC to > 300 in UMIC and HIC, with a global average of 245. An estimate of service coverage can be derived by dividing the estimated number of people with psychosis who received services by the total estimated prevalence of psychosis. Mean service coverage was thus estimated to be 41% (with a standard deviation of 28% and a median of 40%), with a range from < 10% in LIC and > 50% in UMIC and HIC. The representativeness of these estimates is significantly constrained by the low number of included data points, which also meant that it was not feasible to provide estimates by WHO region. These estimates should therefore be considered indicative rather than definitive.

Table 34. Prevalence of treatment and service coverage for psychosis

Service uptake and coverage	Prevalence of treatment of psychosis (per 100 000 population)	Service coverage for psychosis (people with psychosis) (%)
Globally (n=22)	245	41
By World Bank income group		
LIC (n=3)	47	8
LMIC (n=5)	140	23
UMIC (n=4)	322	54
HIC (n=10)	325	54

11. 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. Glob Ment Health. 2021;8:e27. https://doi.org/10.1017/gmh.2021.19.

The administrative data sources available to most focal points for the Mental Health Atlas currently cannot provide detailed or accurate information on the prevalence or coverage of treatment for depression. These questions were therefore not included in the Atlas 2024 survey. The best available information at the time this report was written is from a global analysis of minimally adequate treatment coverage for major depressive disorder in 2021,[12] from which a global estimate of 9.1% was derived. The rate of service coverage was lower for males (7.2%) than for females (10.2%) and varied from > 30% in seven HIC to < 5% in 90 LIC.

Data submitted on mental health information systems (section 1.2) and on service uptake and coverage for psychosis indicate persistent systemic weakness in countries' capacity to collect and report on service use and coverage for mental health conditions. Renewed effort is needed to strengthen their capacity, to which WHO is contributing by identifying, testing and operationalizing core indicators (including service coverage and quality) for use in routine health information systems.

12. Santomauro DF, Vos T, Whiteford HA, Chisholm D, Saxena S, Ferrari AJ. Service coverage for major depressive disorder: estimated rates of minimally adequate treatment for 204 countries and territories in 2021. Lancet Psychiatry. 2024;11:1012–21. https://doi.org/10.1016/S2215-0366(24)00317.

5 Mental health promotion and suicide prevention

5.1 Mental health promotion and prevention programmes

National authorities in and beyond the health sector are all implicated in the prevention of mental health conditions and promotion of mental health throughout the life course. The WHO Comprehensive mental health action plan recommends that Member States lead and coordinate universal, targeted interventions from early childhood throughout life. The purpose should be to prevent poor mental health, reduce stigmatization and protect human rights. They should be integrated into broader national health promotion strategies that are also responsive to individuals' needs at different life stages and tailored to vulnerable populations. Objective 3 of the WHO mental health action plan is for development of national strategies for mental health promotion and suicide prevention, with a target of 80% of countries implementing at least two operational, multisectoral prevention and promotion programmes by 2030.

As in previous versions of the Mental Health Atlas, in this edition a mental health promotion and prevention programme is considered to be "functional" if it meets at least two of the following criteria: it has dedicated financial and human resources; it includes a plan for implementation; and evidence is found of progress and/or impact. In 2024, 63% of responding countries reported that they had at least two functional mental health promotion and prevention programmes, with wide differences by region and income group. For example, 100% of respondents in the SEAR and < 25% in the AFR reported at least two programmes (Fig. 45). This situation is similar to that in 2020 (68%), despite a decrease in the number of country responses (Fig. 46).

The 2024 Mental Health Atlas survey also assessed programme coverage in key thematic areas, including suicide prevention,

Figure 45. Countries that reported at least two functioning mental health promotion and prevention programmes

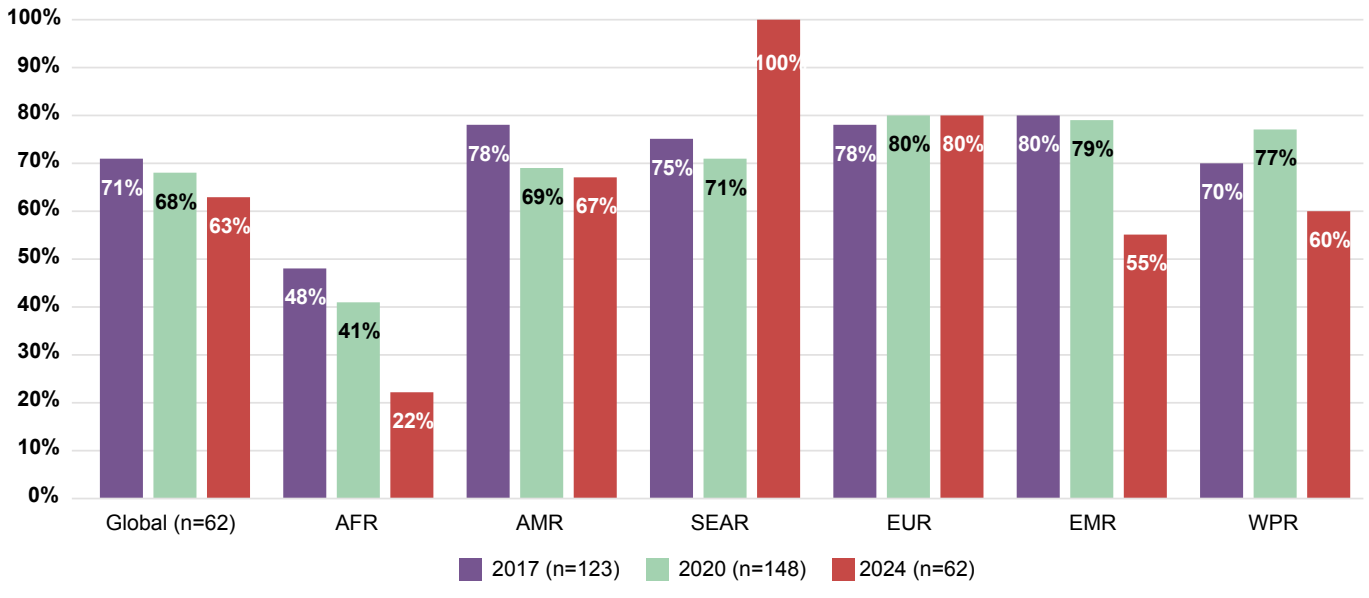
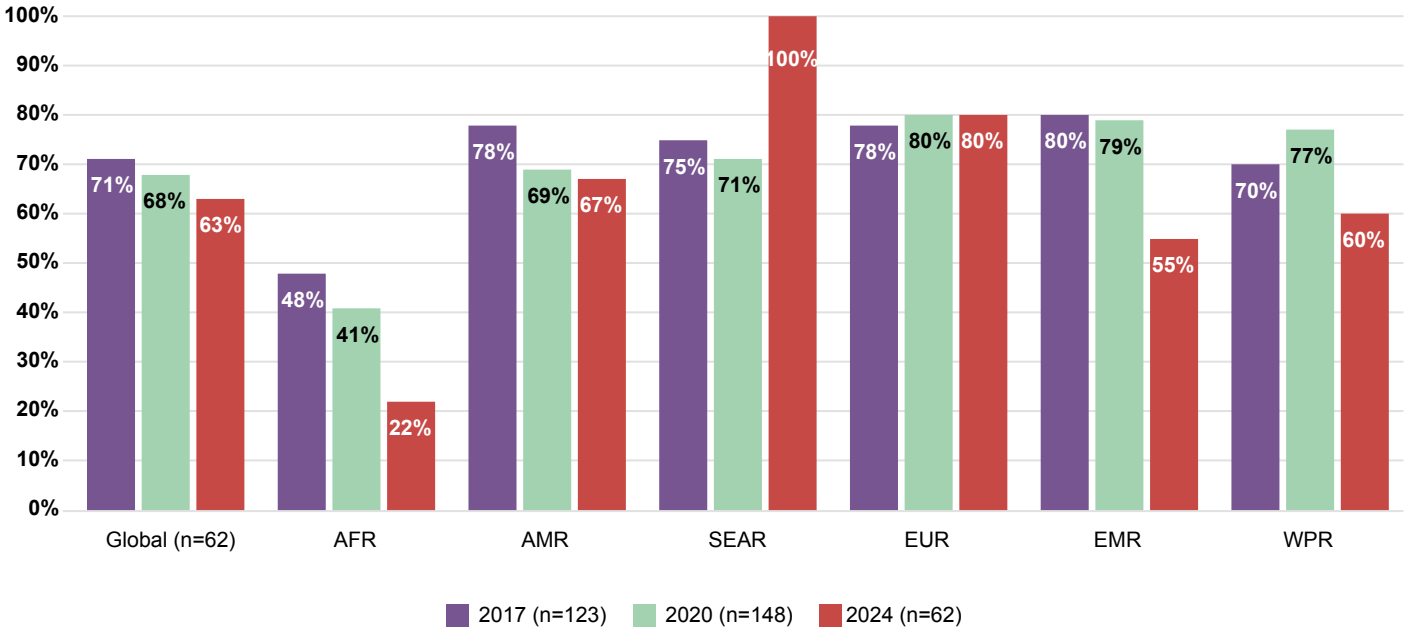


Figure 46. Proportions of responding countries that had at least two functioning mental health promotion and prevention programmes, by WHO region



anti-stigma campaigns, early childhood development, school-based interventions, perinatal mental health and workplace mental health. The most commonly reported functional programmes were those for early childhood development (86% of responding countries), suicide prevention (80%) and school mental health (78%), while those that were less commonly reported were perinatal mental health (69%), anti-stigma campaigns (70%) and mental health programmes in the workplace (72%) (Table 35). More detailed comparisons were, however, limited by the format of the question used in 2024.

Table 35. Main types of functioning programmes in reporting countries

Programme	Countries with functioning programmes (%)	
	2020	2024
Mental health awareness/ anti-stigma (n=46)	51	70
Suicide prevention (n=54)	39	80
Early childhood development (n=50)	45	86
School-based mental health (n=73)	51	78
Perinatal and maternal health (n=54)	29	69
Work-related mental health (n=47)	35	72

5.2 Suicide prevention

In 2021, suicide was responsible for approximately 727 000 deaths globally,[13] making it a key priority for prevention. No more recent data on global suicide mortality were available at the time this report was prepared. Suicide is the third leading cause of death among people aged 15–29 years worldwide and disproportionately affects marginalized populations. Individuals with mental health conditions face significantly higher risks of both physical health problems and suicide. Target 3.2 of the Comprehensive mental health action plan 2013–2030 is for a reduction of the rate of suicide by one third by 2030. As suicide is associated with many risk factors other than mental health conditions, such as chronic pain, acute emotional distress and access to means of suicide, effective prevention requires comprehensive, cross-sectoral strategies. The action plan calls for comprehensive national suicide prevention strategies in collaboration not only with the health sector but also with other sectors.

Suicide prevention strategies and programmes

In the questionnaire for the 2024 Atlas, Member States were asked whether they had a distinct or integrated national suicide prevention strategy, policy or plan. The 47% of responding countries that reported such strategies represents a marginal increase over the rate in 2020 (40%) (Table 36). Clear regional differences were seen, as only 12% of responding countries in the AFR but 68% in the AMR had a suicide prevention strategy. Differences by income were even more striking: only 6% of LIC but 67% of HIC reported a suicide prevention strategy. Of those with a suicide prevention strategy, 88% of responding countries reported that it had been published or revised most recently after 2020, 8% between 2013 and 2019 and 3% before 2013. Table 36 shows the proportions of responding countries that had a suicide prevention programme, differentiated by whether they had a strategy, policy or plan.

Table 36. Countries with a suicide prevention strategy

No. of responding countries	Stand-alone or integrated suicide prevention strategy (%)	Suicide prevention programme (%)
Globally (n=138)	47	47
By World Bank income group		
LIC (n=17)	6	0
LMIC (n=35)	37	36
UMIC (n=42)	51	49
HIC (n=44)	67	73
By WHO region		
AFR (n=32)	12	9
AMR (n=31)	68	58
SEAR (n=8)	50	100
EUR (n=29)	59	54
EMR (n=18)	50	47
WPR (n=20)	50	63

13. Suicide worldwide in 2021: global health estimates. Geneva: World Health Organization; 2025. https://iris.who.int/handle/10665/381495. License: CC BY-NC-SA 3.0 IGO.

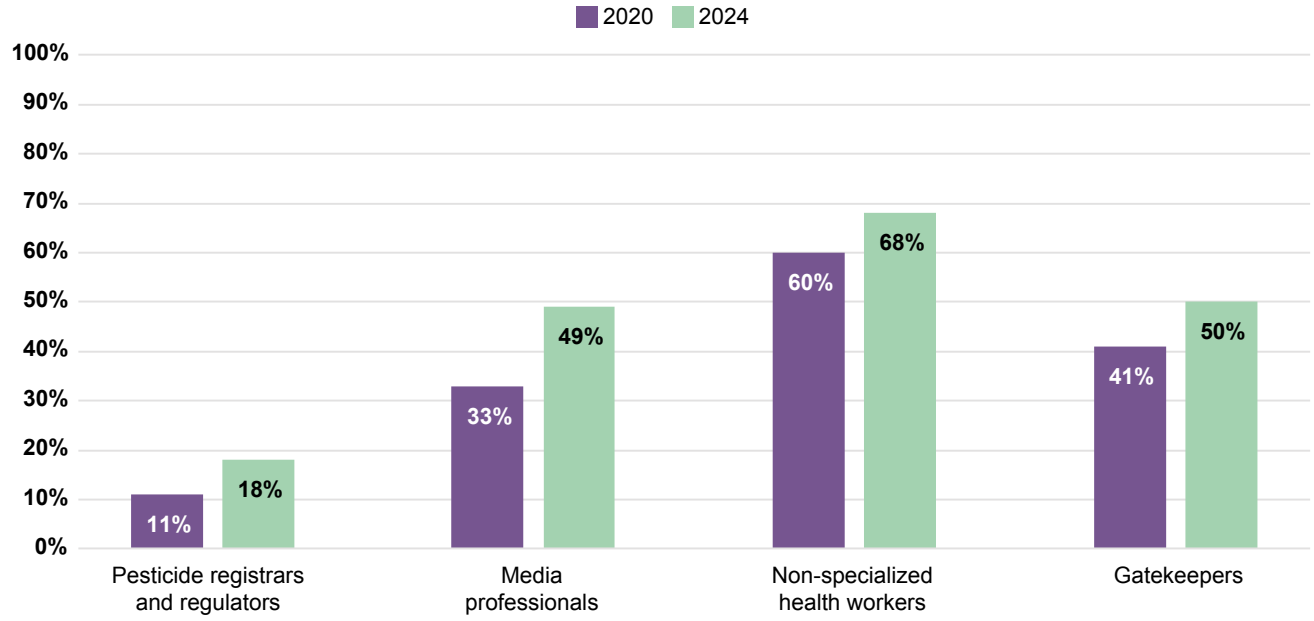
Training in suicide prevention

The Mental Health Atlas 2024 survey also included a question on the groups targeted by their suicide prevention training programmes (Table 37). Of the 132 countries that answered this question, 68% reported that they had such programmes for non-specialized health workers, such as physicians, nurses and community health workers. Fewer countries reported that the programmes in their country were designed for "gatekeepers", such as teachers, police, firefighters, other first responders and faith leaders (50% of responding countries), media professionals (49%) and pesticide registrars and regulators (18%). Overall, the coverage of training has improved since 2020 (Fig. 47).

Table 37. Training programmes for suicide prevention (% of responding countries)

	For pesticide registrars and regulators (%)	For media professionals (%)		For non-specialized health workers (%)	For gatekeepers (%)
Globally (n=129)	18	49	Globally (n=131)	68	50
By World Bank income group					
LIC (n=18)	6	11	LIC (n=18)	28	6
LMIC (n=31)	16	39	LMIC(n=31)	61	35
UMIC (n=37)	26	54	UMIC (n=39)	80	64
HIC (n=43)	17	71	HIC (n=43)	79	65
By WHO region					
AFR (n=29)	0	17	(n=30)	42	19
AMR (n=31)	33	61	(n=31)	84	57
SEAR (n=7)	57	100	(n=6)	100	83
EUR (n=26)	4	69	(n=26)	65	67
EMR (n=19)	33	39	(n=19)	68	37
WPR (n=17)	13	41	(n=19)	79	67

Figure 47. Training programmes for suicide prevention (% of responding countries)



For the first time, the 2024 Atlas questionnaire also posed questions about programme content. Most suicide prevention programmes included the four components of WHO's Live Life framework[14]: restriction of access to means, responsible media reporting, development of socio-emotional life skills in youth and early identification and support for at-risk individuals (Table 38). Most suicide prevention programmes in countries (87%) included a crisis helpline.

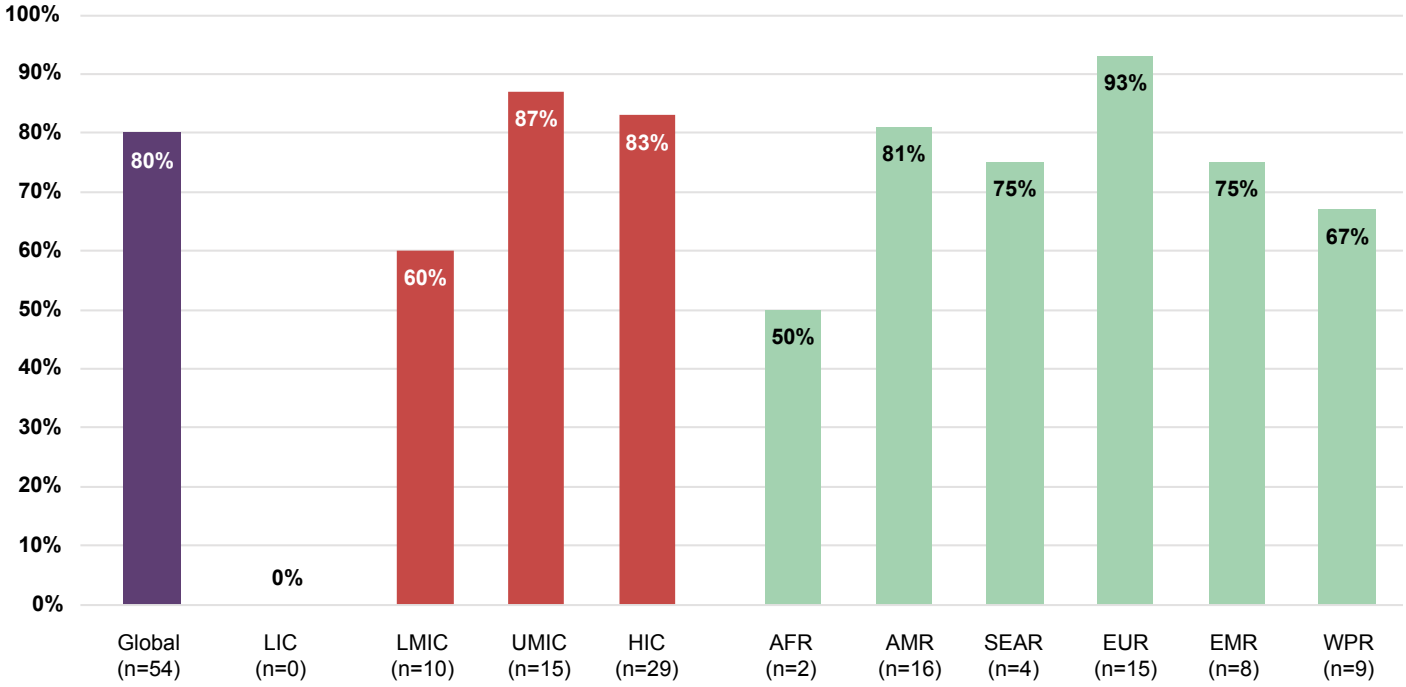
Table 38. Content of suicide prevention programmes

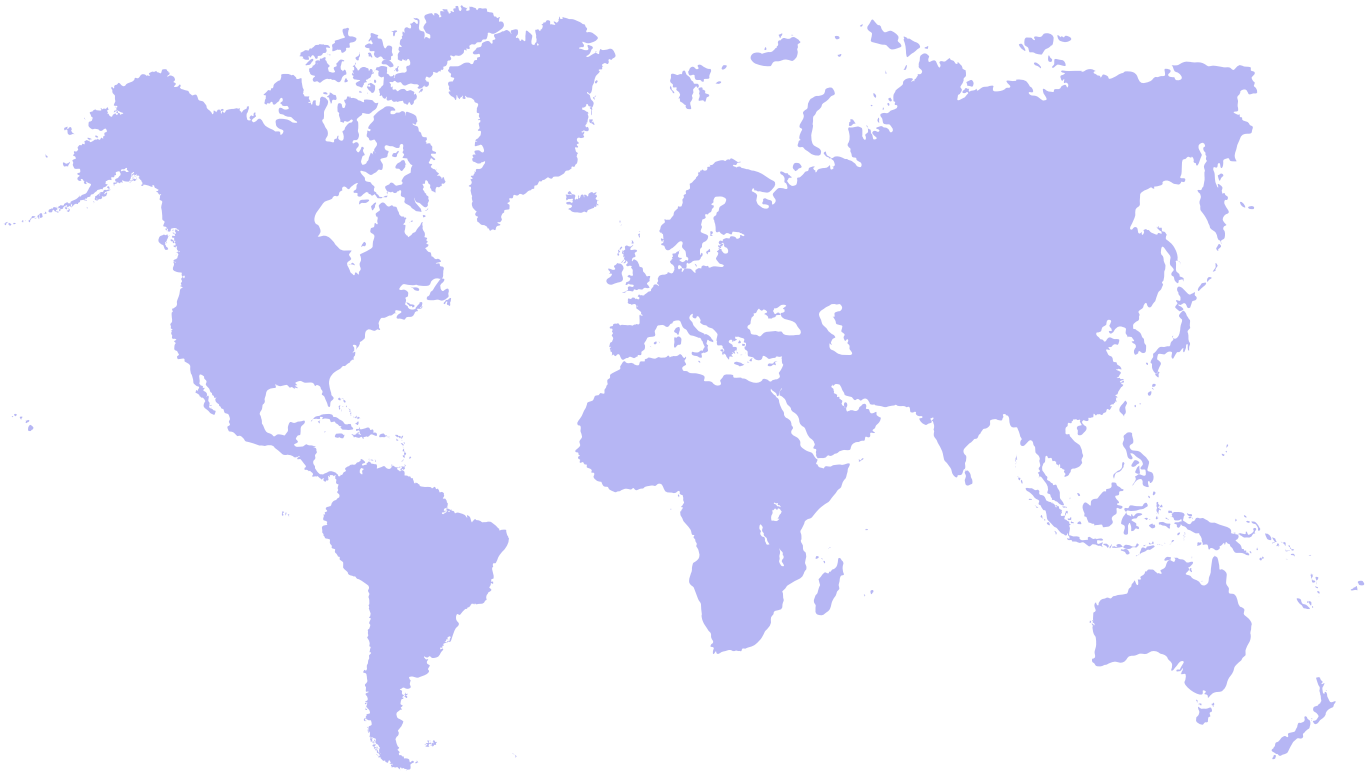
	Limit access to means of suicide (%)	Interaction with media for responsible reporting of suicide (%)	Fostering of socio-emotional life skills in adolescents (%)	Early identification, assessment, management and follow-up of people with suicidal behaviour (%)
Globally (n=62)	69	89	80	92
By World Bank income group				
LIC (n=0)	0	0	0	0
LMIC (n=11)	55	92	67	82
UMIC (n=18)	78	89	88	100
HIC (n=33)	69	88	81	91
By WHO region				
AFR (n=3)	33	67	33	100
AMR (n=18)	65	88	80	100
SEAR (n=6)	67	86	86	83
EUR (n=15)	80	100	80	93
EMR (n=9)	67	89	67	78
WPR (n=11)	73	82	100	92

14. Live life: an implementation guide for suicide prevention in countries. Geneva: World Health Organization; 2021. https://iris.who.int/handle/10665/341726. License: CC BY-NC-SA 3.0 IGO.

A suicide prevention programme was considered to be "functional" if at least two of the following three characteristics were met: dedicated financial and human resources; a defined plan of implementation; and documented evidence of progress and/or impact. Of 54 responding countries, 80% were considered to have a functioning suicide prevention programme (Fig. 48). In comparisons of WHO regions, 50% of responding countries in the AFR, 81% of those in the AMR and 75% of those in the EMR had a functioning suicide prevention programme. Comparisons by income group also show high variation, the percentages differing from 0% of LIC to 83% of HIC.

Figure 48. Countries with a functioning suicide prevention programme by WHO region and World Bank income category





Annex. Responding countries and contributors

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Afghanistan	EMR	LIC	Basharat Hussain Manuel de Lara Waheed Afghan Abdul Qawi Alimi
Albania	EUR	UMIC	Emanuela Tollozhina
Algeria	AFR	UMIC	Mohamed Chakali Souad Dhenane
Andorra	EUR	HIC	Pere Bonet Dalmau Celin Samper Gasset
Angola	AFR	LMIC	Massoxi Adriana Gaspar Vigário
Antigua and Barbuda	AMR	HIC	Teri-Ann Joseph
Argentina	AMR	UMIC	Silvia Pujol
Armenia	EUR	UMIC	Armen Soghoyan Marietta Khurshudyan Garush Ayvazyan Diana Andreasyan Gevorg Pashikyan
Australia	WRP	HIC	Lyndal Corbett
Austria	EUR	HIC	Alexander Grabenhofer-Eggerth

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Bahamas	AMR	HIC	Phillip Swann Christina Johnson Kennita Saunders-Kemp
Bahrain	EMR	HIC	Shaima Ali Bucheeri
Bangladesh	SEAR	LMIC	Helal Uddin Ahmed Hasina Momotaz Niaz Mohammad Kha Tanjir Rashid Soron
Barbados	AMR	HIC	Shakira Mascoll Ingrid Cumberbatch David Leacock
Belgium	EUR	HIC	Anne Swaluë João Henriques Natacha Beugnier Dietlinde Debrabandere Brigitte Bouton lisabeth Miller
Belize	AMR	UMIC	Iveth Quintanilla Edgar Nah Nedia Romero Aura Gonzalez
Benin	AFR	LMIC	Klikpo
Bhutan	SEAR	LMIC	Pemba Wagchuk
Bolivia (Plurinational State of)	AMR	LMIC	Jhesica Alejandra Estrada Medina Sandra Ximena Domínguez Fernández Mayra Jimena Reynaga Condori
Botswana	AFR	UMIC	Boikanyo Nnoko Bikimane W.Sheik
Brazil	AMR	UMIC	Sônia Barros Andrea Domanico Mauro Pioli Rehbein
Brunei Darussalam	WRP	HIC	Fariza Sani Raidah Mohamed Farid Rifai Norsyahmun Matassan Maidin Hani
Burkina Faso	AFR	LIC	Olivia Marie Angèle Awa Ouedraogo Kpoune Karfo Kouesvandé Joseph Soubeiga Laurent Moyenga
Burundi	AFR	LIC	Marie louise Inama Horo
Cabo Verde	AFR	LMIC	Fernanda Marques
Cambodia	WRP	LMIC	Chhit Sophal
Canada	AMR	HIC	Kaitlyn Schatteman
Chad	AFR	LIC	Raouda Mahamat Youssouf

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Chile	AMR	HIC	Javiera Erazo Viviana Hernandez Leslie Mackay
China	WRP	UMIC	Yang Xi
Colombia	AMR	UMIC	Aldemar Parra Espitia
Cook Islands	WRP	HIC	Evangelene Wong
Costa Rica	AMR	UMIC	María Marcela Lopez Bolaños Allan Rímola Rivas Wilburg Alonso Díaz Cruz Harold Segura Quesada Elissa Arroliga Umaña Wendy Granados Granados
Croatia	EUR	HIC	Danijela Štimac Grbić Ana Žegrec Dubravka Pezelj Duliba Mario Trošelj Maja Silobrčić Radić Sandra Mihel
Cuba	AMR	UMIC	Carmen Borrego Calzadilla María Elena Pérez Leyva Maite Ramos Requeiferos Evelyn Martínez Cruz Mayelin Vázquez Santiesteban
Cyprus	EUR	HIC	Anna Paradeisioti
Democratic Republic of the Congo	AFR	LIC	Marie-Louise Kpanda Mbongosi Olea Balayulu Josue Ozowa Florence Mbiya Abrham Mifundu Berthe Sikuyanza
Denmark	EUR	HIC	Marie Skaaning Andersen
Djibouti	EMR	LMIC	Awo Youssouf Kayad, Maoulid Mohamed Ibrahim
Dominica	AMR	UMIC	Lester Guye Nadia Wallace Julia Charles-Jules Keiran Newton Arlene Ferrol
Dominican Republic	AMR	UMIC	Cristian Paredes Silverio Alejandro Uribe Margaret Medina Rafael Elias Tejeda

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Ecuador	AMR	UMIC	Edison Cárdenas Ortega Diana Verónica Murillo Zúñiga Cristina Ortiz Johana Mozo Maritza Troya Alexis Alvear
Egypt	EMR	LMIC	Menan Rabie
El Salvador	AMR	UMIC	Carlos Gabriel Alvarenga Cardoza Hazel Valdez Rafael Chavez
Estonia	EUR	HIC	Minni Timberg Mari Ader Eleri Lapp Tiiu-Liisa Rummo
Eswatini	AFR	LMIC	Violet David Mwanjali
Ethiopia	AFR	LIC	Agitu Tadesse Eleni Misganaw Medhin Selamu Jemal Teshome
Fiji	WRP	UMIC	Shawal Sanjeshni Prasad Kiran Gaikwad
Finland	EUR	HIC	Mika Gissler Jaana Suvisaari Helena Vorma Petri Matveinen Essi Karvonen
France	EUR	HIC	Jean-baptiste Hazo Clémentine De Champs Stéphanie Lafont Rapnouil, Frank Bellivier Simon Vasseur-Bacle Pascale Fritsch
Gambia	AFR	LIC	Jarra Marega Momodou T. Nyassi Mamudou Jassey Fatmata Dukureh Momodu Gassama
Ghana	AFR	LMIC	Pinaman Appau Kwadwo Obeng Amma Boadu Dan Taylor Ruth Owusu Antwi
Greece	EUR	HIC	Konstantinos Moschovakis
Grenada	AMR	UMIC	Josh Hector
Guatemala	AMR	UMIC	Fluvia Aracely Téllez Orellana

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Guinea	AFR	LMIC	Ousmane tanou Diallo Mariama Barry Cécé Kolié Vieux Kémo Soumaoro
Guinea-Bissau	AFR	LIC	Finhamba Quessangue Silva Aitolo Higinio Correia
Guyana	AMR	HIC	Timothy Morgan
Haiti	AMR	LMIC	René Junior Domersant
Honduras	AMR	LMIC	Tania Reyes
Iceland	EUR	HIC	Ingibjörg Sveinsdóttir
India	SEAR	LMIC	Saurubh Jain Neha Garg Shalini Kelkar Pratima Murthy Atul Kotwal
Indonesia[15]	SEAR	UMIC	Imran Pambudi Hervita Diatri Keliat Budi Ana Ashra Vina Daswin Fransiska Mardiananingsih
Iran (Islamic Republic of)	EMR	UMIC	Mohammadreza Shalbafan Maryam Abbasinejad
Iraq	EMR	UMIC	Mohammed Adnan Yaseen Adnan Yasin Ahmad Gulzar
Ireland	EUR	HIC	Oisín Murphy Antoinette Daly Derek Chambers
Italy	EUR	HIC	Giuseppe Salamina Natalia Magliocchetti Antonella Costantino
Jamaica	AMR	UMIC	Kevin Goulbourne Carol Baker-Burke Judith Lieba Luraine Brown Jasper Barnett Jermaine Martin
Japan	WRP	HIC	Takuya Nakamura
Jordan	EMR	LMIC	Mohammed Al Qaddoumi
Kenya	AFR	LMIC	Peris Wambui
Kiribati	WRP	LMIC	Toobia Smith Revite Kiritione Wendy Snowdown
Kuwait	EMR	HIC	ariem H Alqattan Ammar Al-Sayegh

15. In accordance with resolution WHA78.25 (2025), Indonesia was reassigned to the WHO Western Pacific Region as of 27 May 2025.

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Latvia	EUR	HIC	Patricija Kradina
Lebanon	EMR	LMIC	Rabih El Chammay Edwina el Zoghbi Nayla Geagea Jinane Abi Ramia Jiana Tabbara
Lesotho	AFR	LMIC	Pearl Letsoela
Liberia	AFR	LIC	Wilbur T. S. Harris
Libya	EMR	UMIC	Amel Abdugadir Knan
Lithuania	EUR	HIC	Marija Oleškevičienė
Madagascar	AFR	LIC	Vola Nirina Andrianavalona
Malaysia	WRP	UMIC	Nurashikin Binti Ibrahim Nor Azilah Binti Abu Baka Tunku Saraa Zawyah binti Tunku Badli Yusni Binti Mohd Yunus Mohd Safiee B. Ismail Zainab Binti Tambol
Maldives	SEAR	UMIC	Aminath Shahuza
Mali	AFR	LIC	Souleymane dit Papa Coulibaly
Malta	EUR	HIC	Antonella Sammut
Marshall Islands	WRP	UMIC	Frand Underwood
Mauritania	AFR	LMIC	Cheikh Mohamed Fadel Mohamed Lemine Ainina Sogho
Mexico	AMR	UMIC	Lucía Ledesma Torres
Mongolia	WRP	UMIC	Ninj Byambadorj Altanzul Narmandakh Erdenesuvd Lkhagvasuren
Morocco	EMR	LMIC	Bouram Omar
Mozambique	AFR	LIC	Helder Fumo
Myanmar	SEAR	LMIC	Thida Win Sun Lin Nyo Nyo Aung Nwe Ni Win Moh Moh Thit
Namibia	AFR	UMIC	Magdalena Didalelwa Alex Kampanza
Nauru	WRP	HIC	Susana Nakalevu
Nepal	SEAR	LMIC	Anant Adhikari Basudev Karki Jasmine Ma Kedar Marahatta Paban Ghimire Roshan Karn

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Netherlands (Kingdom of the)	EUR	HIC	Laura Shields-Zeeman Annemarie Luik Hans Kroon
New Zealand	WRP	HIC	Kiri Richards
Nigeria	AFR	LMIC	Ojo Tunde Masseyferguson
North Macedonia	EUR	UMIC	Stojan Bajraktarov Zhaklina Chagoroska Margarita Spasenoovska Onur Klince Milosh Milutinovik Georgi Kalpak
Oman	EMR	HIC	Bader Al Habsi Said Alkaabi Nasser Al Wadhahi Mohamed Al Maashani
Pakistan	EMR	LMIC	Parvez Ahmed Shaikh Zahida Bhurghri Parvez Ahmed Shaikh Abdul Hussain Soomro Ghulam Shabir Shaikh Nisar Ahmed Soho
Panama	AMR	HIC	David Sanjur Reina Roa Aldacira de Bradshaw Félix Correa
Papua New Guinea	WRP	LMIC	Monica Hagali Kura David Julius Ngason
Paraguay	AMR	UMIC	Maria Fernanda Rojas Valeria Ureta Daniel Cantero Hans Buggenthin Aldo Castiglioni Luis Taboada
Peru	AMR	UMIC	Miguel Angel Hinojosa Mendoza
Philippines	WRP	LMIC	Carmela N. Granada
Qatar	EMR	HIC	Susan Clelland Iain Tulley Samya Ahmad Al Abdulla Annette Dale Muhammad Waqar Azeem
Republic of Korea	WRP	HIC	Jongcheon Choi
Republic of Moldova	EUR	UMIC	Chihai Jana
Romania	EUR	HIC	Catalina Constantin
Russian Federation	EUR	HIC	Natalia Semenova Svetlana Shport Oksana Makushkina

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Rwanda	AFR	LIC	Darius Gishoma Frederic Nsanzumuhire Jean Damascene Iyamuremye
Saint Vincent and the Grenadines	AMR	UMIC	Cuthbert Knights Alisa Alvis Shamanti Labban Deroy Ferdinand
Sao Tome and Principe	AFR	LMIC	Flávio Castelo David dos Santos Andrade Mario Sousa Pontes
Saudi Arabia	EMR	HIC	Hassan Alshehri
Senegal	AFR	LMIC	Jean Augustin Diégane Tine Abdoulaye Gueye Papa Lamine Faye Mady Ba
Serbia	EUR	UMIC	Jelena Jankovic
Seychelles	AFR	HIC	Gina Michel Daniella Malulu Jeff Confiance Veronique Lucie
Sierra Leone	AFR	LIC	Abdul Jalloh Santigie Sesay Joshua Duncan Lucy Lamin
Slovakia	EUR	HIC	Zuzana Novakova
Somalia	EMR	LIC	Zeynab Ahmed Noor Ahmed Jama Shidane Adam Ahmed Noor Mohamed Abdiqadir Osman Fadumo Abdi Maow Hassan Mursal Ahmed
South Africa	AFR	UMIC	Dudu Shiba
Spain	EUR	HIC	Belén gonzález callado
Sri Lanka	SEAR	LMIC	Rohan Ratnayake
Sudan	EMR	LIC	Zienat Balla M.A. Sanhori Suad Eltahir Ahmed Hoyam Ibrahim Abdallh Aida Hashim Mohamed Alriyah Amel Eltigani Mohamed Sali Mhamoud Shadoul
Suriname	AMR	UMIC	Tatiana Ashruf Cheshta Sewtahal Jitan Jeetendra R. Nanda Mirjam Plein Raquel Maguele
Thailand	SEAR	UMIC	Alisa Udomweerakasem

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Togo	AFR	LIC	Kondoh N'takinawé Tchaa Kadjanta Sama Marius Tchindo Komivi Mawusi Aho Sonia Kanekatoua Mawunyo Zigan
Tonga	WRP	UMIC	Reynold 'Ofanoa
Trinidad and Tobago	AMR	HIC	Asif Ali Hazel Othello Joanna Maharaj Gerard Hutchinson Keisha Lewis Sreenivasulu Mallakunta
Tunisia	EMR	LMIC	Fatma Charfi Wahid Melki Nadia Boudrigua Lotfi Ben Hamouda Rym Ghachem
Türkiye	EUR	UMIC	Ugur Ortac
Tuvalu	WRP	UMIC	Natano Elisala Melisula Telongo Alice Ave
Uganda	AFR	LIC	Kenneth Kalani Okware Hafsa Lukwata Juliet Nakku Dickens Akena Grace Obalim Harriet Birabwa
Ukraine	EUR	UMIC	Serhii Shum Olena Garmata Iryna Ivanchuk, Vita Sydorenko Vasil Piven
United Arab Emirates	EMR	HIC	Buthaina Bin Belaila Suhair Akhlaq Iaila Suliman Mahamed Moustafa Huda Alabdoulii Suad Alawar
United Kingdom of Great Britain and Northern Ireland	EUR	HIC	Elizabeth Brocklehurst
United States of America	AMR	HIC	Robert Day
Uruguay	AMR	HIC	Alejandra Moreira Hector Suarez
Vanuatu	WRP	LMIC	Jimmy Obed

WHO Member State	WHO region	World Bank income category	Contributors to the 2024 Atlas
Venezuela (Bolivarian Republic of)	AMR	UMIC	Nectali Tovar
Viet Nam	WRP	LMIC	Nguyen Thi Thanh Tyuen
Yemen	EMR	LIC	Mohammed Abdullah Bin Hosyyah
Zambia	AFR	LMIC	Gabriel Lungu Muchindu Mapiki Thandiwe Martha Tembo Rita Mweeka Banda Maudy Kaoma Susan Banda
Zimbabwe	AFR	LMIC	Fabian Musoro

World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland