



Countdown Global Mental Health 2030:
Making Mental Health Count



Foreword

Around the world, there is insufficient data on mental health. Without this data we cannot hope to correctly design and deliver mental health prevention, promotion and treatment programmes. The first step in addressing this challenge is to make the data we do have as accessible as possible. The second step is to improve the quality and quantity of mental health data, so we can expand what we know. And these steps will only have real impact if we ensure data is used effectively to improve policy-making and investment decisions.

Countdown for Global Mental Health 2030 as a whole, and this report in particular, is a multi-partner effort. Together we aim to transform mental health data and monitor progress towards improving mental health for all within the framework of the UN Sustainable Development Goals (SDGs). We are very grateful to all the experts who generously contributed their time to this project.

In this, the second report of the Countdown for Global Mental Health 2030 partnership, we delve into what indicators most impact and reflect mental health at a population level. We look across multiple sectors, explaining how certain indicators were selected, why they matter and how to use them. We highlight the range of data sources we can draw upon to inform our decision making, and where there are data gaps that need addressing.

This report is for those who want to know about the state of the world’s mental health and how we can improve it. We recommend that all those seeking to design and deliver effective mental health programmes and/or systems should consider the full range of determinants of mental health outlined in this report. It should be read in conjunction with the newly updated Countdown for Global Mental Health 2030 dashboard, which shows the indicators explained in the report and enables the reader to view the data on them across different countries.

Mental health is increasingly a societal and political issue. It is rising in the public policy agenda and people are demanding better services and support. They are calling for better protection from threats to the mental health of whole populations. Only with greater understanding and use of data can we hope to measure what works and why.

As of now, mental health data on children and adolescents growing up in low- and middle-income countries (LMICs) is particularly scarce-for example, prevalence estimates are based on less than 5% of the population of interest.¹ We need all those investing in mental health to fund increased collection and use of data if we are to be sure of delivering positive outcomes for those who need them most. And for advocates seeking to drive change in their societies, this report and the dashboard can help you track what progress is happening and where, and help you hold decision-makers to account.

Sarah Kline, CEO, United for Global Mental Health and Shekhar Saxena, Professor of the Practice of Global Mental Health at the Department of Global Health and Population at the Harvard T. H. Chan School of Public Health

¹ Erskine H. and others (2017) The global coverage of prevalence data for mental disorders in children and adolescents

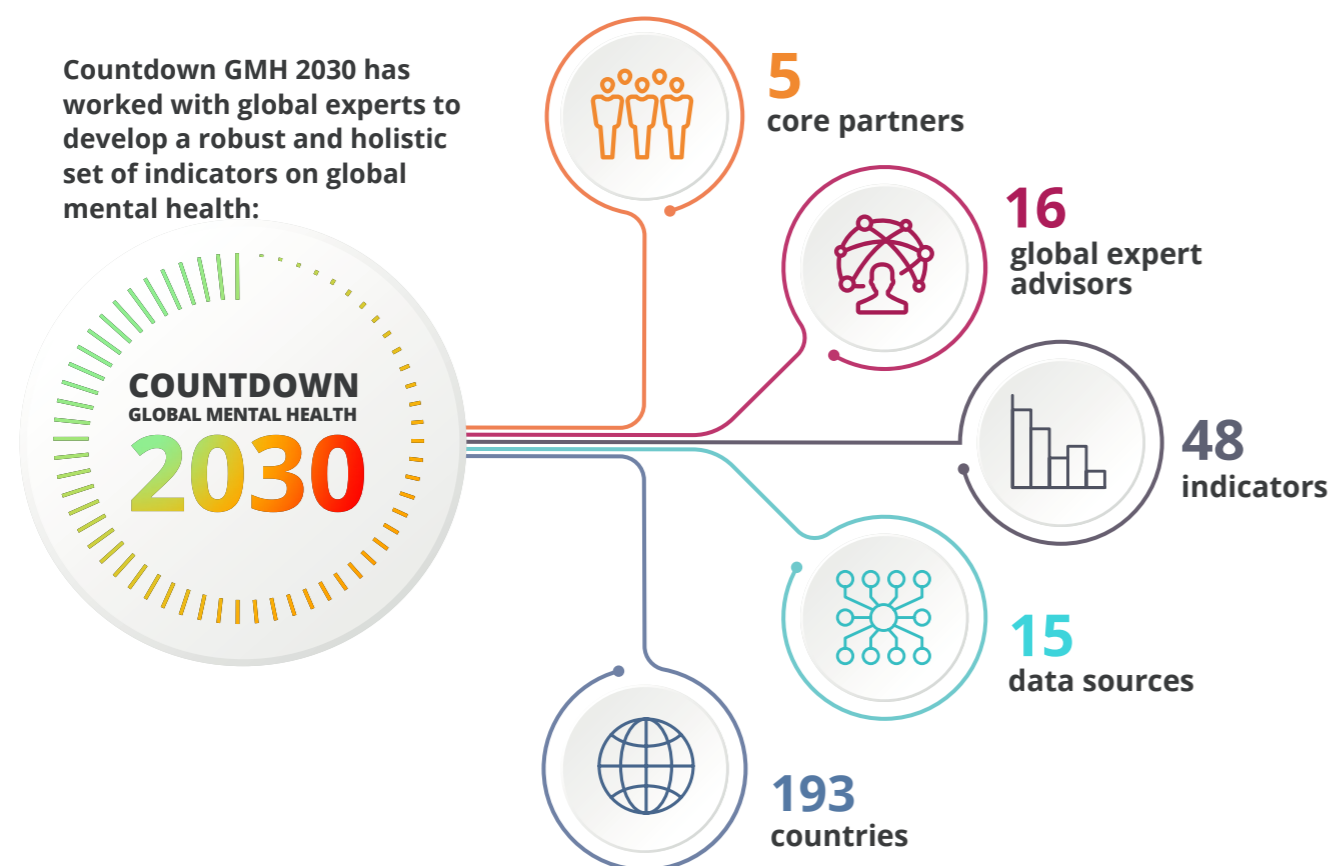
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Executive summary

Countdown for Global Mental Health 2030 (Countdown GMH 2030) was launched in 2019 to monitor progress on global mental health. It was designed to promote the use of data to inform policy, advocacy and action, while ensuring accountability. It is a collaboration between Global Mental Health @Harvard, the World Health Organisation (WHO), UNICEF, the Global Mental Health Peer Network (GMHPN) and United for Global Mental Health (UnitedGMH).

Countdown GMH 2030 has worked with global experts to develop a robust and holistic set of indicators on global mental health:



This is the second Countdown GMH 2030 report. It is underpinned by an indicator framework composed of four main pillars: determinants of mental health, factors shaping the demand (and need) for mental health care, factors shaping the strength of the mental health system, and wellbeing. The report presents an updated and extended indicator set, developed with the support of a dedicated Technical Working Group comprised of 16 global experts in mental health data (see Annex 1). The group aimed to offer a more robust and holistic picture of mental health determinants, needs and services at national level. The resulting indicator set includes 48 indicators with data drawn from 15 different sources, reflecting a continuum of services covering prevention, promotion and treatment. It enables Countdown GMH 2030 to highlight the need for action across each of these dimensions to achieve good mental health and wellbeing for all.

The data can be accessed via the [Countdown GMH 2030 dashboard](#), where users can view, explore and download data by country and/or indicator. This report introduces the updated indicator set, presents an overview of the data and provides examples of how it can be used.

Effective mental health programmes should focus on measures to reduce the impact of rising poverty and inequality





Key findings and recommendations

Poverty and inequality are key determinants of mental health and both are worsening – leading to a likely increase in the prevalence and burden of mental ill health. High levels of domestic violence and conflict as well as climate-related stress and displacement also have a negative impact on mental health.

Recommendation: Effective mental health programmes should focus on measures to reduce the impact of rising poverty and inequality, e.g. by extending social protection and national health insurance to people with mental health conditions.

The prevalence and burden of mental health and substance use disorders remains high in the majority of countries, while access to free or affordable mental health services is limited. The stigma, discrimination and potential punishments people face mean they are often reluctant to seek help, making it difficult to gather accurate data.

Recommendation: Reducing the burden of mental health and substance use disorders needs to be given greater political priority, along with measures to make services more affordable, to end stigma and discrimination, and to encourage individuals to seek help.

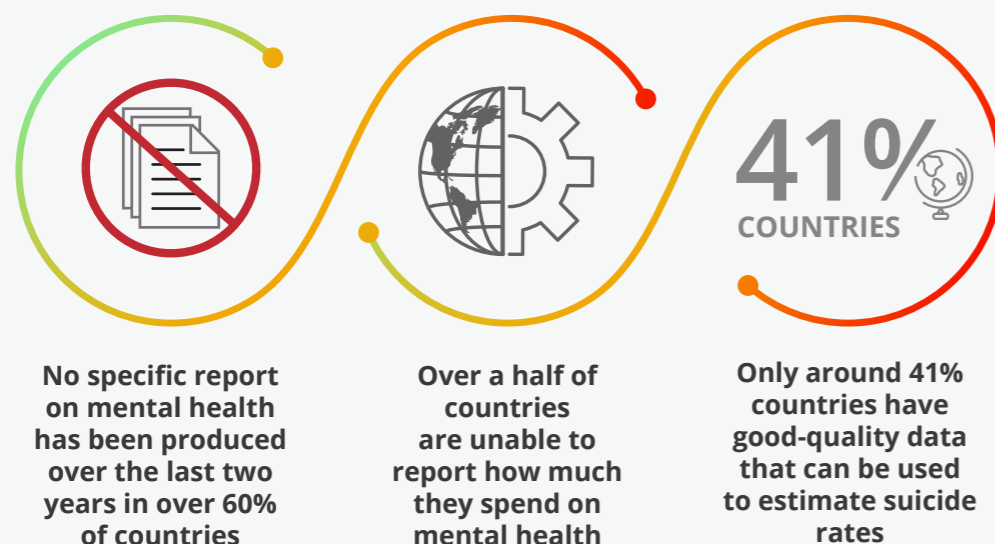
The human resources available for mental health services remain very limited in the majority of countries, especially LMICs, and vary widely between countries even within the same income group. All countries are capable of developing and expanding their workforce.

Recommendation: Priorities include better integration of mental health into primary care within the Universal Health Coverage (UHC) framework and increased investment in mental health promotion and prevention programmes.

Wellbeing is increasingly discussed among policy-makers but defining and measuring it is complex. This report uses the 2018 Lancet Commission on global mental health and sustainable development's definition of wellbeing as "subjective evaluation of life satisfaction" and includes the Happiness Ladder scores generated by Gallup's Annual World Poll as an indicator.

Recommendation: Measures of wellbeing should be increasingly used to inform policy. However, it is important that wellbeing is not considered in isolation, but alongside the socio-economic determinants of mental health.

Good quality data on mental health is essential to inform decision-making but significant data gaps persist



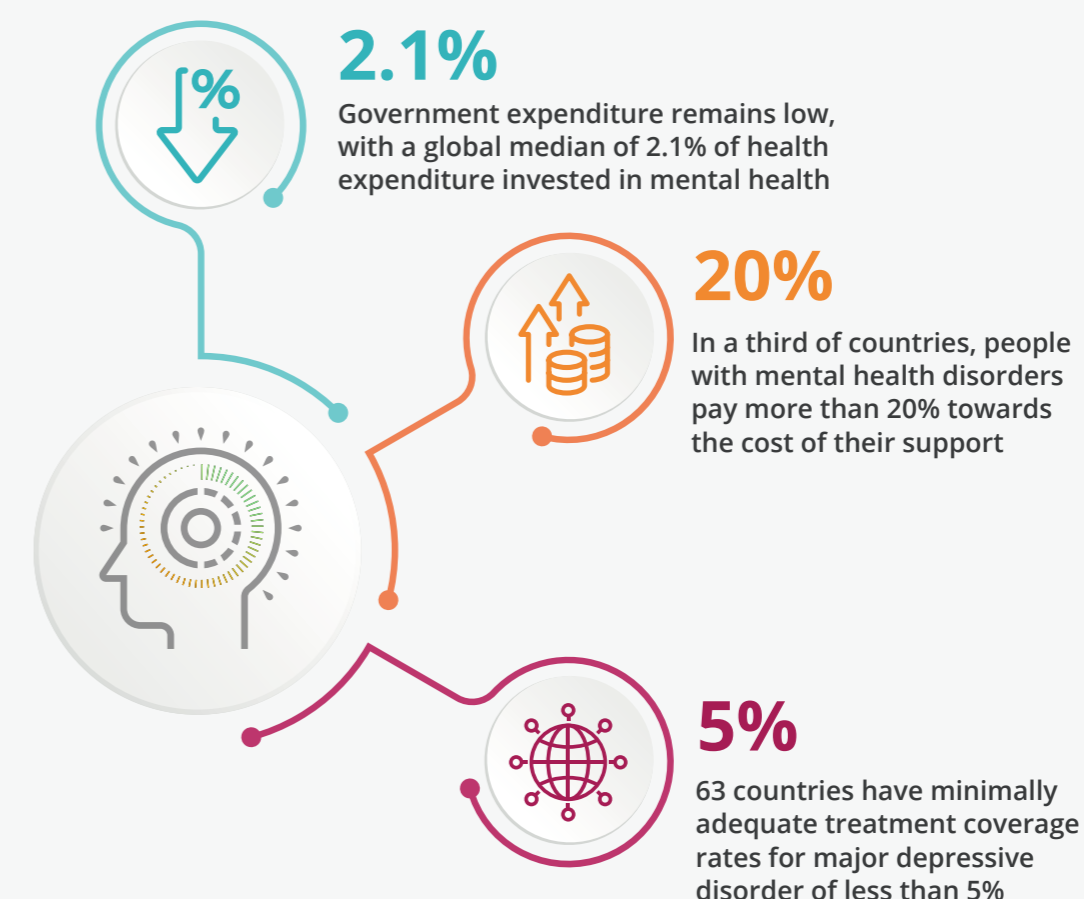
There are significant gaps in mental health data, especially in LMICs. Timely, comprehensive, high-quality data on mental health is essential to accurately assess the prevalence of mental health conditions, the demand for services and the strength of countries' mental health systems.

Recommendation: Specific measures to address the lack of data should include: regular collection and use of mental health data at national, subnational and facility level; more complete reporting by governments to international organisations like the WHO and UNICEF; the adoption of validated mental health modules in household surveys, school surveys and health information systems; the strengthening of vital registration systems to obtain more accurate data on suicide; and the inclusion of mental health indicators in broader monitoring efforts at global and national levels.

Government expenditure remains woefully inadequate, with a global median of 2.1% of health expenditure invested in mental health.² Where government expenditure is low, the costs of treatment fall on individuals and their families, creating a significant barrier to access. In the poorest countries, neither the government nor individuals can afford to fund mental health care.

Recommendation: Increase government financing for mental health towards the levels proposed by the 2018 Lancet Commission³ (10% of overall health expenditure for high-income countries and 5% for LMICs), spend more of it at community level, and increase support from donors and philanthropic foundations.

Rising concerns about mental health have not yet resulted in increased financial investment



² WHO (2021) Mental Health Atlas 2020

³ Patel V., Saxena S. and others (2018) The Lancet Commission on global mental health and sustainable development

Introduction

Countdown for Global Mental Health 2030 (Countdown GMH 2030) was launched in September 2019 in response to the 2018 Lancet Commission report on global mental health and sustainable development.⁴ The report proposed “a broad and integrated set of indicators to monitor progress for mental health in the Sustainable Development Goals (SDGs) era, spanning the social determinants of mental health, the mental health status of populations, and the inputs into and outcomes of mental health services and systems.” The Lancet Commission’s report also recommended the implementation of a comprehensive monitoring mechanism for mental health – a role Countdown GMH 2030 has been developed to fulfil.

Countdown GMH 2030 is led by Dr Shekhar Saxena, co-author of the 2018 Lancet Commission report and a mental health expert and practitioner, and is hosted by United for Global Mental Health (UnitedGMH). The project’s core group is composed of senior representatives of Global Mental Health @Harvard, the WHO, UNICEF, UnitedGMH and the Global Mental Health Peer Network.

Countdown GMH 2030’s vision

Drawing on the success of other Countdown initiatives, Countdown GMH 2030 aims to provide an overall monitoring framework on global mental health and a set of indicators for measuring progress. It also produces a suite of products that can be used by a range of organisations in the mental health sector and beyond to inform action: action to campaign, to advocate, to communicate and to change policy and practice so that everyone, everywhere can exercise their right to good mental health. The scope of Countdown GMH 2030 is global, with each country a unit for data collection and analysis.

Progress to date

An initial Countdown GMH 2030 report was published in October 2021,⁵ which:

- mapped the available data sources for mental health across different international organisations and at national level
- gave examples of how data can be used to inform policy-making
- made recommendations on how mental health data collection and use could be improved.

The report was underpinned by the development of a set of indicators relevant to the mental health of young children and their caregivers. They are a key demographic because early years experiences can impact mental health in later life. The report was accompanied by the launch of an [interactive dashboard](#). It allows users to access and download mental health data by country across the full range of Countdown GMH 2030 indicators, enabling country comparisons via a series of heatmaps. The dashboard also highlights the many gaps in mental health data, especially in LMICs. A subsequent [policy brief](#) analysed Countdown GMH 2030’s data to determine the action required to improve child and caregiver mental health outcomes.⁶

Since then, the indicator set for monitoring global mental health has been updated and extended. This new proposed core indicator set forms the basis of this second Countdown GMH 2030 monitoring report and showcases how the data can be used to inform advocacy and drive change.

Selection of the Countdown GMH 2030 indicators

The importance of mental health and wellbeing are recognised in SDG target 3.4: ‘by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing’. While only one SDG indicator relates specifically to mental health (Indicator 3.4.2: Suicide mortality rate) and another two concern substance use,⁷ the 2018 Lancet Commission argued that mental health and wellbeing are inextricably linked with many of the other SDGs. A wide range of social, economic, political and environmental factors can interact to either undermine or support people’s mental health and wellbeing. The set of SDGs identified as relevant to mental health by the Lancet Commission, and the indicators in the WHO’s updated Comprehensive Mental Health Action Plan 2013-2030, formed the starting point for the development of the Countdown GMH 2030 indicator set. Relevant indicators from many other sources were also reviewed.

A Technical Working Group helped develop the Countdown GMH 2030 indicator set (see Annex 1). The group assessed 140 potential indicators on the basis of relevance, feasibility and sensitivity to change. As a result, Countdown GMH 2030 has drawn together a core set of 48 indicators from 15 sources, including UN sources, the World Bank, academic institutions, international NGOs and a global polling organisation. The indicator framework is divided into four components:

- A – Determinants of mental health**
- B – Factors shaping the demand (and need) for mental health care**
- C – Factors shaping the strength of the mental health system**
- D – Wellbeing.**

Taken together, these components reflect a continuum of service provision, covering prevention, promotion and treatment. They enable Countdown GMH 2030 to present data and highlight the need for action across each of these dimensions to achieve good mental health and wellbeing for all within the SDGs framework. Presenting a single dataset covering all these components allows the interrelation between them to be analysed, as the use cases below demonstrate.

Updated Countdown GMH 2030 indicator set: key data points and illustrative examples

A table setting out full details of the Countdown GMH 2030 indicator set is available in Annex 1. This includes detailed descriptions of each indicator and an explanation of the associated data values. The table also notes which Countdown GMH 2030 indicators are derived from the UN Statistics Department’s [SDG indicator framework](#) or [WHO’s Comprehensive Mental Health Action Plan 2013-2030 \(MHAP\)](#). The following section provides a brief overview of the updated framework, a summary of the indicators in each component and illustrative examples from the Countdown GMH 2030 dashboard.

⁴ Patel V, Saxena S. and others (2018) The Lancet Commission on global mental health and sustainable development
⁵ United for Global Mental Health (2021) Countdown Global Mental Health 2030: Using Data to Inform Action
⁶ United for Global Mental Health (2021) Child and Care-giver Mental Health: Using Data to Make Progress

⁷ Indicators 3.5.1 - Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders and 3.5.2 - Alcohol consumption per capita

A – Determinants of mental health

Component A of the framework focuses on the determinants of mental health: the external factors that can impact people’s mental health negatively as risk factors, or positively as protective factors. Subcomponents include society/family, the economy, education, conflict, the environment and the COVID-19 pandemic.

The Countdown GMH dashboard presents data on 18 indicators within this component, drawn from 14 different sources:

Indicator number	Framework subcomponent	Indicator name	Data source	Number of countries for which data is available
A.1.1	Society/Family	Inclusiveness index	UC Berkeley	136
A.1.2	Society/Family	Percentage of children aged 1 to 14 years who have experienced any violent discipline in the past month	UNICEF	88
A.1.3	Society/Family	Proportion of women subjected to physical and/or sexual violence in the last 12 months	UN Statistics Division (UNSD)	106
A.1.4	Society/Family	Women, Business and the Law Index	World Bank	185
A.2.1	Economy	Unemployment, total (% of total labour force)	ILO	178
A.2.2	Economy	GINI index [a measure of income inequality]	World Bank	121
A.2.3	Economy	Poverty headcount ratio at \$2.15 a day (2017 PPP) (% of population)	World Bank	161
A.3.1	Education	Proportion of children and adolescents at school who are exposed to bullying	IHME	192
A.3.2	Education	Percentage of children (aged 36-59 months) developmentally on track	UNICEF	60
A.3.3	Education	Mean years of schooling	UNDP	189
A.3.4	Education	Children out of school (% of primary school age)	UNESCO	181
A.4.1	Conflict	Number of internally displaced people by country per 100,000 population	Internal Displacement Monitoring Centre	99

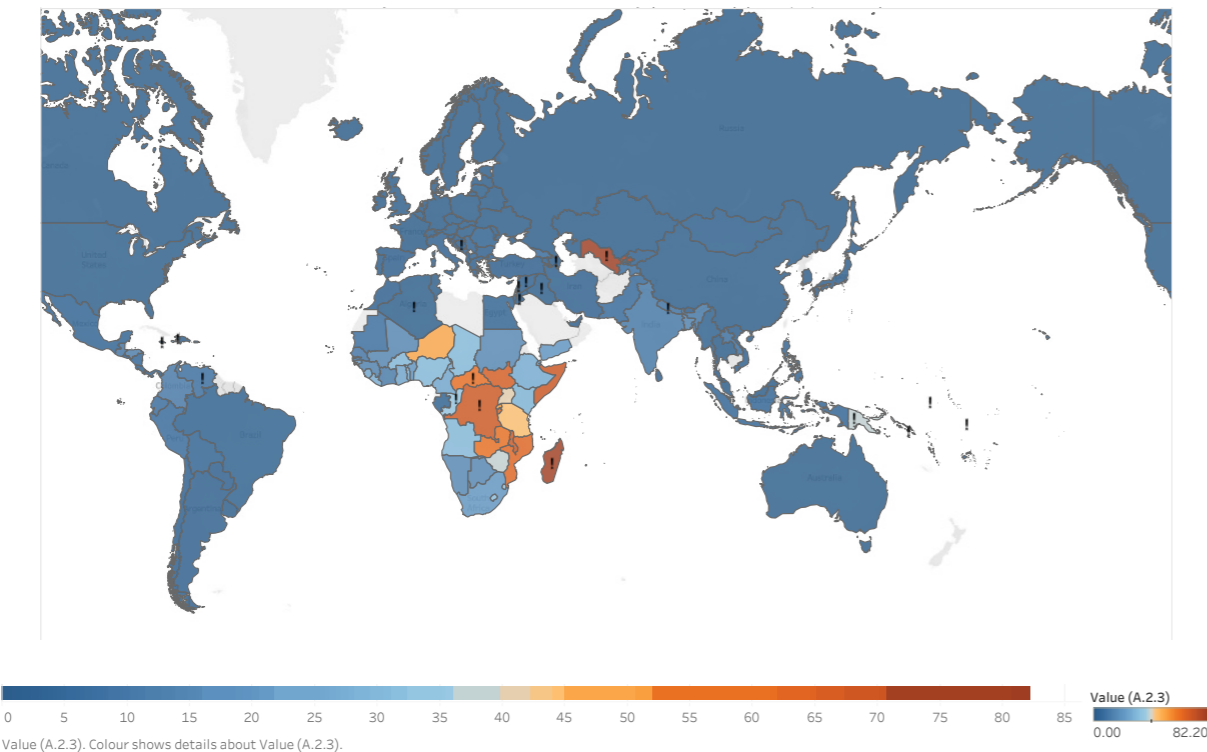
A.4.2	Conflict	Percentage of population made up of refugees in each country or territory of asylum	UNHCR	159
A.5.1	Environment	Average share of urban population with access to an open space for public use	UN Habitat	91
A.5.2	Environment	Mortality rate attributed to household and ambient air pollution, age-standardised (per 100,000 population)	WHO	183
A.5.3	Environment	Percentage of population of both sexes who feel safe walking alone around the area they live	UNODC	23
A.6.1	Mental Health and the COVID-19 Pandemic	Average COVID-19 stringency index	Oxford Covid-19 Government Response Tracker	172
A.6.2	Mental Health and the COVID-19 Pandemic	COVID-19 pandemic-related excess anxiety and depression burden	IHME	192

The **subcomponent on society/family** includes indicators on inclusiveness and gender equality – both regarded as protective factors – and domestic violence which is associated with depression, anxiety, PTSD and substance abuse in the general population.⁸

The economic subcomponent includes indicators on unemployment, income inequality and poverty headcount ratio. Analysis conducted for the 2018 Lancet Commission confirmed that poverty and inequality are both key determinants of mental health.⁹ This is consistent with academic research, with a review of 115 studies in LMICs reporting positive associations between a range of poverty indicators and common mental disorders, although substantial variations were noted between different poverty dimensions.¹⁰ These findings are of particular concern at a time when poverty is rising and inequality is widening.¹¹ The heatmap on the Countdown GMH 2030 dashboard shows that 30 countries have poverty headcount ratios of over 20%, and 11 countries in sub-Saharan Africa have ratios of over 50%.

8 Trevillion, K., Oram, S., Feder, G., & Howard, L.M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis
9 Vikram Patel and others (2018), The Commission on global mental health and sustainable development
10 Crick Lund and others (2010) Poverty and common mental disorders in low and middle income countries: A systematic review
11 Carolina Sanchez-Paramo and others (2021) World Bank Blogs, [COVID-19 leaves a legacy of rising poverty and widening inequality](#)

A.2.3: Poverty headcount ratio at \$2.15 a day (2017 PPP) (% of population)



The prospects for the global economy are bleak. The World Bank warns that “Global growth is projected to slow to its third-weakest pace in nearly three decades, overshadowed only by the 2009 and 2020 global recessions.”¹² There is growing evidence that economic recession is associated with worsening mental health,¹³ including an increase in suicide.¹⁴ It is therefore vital that governments integrate mental health into measures to reduce the impact of economic downturns on the most vulnerable. The relationship between poverty, inequality and wellbeing is further examined in the section on using the data below.

The third subcomponent focuses on education, an important protective factor – higher levels of education are associated with better mental health.¹⁵ Data on this subcomponent is analysed in the section on child, adolescent and youth mental health.

Conflict is another recognised risk factor.¹⁶ This subcomponent includes indicators on the number of internally displaced people (IDPs) in each country per 100,000 and the percentage of the population made up of refugees.

The next subcomponent focuses on environmental determinants, with data on these explored below in Box 7.

The final subcomponent focuses on the impact of **COVID-19**. While this may become less relevant as the world learns to live with COVID-19, the Technical Working Group felt it was important to include these indicators, as they are both factors impacting mental health now and potentially in the future.

¹² World Bank (January 2023) Global Economic Prospects
¹³ Diana Frasquillo and others (2016) Mental health outcomes in times of economic recession: a systematic literature review
¹⁴ Oyesanya M, Lopez-Morinigo J, Dutta R. (2015) Systematic review of suicide in economic recession. *World J Psychiatry* 2015; 5(2): 243-254 [PMID: 26110126 DOI: 10.5498/wjp.v5.i2.243]
¹⁵ Fjolla Kondiroli and Naveen Sunder (2022) Mental Health effects of education
¹⁶ Charlson F, van Ommeren M, Flaxman , Cornett J, Whiteford H, Saxena S New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis.Lancet. 2019; 394: 240-248

Key insight: Poverty and inequality are key determinants of mental health and both are worsening – the prevalence and burden of mental ill health is likely to increase as a result. All those seeking to design and deliver effective mental health programmes should take account of the full range of determinants, with a particular focus on measures to reduce the impact of rising poverty and widening inequality.

B – Factors shaping the demand (and need) for mental health care

The framework’s second component covers the factors that shape the demand (and need) for mental health care. The Countdown 2030 dashboard presents seven indicators with data from the WHO and the Institute for Health Metrics and Evaluation at the University of Washington (IHME).

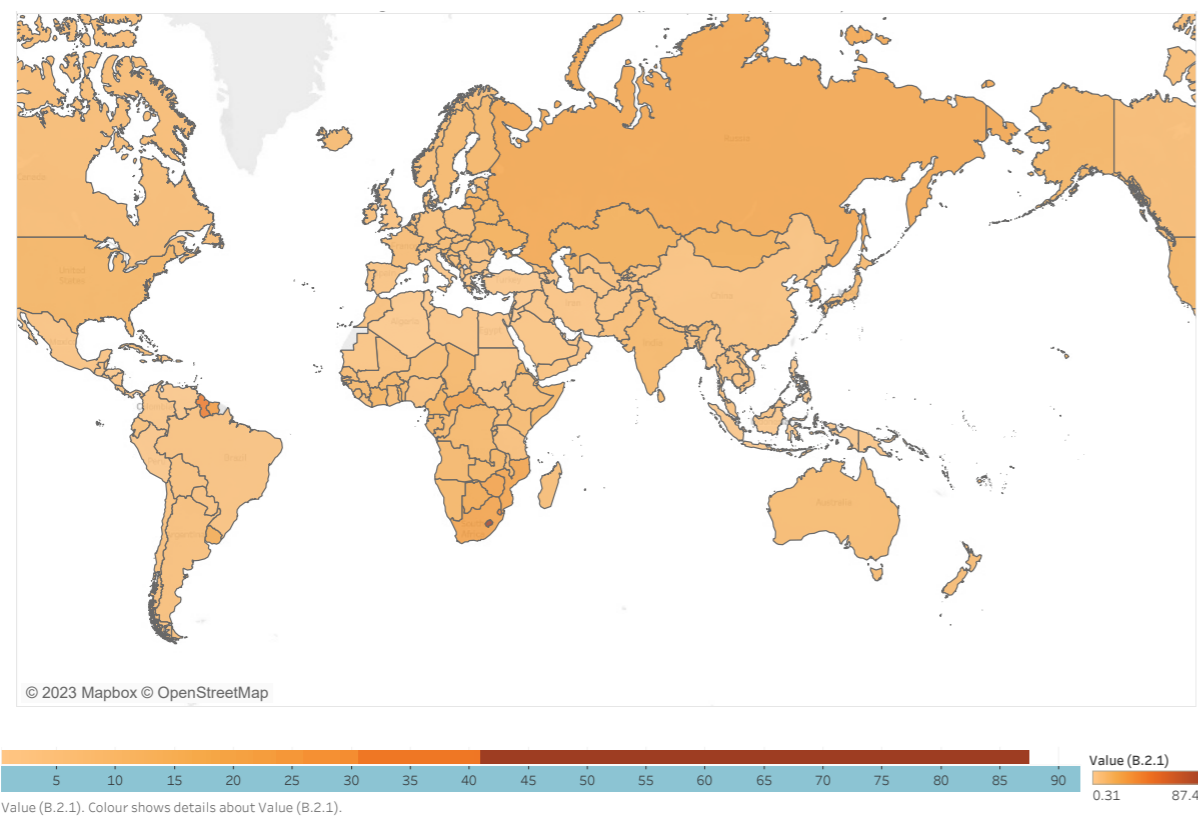
Indicator number	Framework subcomponent	Indicator name	Data source	Number of countries for which data is available
B.1.1	Burden	Age-standardised suicide rates (per 100,000 population)	WHO	183
B.1.2	Burden	Total alcohol consumption per capita	WHO	186
B.1.3	Burden	Age-standardised prevalence of mental disorders (% of population)	IHME	192
B.1.4	Burden	Age-standardised prevalence of substance use conditions (% of population)	IHME	192
B.1.5	Burden	Percentage of total DALYs ¹⁷ due to mental, neurological and substance use conditions	IHME	192
B.2.1	Financial accessibility of care	Whether the majority of people pay nothing (fully insured) or at most 20% towards the cost of their mental health services	WHO Mental Health Atlas 2020	166
B.2.2	Financial accessibility of care	Whether the care and treatment of people with major mental disorders is included in the national health insurance or reimbursement scheme	WHO Mental Health Atlas 2020	134

The first subcomponent focuses on the public health burden, with indicators covering prevalence rates of mental health and substance use conditions. Indicator B.1.3 provides age-standardised data on the prevalence of mental disorders, with IHME estimates showing relatively high levels in all countries, ranging from 9% to 18%. The second subcomponent considers the financial accessibility of care with data on these indicators included in the analysis for the section on financing below.

The illustrative indicator chosen from this component is on age-standardised suicide rates per 100,000 population. It was selected because it is also a SDG indicator (SDG 3.4.2). Over 700,000 people die as a result of suicide every year, and many more people attempt suicide. It is the fourth leading cause of death of 15-29 year olds, and three-quarters of suicides occur in LMICs.¹⁸ Suicide also remains illegal in at least 20 countries, with punishments for attempted suicide ranging from fines to imprisonment.

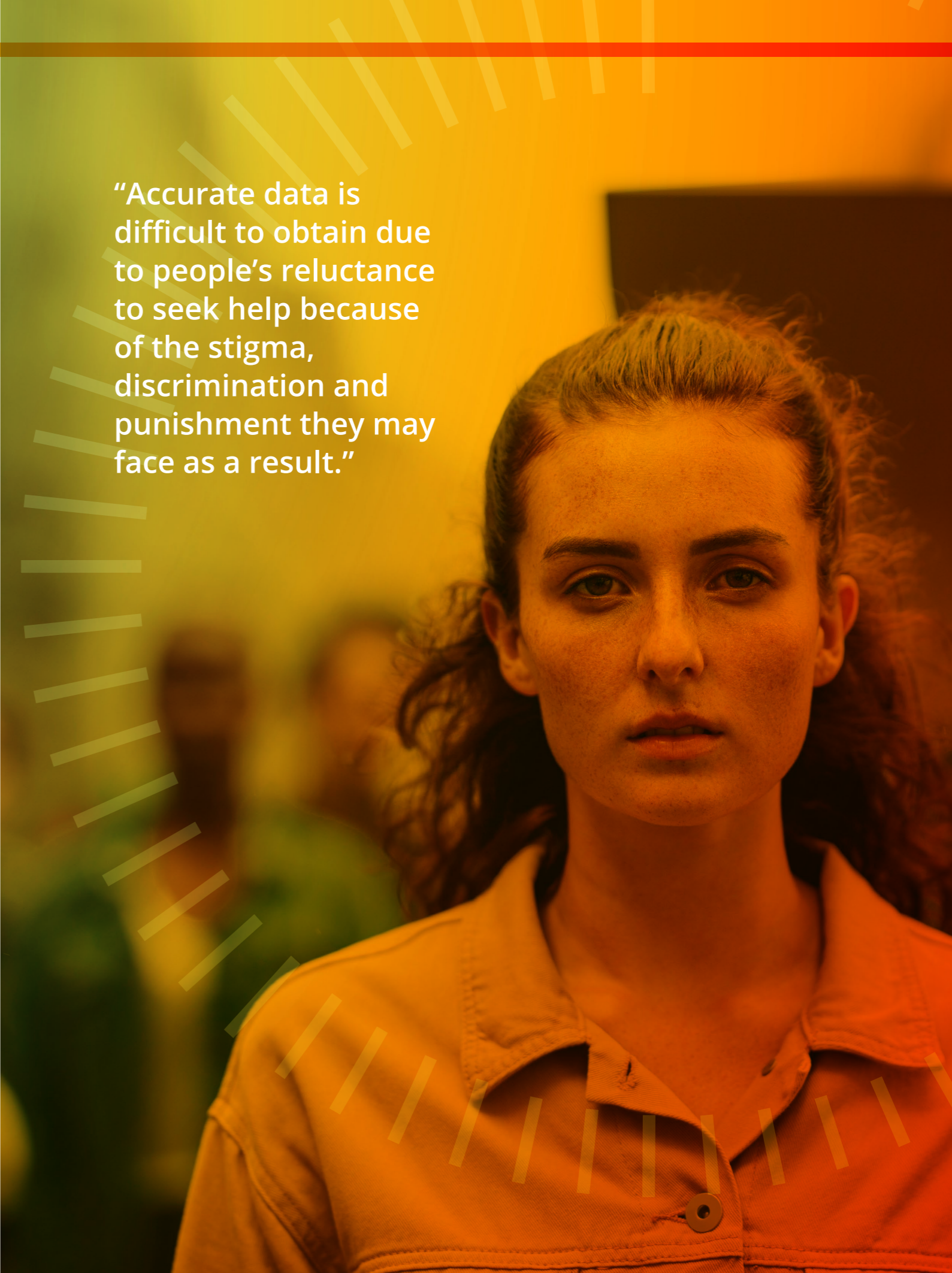
Data for this indicator is based on WHO estimates, and ranges from less than 1 per 100,000 population in three Caribbean countries (Barbados, Antigua and Barbuda, and Grenada) to 87 in Lesotho.

B.1.1: Age-standardised suicide rates (per 100 000 population)



18 <https://www.who.int/news-room/fact-sheets/detail/suicide>

“Accurate data is difficult to obtain due to people’s reluctance to seek help because of the stigma, discrimination and punishment they may face as a result.”



The availability and quality of data on suicide and suicide attempts is poor. Only around 80 countries have good enough death registration data¹⁹ to provide the basis of direct estimates of suicide rates. Suicide is surrounded by stigma in many countries, making people less likely to seek help, contributing to under-reporting. This is especially true in the 20 or so countries where suicidal behaviour is still criminalised. More complete death registration data, including accurate recording of the cause of death, is essential to understand the true picture, and to inform national suicide prevention strategies. The decriminalisation of suicide is a potentially crucial step in reducing the stigma associated with it.

Key insight: The prevalence and burden of mental health and substance use disorders remain high in most countries, while access to free and affordable mental health services is limited. Accurate data is difficult to obtain due to people's reluctance to seek help because of the stigma, discrimination and punishment they may face as a result.

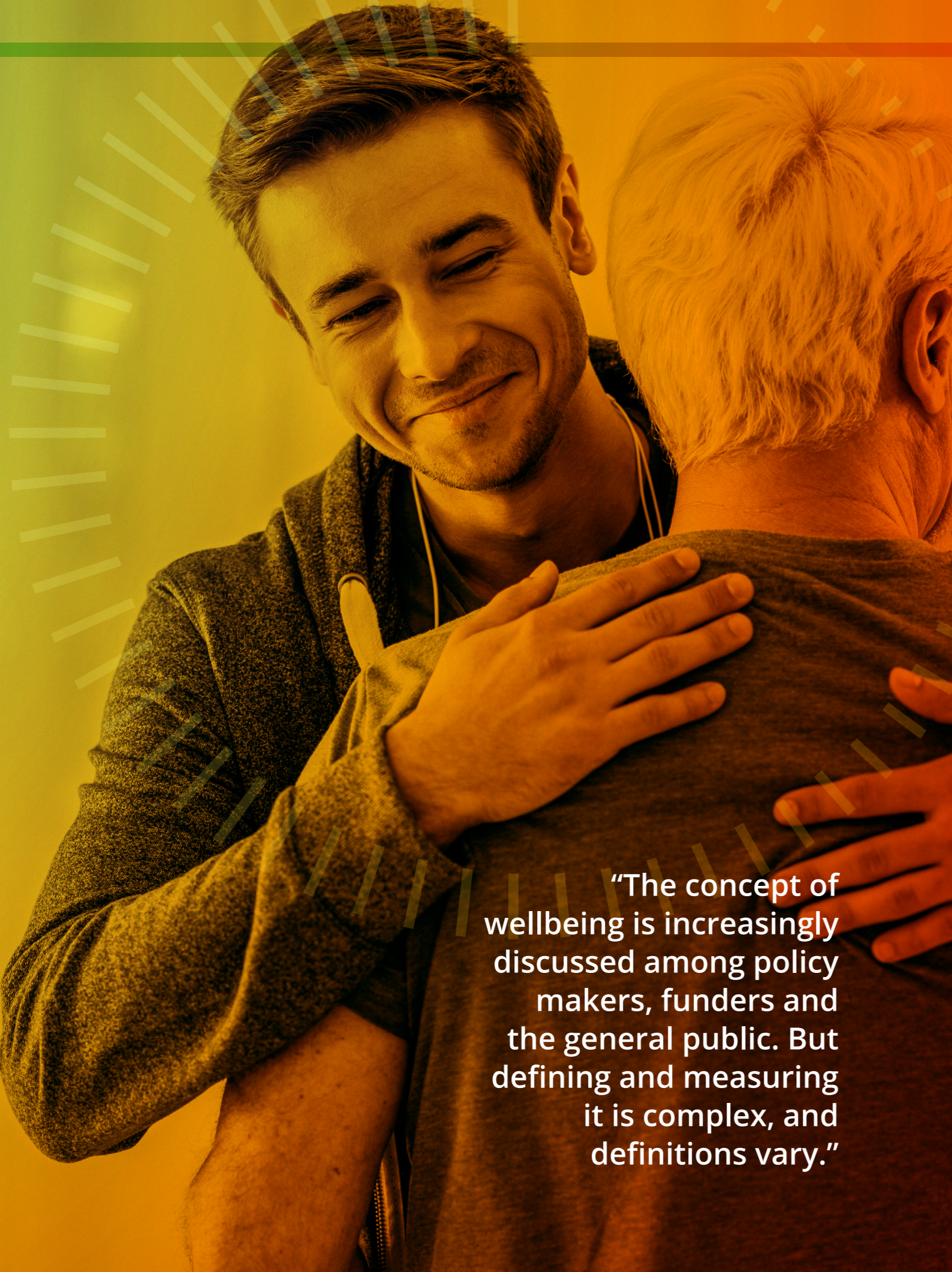
C – Factors shaping the strength of the mental health system

This component is divided into eight subcomponents covering key aspects of system capacity, resources and service provision.

Indicator number	Framework subcomponent	Indicator name	Data source	Number of countries for which data is available ²⁰
C.1.1	Laws, policies and leadership	Presence of a national standalone policy or plan for mental health	WHO Mental Health Atlas 2020	169
C.1.2	Laws, policies and leadership	Presence of national standalone law for mental health	WHO Mental Health Atlas 2020	170
C.1.3	Laws, policies and leadership	Extent to which the policy/plan complies with international human rights instruments	WHO Mental Health Atlas 2020	147
C.1.4	Laws, policies and leadership	Extent to which the law complies with international human rights instruments	WHO Mental Health Atlas 2020	118
C.2.1	Sustainable financing	Total mental health expenditure as a percentage of total health expenditure	WHO Mental Health Atlas 2020	85
C.2.2	Sustainable financing	Development assistance for mental health	IHME	135
C.3.1	Human resource levels	Total number of psychiatrists (per 100,000 population)	WHO Mental Health Atlas 2020	159

¹⁹ *ibid*
²⁰ There are some small discrepancies between the number of countries noted here and those referenced in WHO's Mental Health Atlas. These reflect i) a difference in the number of Member States of WHO versus the UN (this report uses the latter), and ii) the absence of a Mental Health Atlas country profile for some Member States. For these countries, data is included in aggregate analysis for this report but Mental Health Atlas indicators on the Countdown GMH 2030 dashboard are not shown.

C.3.2	Human resource levels	Total number of all other mental health professionals (per 100,000 population)	WHO Mental Health Atlas 2020	159
C.4.1	Service levels	Proportion of persons with psychosis using services over the last 12 months (%)	WHO Mental Health Atlas 2020	54
C.4.2	Service levels	Mental health outpatient visits (rate per 100,000 population)	WHO Mental Health Atlas 2020	76
C.4.3	Service levels	Total mental health beds (number per 100,000 population)	WHO Mental Health Atlas 2020	157
C.4.4	Service levels	Rates of minimally adequate treatment for major depressive disorder	IHME	191
C.5.1	Service quality	Percentage of involuntary mental hospital admissions	WHO Mental Health Atlas 2020	57
C.5.2	Service quality	Percentage of inpatients staying less than one year in mental hospitals	WHO Mental Health Atlas 2020	86
C.5.3	Service quality	Psychosocial interventions for mental health conditions are available and provided at primary care level	WHO Mental Health Atlas 2020	164
C.5.4	Service quality	Percentage of mental health inpatients who receive timely diagnosis, treatment and follow-up for physical health conditions	WHO Mental Health Atlas 2020	131
C.6.1	Integration of mental health into other services	Functional integration of mental health into primary care	WHO Mental Health Atlas 2020	159
C.6.2	Integration of mental health into other services	Proportion of people with mental health conditions who receive social support	WHO Mental Health Atlas 2020	163
C.7.1	Promotion and prevention	Extent to which countries offer promotion and prevention programmes	WHO Mental Health Atlas 2020	147
C.8.1	Monitoring and evaluation	Frequency of key mental health system data collection	WHO Mental Health Atlas 2020	163



“The concept of wellbeing is increasingly discussed among policy makers, funders and the general public. But defining and measuring it is complex, and definitions vary.”

C.8.2	Monitoring and evaluation	Existence of indicators/ targets to monitor implementation of policies/plans	WHO Mental Health Atlas 2020	166
C.8.3	Monitoring and evaluation	Collection of data at facility level on number of involuntary admissions	WHO Mental Health Atlas 2020	155

The majority of indicators in this component are drawn from the WHO’s Mental Health Atlas – the most accurate and comparable mental health data source globally-demonstrating the significant value of this work. Latest data is provided by Mental Health Atlas 2020²¹ and associated country profiles.²²

The first subcomponent focuses on law, policies and leadership, with data on indicator C.1.1 showing that 23 countries do not have a standalone policy or plan on mental health. Data on the second subcomponent, sustainable financing, is analysed in detail in the section on financing below.

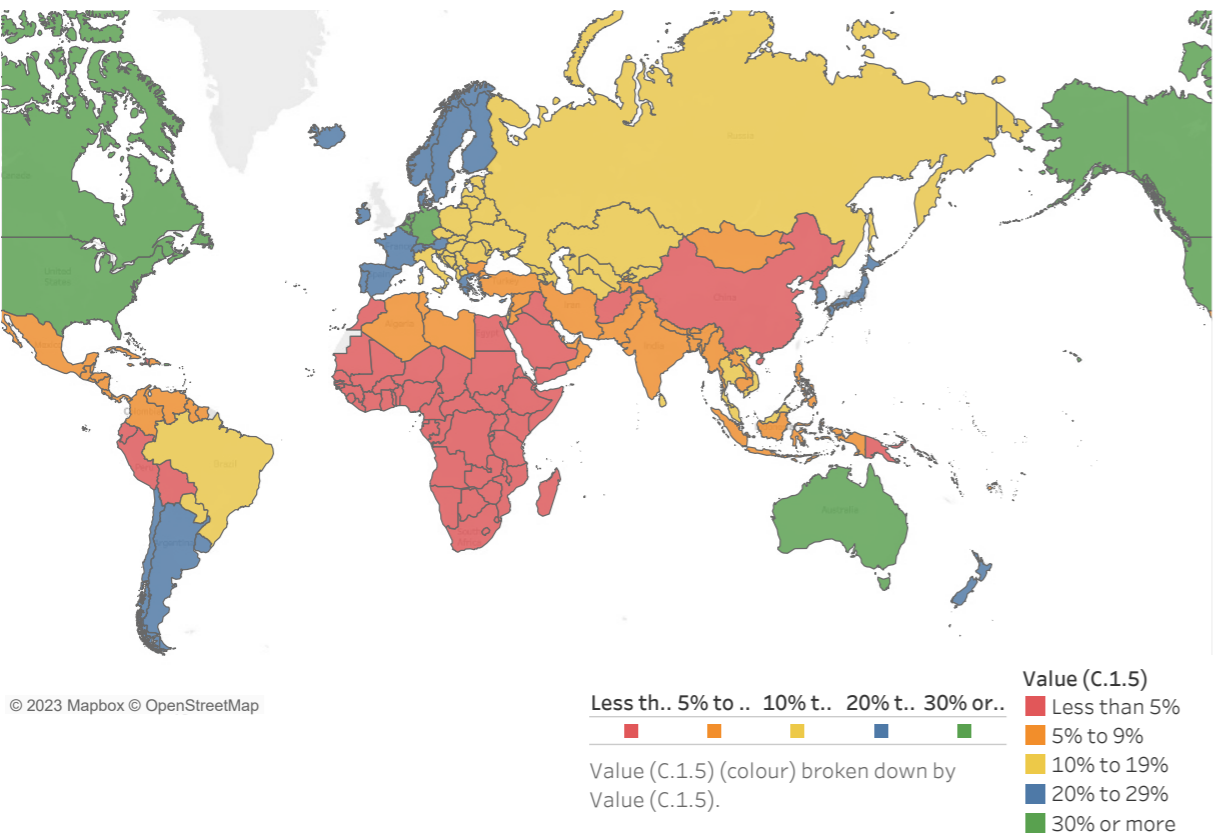
Human resource levels are covered by subcomponent three, with data on indicator C.3.1 showing that while 26 (nearly all high-income) countries report having over 10 psychiatrists per 100,000 population, 64 LMICs report fewer than 1.

The illustrative indicator for this component is service level indicator C.4.4 on minimally adequate treatment of major depressive disorder (MDD).²³ This is a newly available indicator at the country level, developed by the University of Queensland in collaboration with IHME.

Major depression is a common mental health condition, estimated to affect around 3% of the adult population globally.²⁴ It is a leading cause of disability and a major contributor to the global burden of disease.²⁵ The indicator presents data on the availability of minimally adequate treatment in five categories of coverage: over 30%, 20-29%, 10-19%, 5-9% and less than 5%.²⁶

21 WHO (2021) Mental Health Atlas 2020
22 <https://www.who.int/teams/mental-health-and-substance-use/data-research/mental-health-atlas>
23 Minimally adequate treatment is defined as being either pharmacotherapy (One month of a medication, plus 4 visits to any type of medical doctor) or psychotherapy (8 visits with any professional).
24 <https://www.who.int/news-room/fact-sheets/detail/depression>
25 ibid
26 Data was taken from multiple sources and consisted of 205 estimates across 53 studies and 32 countries. The data was adjusted to account for varying leniency in definition of minimally adequate treatment and reporting on differing metrics (e.g. antidepressant use and mental health service utilisation). Where source data did not include disaggregation by sex, the pooled sex ratio of available sex-specific data was assumed. Prior estimates of 0% coverage were used for infants below one and a decreasing slope for adults between 80 and 100. The healthcare access quality index was included in the model for estimating minimally adequate treatment. The method outlined above provided estimates of minimally adequate treatment of major depressive disorder by age, sex, location, and year.

C.4.4: Rates of Minimally Adequate Treatment for MDD



As can be seen in the heatmap for this indicator, only six countries (Australia, Canada, USA, Belgium, Germany and the Netherlands – all high-income) have minimally adequate treatment rates for MDD that exceed 30%. Meanwhile 63 countries (of which 62 are LMICs) are estimated to have minimally adequate treatment rates for MDD of less than 5%. A further 70 countries (spanning all income groups) have rates of only 5-9%. This highlights the huge treatment gaps in the majority of countries for one of the most common mental disorders.

Service quality is captured in subcomponent five, with indicator C.5.3 tracking whether psychosocial interventions for mental health conditions are available and provided at primary care level in more than 75% of facilities – only 35 countries give a positive response.

Indicators from subcomponent six on integrating mental health into other services are explored in more detail in Box 6 below.

Subcomponent seven covers promotion and prevention, with indicator C.7.1 showing whether countries offer functional²⁷ promotion and prevention programmes in seven categories.²⁸ The data shows the weakness of promotion and prevention programmes in all countries. Only 12 countries report functional programmes in all seven areas and 31 countries report no functional programmes at all.

²⁷ Functional is defined as meeting two out of three of the following: a) Dedicated financial and human resources; b) A defined plan of implementation; c) Documented evidence of progress and / or impact
²⁸ suicide prevention, mental health awareness/anti-stigma, early childhood development, school-based mental health prevention and promotion, parental/maternal mental health promotion and prevention, work-related mental health prevention and promotion and psychosocial support (MHPSS) components of disaster preparedness and/ or disaster risk reduction.

Indicator C.8.1 from the final subcomponent is especially relevant to this report, focusing on how frequently key mental health system data is collected. The data shows that 62 countries have published a report in the last two years focusing on public and private mental health activities. Meanwhile 24 countries report that no mental health data has been compiled in a policy planning or management report in the last two years. This underlines the need for greater investment in the collection, analysis and use of data on mental health to inform policy.

Key insight: The resources available – both human and financial – in the majority of countries (especially LMICs) for mental health remain very limited. And these resources vary widely between countries even within the same income group. All countries are able to expand effective services, better integrate mental health into primary care and invest more in mental health promotion and protection.

D – Wellbeing

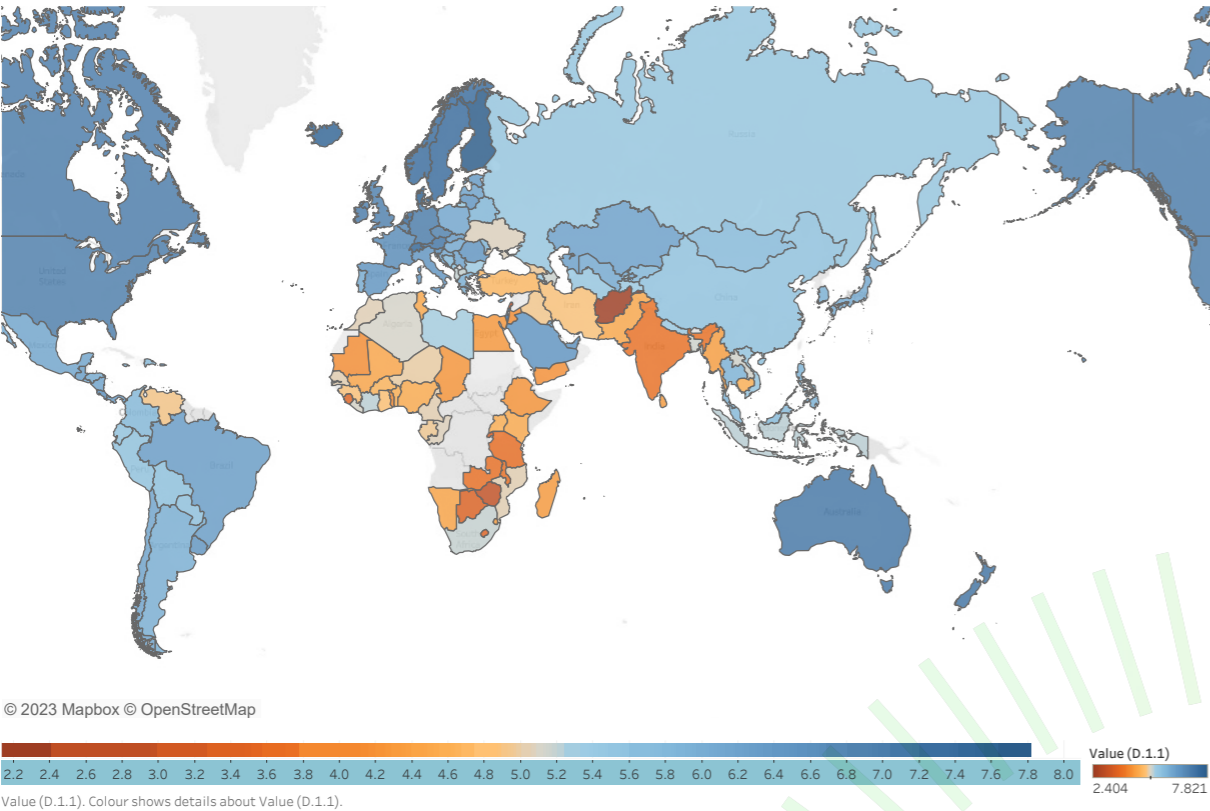
Much of the discourse on global mental health focuses on the prevention and treatment of mental ill health, but SDG 3.4 highlights the promotion of wellbeing, defined by the 2018 Lancet Commission as ‘subjective evaluation of life satisfaction’. Component D was added to the Countdown 2030 indicator framework to capture this dimension. For now, it includes indicator D.1.1. based on the Happiness Ladder score developed by global polling organisation Gallup. Its World Poll data powers the annual World Happiness report published by the Sustainable Development Solutions Network.²⁹

Indicator number	Framework component	Indicator name	Data source	Number of countries for which data is available
D.1.1	Wellbeing	Happiness Ladder score	Gallup	141

The 2022 Happiness Ladder score for each country is based on a three-year average of 2019-2021.³⁰ Data for this indicator is available for 141 UN member states, with Happiness Ladder scores on a scale of 0-10 – ranging from 2.4 for Afghanistan to 7.8 for Finland, who topped the index in 2022.

²⁹ John F Helliwell and others (2022) World Happiness Report
³⁰ The respondents’ wellbeing is assessed via a single-item Cantril ladder life-evaluation question (worst possible life = 0, best possible life = 10). These responses are population-weighted to understand a nation’s subjective wellbeing.

D.1.1: Happiness Ladder Score (0-10)



The relationship of the wellbeing indicator with the socio-economic determinants of mental health is further examined in the section on using the data below.

Key insight: The concept of wellbeing is increasingly discussed among policy makers, funders and the general public. But defining and measuring it is complex, and definitions vary. Wellbeing cannot be measured in isolation: it is influenced by a range of socio-economic determinants.

Exploring the data via the Countdown dashboard

Countdown GMH 2030 focuses on countries as its unit of analysis. The latest data can be accessed, explored and downloaded by country and/or by indicator via the [Countdown GMH 2030 dashboard](#),³¹ which features a series of heatmaps that can be used to compare countries. These core indicators will form the basis of future monitoring and provide a mechanism for holding governments to account for their performance.

About the data

While the Countdown GMH 2030 dashboard and this report seek to present the best available data, it is important to acknowledge the limitations and challenges. There are significant gaps in mental health data, especially in LMICs, and gaps in the Countdown GMH 2030 dataset can be seen in the tables above.

Some indicators depend on self-reporting by governments while others rely on heavily modelled data to fill gaps and present a complete dataset. Where donors fund data collection, there is a risk of this reflecting their priorities, rather than those of national governments. Some of the datasets include data points for countries that are significantly out of date and these are flagged in the dashboard heatmaps by (!).

A significant proportion of the data collected also pre-dates the COVID-19 pandemic, the first year of which triggered a 25% increase in the global prevalence of anxiety and depression, and severely disrupted access to mental health services.³² While it is anticipated that future monitoring will chart the pandemic’s full impact on mental health, the latest data we have for many of the Countdown GMH 2030 indicators does not yet show this impact. It should also be noted that the pandemic is likely to have made indicators that depend on modelled data less reliable, as it undermined the basis of many of the projections. For example, many models assume continued and consistent economic growth, which was reversed in the early stages of the pandemic.³³

Key insight: There are significant gaps in mental health data, especially in LMICs. Timely, comprehensive, high-quality data on mental health is essential to accurately assess the prevalence of mental health conditions, the demand for services and the strength of national mental health systems. Specific measures to attain such data include: regular collection and use of mental health data at national, subnational and facility level; more complete reporting by governments to WHO’s Mental Health Atlas; the adoption of validated data collection mental health modules in household surveys, school based surveys and health information systems; and the strengthening of death registration systems in order to obtain more accurate data on suicide.

31 All datasets used in this report and the Countdown 2030 were downloaded in September 2022.
32 WHO news release - <https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide>
33 <https://www.un.org/pt/desa/covid-19-likely-shrink-global-gdp-almost-one-cent-2020>

Boxes 1 and 2 provide details of two initiatives that seek to address this.

Box 1: Measurement of Adolescent Mental Health at the Population level tool

UNICEF's launch of the Measurement of Adolescent Mental Health at the Population level (MMA) tool³⁴ is a crucial step towards addressing the mental health needs of adolescents globally. The MMA approach consists of integrating a mental health data module into routine data collection efforts to generate reliable and representative data on adolescent mental health. The use of culturally adapted, standardised modules and tools for adaptation across contexts will ensure that the data is comparable and inclusive.

The MMA tool will enable the generation of critical insights into the burden of critical mental health conditions like anxiety and depression and other aspects including functional limitations, suicidal thoughts and behaviors, mental health care-seeking, and connectedness with peers and caregivers. The data generated using the MMA tool will be a game changer in terms of providing actionable insights for policy makers, programmes, and investments in adolescent mental health across countries.

UNICEF's MMA tool provides a valuable opportunity for countries to better understand the mental health needs of their adolescent population and take action to support their well-being. Policy makers and stakeholders should take advantage of this opportunity and invest in the mental health of our future generation.

Box 2: Inclusion of mental health in the WHO's NCD surveillance tool


The WHO's STEPwise Approach to noncommunicable diseases (NCD) Risk factor Surveillance (STEPS) is a simple, standardised method for collecting, analysing and disseminating national-level data on key NCD risk factors. It has been administered in more than 100 LMICs.

A new STEPS mental health module on depression has been developed that will enable interested countries to obtain population-representative estimates of depression surveillance (in line with ICD-11 International Classification of Diseases 11th Revision) and service uptake.

This initiative can improve measurement and information about service coverage for depression in different regions of the world. It is an example of the kind of tool whose adoption should be promoted by all mental health funders to effectively address data gaps.

Data to inform national mental health policy and practice should include qualitative data, particularly the views of people with lived experience, their family members and mental health professionals about service delivery. The aim is that future Countdown GMH 2030 reports will draw on data from a planned GMHPN annual survey. Key findings from a GMHPN survey for the Lancet Commission on Ending Stigma and Discrimination in Mental Health are summarised in Box 3. They demonstrate the significant added value of collecting and using qualitative data.

³⁴ <https://data.unicef.org/topic/child-health/mental-health/mma/>



UNICEF's MMA tool provides a valuable opportunity for countries to better understand the mental health needs of their adolescent population and take action to support their well-being

Box 3: Lancet Commission on ending stigma and discrimination in mental health

In October 2022, the Lancet Commission on ending stigma and discrimination in mental health report was published. It was the result of a collaboration of more than 50 people around the world and was co-produced with people with lived experience (PWLE).

The report included an umbrella review of 216 review papers to identify effective interventions to reduce stigma. The report stated: “The evidence summarised in this report shows that PWLE are the key change agents for stigma reduction.” To inform the report, a global survey of PWLE was commissioned and almost 300 respondents from 45 countries (mostly LMICs) took part. Over 90% agreed that PWLE should be treated equally to those with physical mental health conditions, that stigma and discrimination negatively affect most people with mental health conditions, and that the media could play an important part in reducing stigma and discrimination.

Using this survey, along with the umbrella review, enabled the report authors to hear directly from PWLE and to gather evidence in areas for which peer-reviewed data remains limited. For example, the survey explored the positive and negative role of the media in mental health stigma and discrimination. A range of strategies for how the media could improve its reporting were developed.

Based on this survey, UnitedGMH and the Global Mental Health Peer Network developed a [media manifesto](#) to help the media improve mental health reporting. It builds on [the WHO guidance on reporting suicide](#).

This kind of survey, based on hearing directly from PWLE, is a critical part of growing the evidence base available to inform mental health policy and practice. Without listening to PWLE it is impossible to correctly identify the greatest challenges in mental health, and design and deliver effective interventions.

Using the data to inform advocacy

Countdown GMH 2030 is not simply about presenting data on a set of indicators for monitoring progress on mental health. It is about promoting the use of that data to inform advocacy and drive policy change, as the following word examples.

Poverty, inequality, mental health and wellbeing

Poverty and inequality are two key determinants of mental health,^{35,36} and they are both worsening: data from multiple sources confirms COVID-19 has left a legacy of rising poverty and widening inequality.³⁷ This is being compounded by climate change and the impact of conflict in Ukraine, Afghanistan, Ethiopia, South Sudan, Syria, Yemen and elsewhere, all of which is contributing to rising food insecurity and a global cost-of-living crisis. Exploring the complex associations between poverty, inequality and mental health is essential to understanding and addressing rising concerns about all three.

We used the Countdown GMH 2030 dataset to examine this trio of interconnected issues. First, we conducted a cross-tabular analysis of relevant poverty and inequality indicators (from component A of the framework) with wellbeing (component D). By mapping each of these indicators to the Happiness Ladder score we found clear and predictable correlations in each case. In addition to log GDP³⁸ (which has already been shown by the World Happiness Report to be positively associated), the most significant associations were seen in relation to unemployment and inclusiveness, followed by poverty headcount ratio. All showed a clear relationship to a country's Happiness Ladder score. See Figure 1

Log GDP is correlated positively: the higher the GDP per capita, the higher the Happiness Ladder score. When GDP per capita is low, a set increase in GDP per capita is correlated with a large increase in wellbeing. However, when GDP per capita is already high, increasing it further by the same amount does not affect wellbeing very much. In a model with the A component indicators listed above, if a country doubles its GDP, with all other factors constant, its Happiness Ladder score is likely to rise by 0.42. In addition to log GDP, the other variables add more information to allow a more accurate prediction of wellbeing.

The unemployment rate of a country emerged as a significant predictor for wellbeing when added to log GDP. It is correlated negatively: the higher the rate of unemployment, the lower the Happiness Ladder score.

The Inclusiveness index, a non-economic predictor, also has a significant relationship with wellbeing. It is correlated positively with the Happiness Ladder score: the higher the Inclusive index score, the higher the Happiness Ladder score.

Used in addition to log GDP, the proportion of a country's population living on less than \$2.15 a day is correlated negatively: the higher the proportion, the lower the Happiness Ladder score.

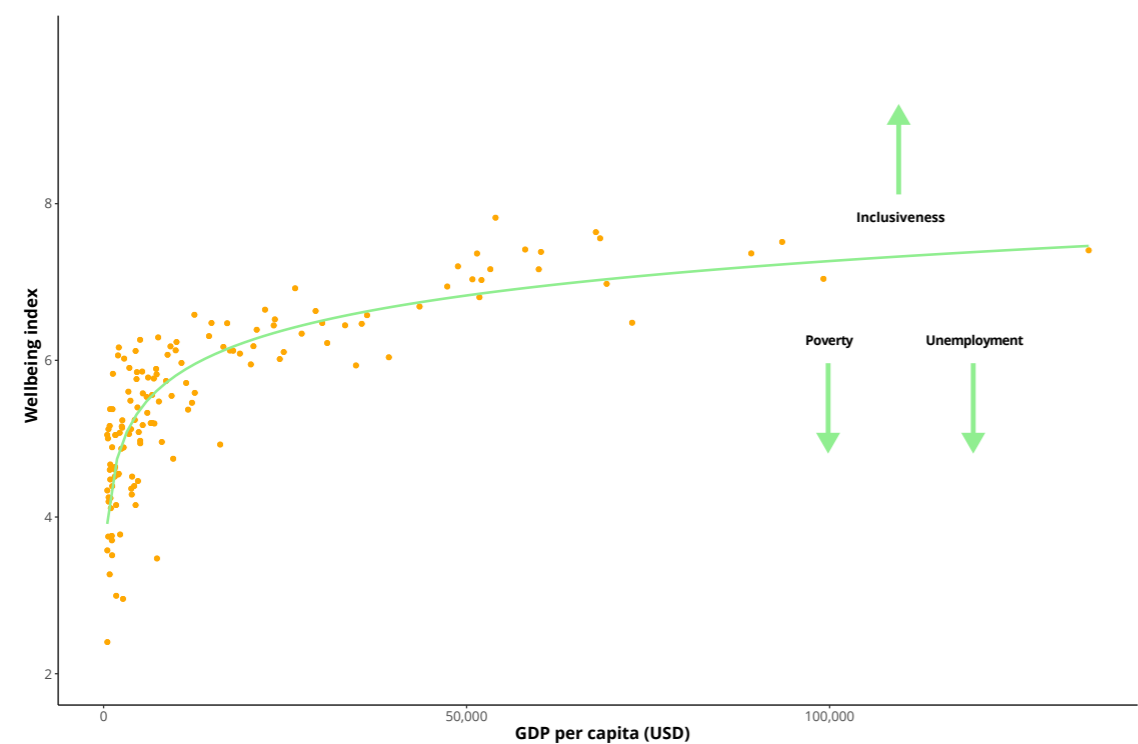
³⁵ Vikram Patel and others (2018), The Lancet Commission on global mental health and sustainable development

³⁶ Püras, D. (2019) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. United Nation Human Rights Council, Forty-first session (24 June–12 July 2019). A/HRC/41/34.

³⁷ Carolina Sanchez-Paramo and others (2021) World Bank Blogs, [COVID-19 leaves a legacy of rising poverty and widening inequality](#)

³⁸ Logarithms are used frequently when handling economic data since improving economic conditions often has diminishing returns with respect to outcome indicators - a unit increase has a greater effect when small than when the economic condition is already large

Figure 1: The impact of socio-economic determinants on wellbeing



The associations between poverty and inequality and wellbeing are significant. Governments need to acknowledge these connections and integrate mental health and wellbeing into their strategies for responding to the global economic crisis, protecting the poorest and most marginalised people in society.

In a subsequent analysis, indicators on social and economic determinants were mapped to key indicators in components B (burden/demand) and C (strength of systems). No clear patterns emerged, and it was not possible to identify any obvious associations. The reasons for this include the unit of analysis (whole countries, as opposed to socio-economically defined sub-groups within countries) and the large number of data gaps. This underlines the need for greater investment in data collection, and for Countdown GMH 2030 to expand its focus beyond countries to include subnational data.

Key insight: An increase in per capita GDP results in higher wellbeing, with a greater effect in poorer countries than richer ones. A country's unemployment rate, poverty headcount ratio and Inclusiveness index score also all influence wellbeing.

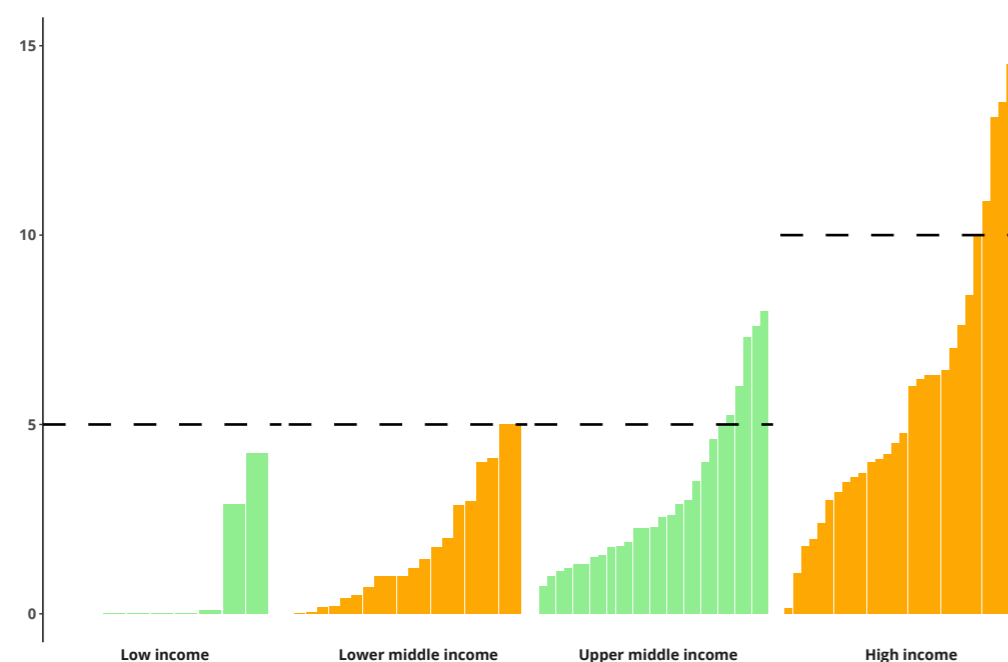
The associations between indicators on poverty and inequality and wellbeing are significant. Governments need to acknowledge these connections and integrate mental health and wellbeing into their strategies for responding to the global economic crisis, protecting the poorest and most marginalised people in society.

Financing

As highlighted by the 2018 Lancet Commission, countries in all income groups fail to allocate sufficient spending to mental health, despite the availability of cost-effective interventions. Expenditure is not commensurate with the level of unmet need or the high economic cost of mental health conditions. The Commission proposed that high-income countries should increase their expenditure on mental health to at least 10% of their total health budget, while LMICs should raise such spending by 5%. Countdown Indicator C.2.1 provides data on the proportion of their total health budgets 85 countries report spending on mental health. The majority of countries for which data is available are either high-income countries or upper-middle-income countries, with far less data from lower-middle and low-income countries.

Data collected by the WHO for this indicator confirms public expenditure on mental health remains very low, with a global median of 2.1% of government health expenditure.³⁹ As Figure 2 below shows, only 13 of the 85 countries for which data is available meet the proposed expenditure targets. Five of these are high-income countries (Barbados, France, Germany, Netherlands and Norway), six are upper-middle-income countries (Jamaica, Marshall Islands, Mauritius, North Macedonia, St Vincent and the Grenadines, and South Africa) and two are lower-middle-income countries (Kiribati and Lebanon).

Figure 2: Total mental health expenditure as a percentage of total health expenditure by country income group



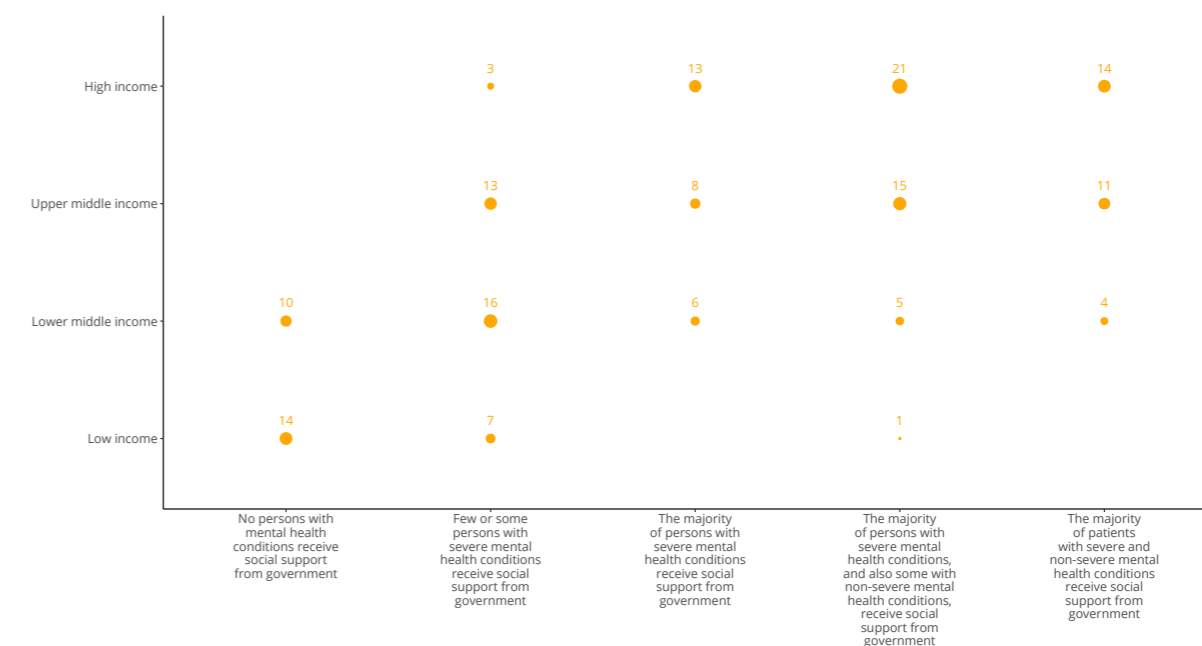
Where government expenditure in LMICs is low, it could be supplemented by development assistance for mental health. Indicator C.2.2 provides data on this. Between 2016 and 2018, 115 countries received some level of development assistance for mental health. Amounts are typically low, with an average of US\$0.78 million per country, ranging from as little as US\$1,000 to up to US\$14 million in the case of Yemen.

Development assistance for mental health does increase the support given to those suffering from mental health conditions in recipient countries and, at an aggregate level, increase the overall level of financial support for mental health. However, with under 1% of development assistance targeting mental health, it remains a very small part of the overall financing landscape. Many view private philanthropy as an important element of future mental health funding, but at present it apportions less than 1% of health assistance to mental health.⁴⁰

Where public expenditure on mental health is inadequate, the cost of treatment falls on patients and their families, creating a significant barrier to access. Low government expenditure on mental health might be expected to put a financial strain on individuals through out-of-pocket expenditure (indicator B.2.1), lack of insurance support (indicator B.2.2) and exclusion from social protection (indicator C.6.2), but the data did not show such a relationship. Sadly, this is likely to reflect the fact that in the poorest countries, individuals cannot afford to pay for mental health services. Our analysis shows that the wealth of a country is once again the main predictor of financial accessibility of care.

In 94% of high-income countries, the majority of people with severe mental health problems receive social support. This is compared to 72% of upper-middle-income countries and just 37% and 5% of lower-middle and low-income countries, respectively. Similar trends are seen for low out-of-pocket expenditure and the inclusion of mental health in insurance/reimbursement schemes.

Figure 3: Inclusion of mental health in social support and health insurance/reimbursement schemes



³⁹ WHO (2021) Mental Health Atlas 2020

⁴⁰ UnitedGMH, Arabella Advisors and #MHPPhilanthropy (2021) Funding the future of mental health: The potential of next generation philanthropists to catalyse action

The costs of providing a significantly scaled up package of specified cost-effective interventions for prioritised mental, neurological and substance use disorders in LMICs is estimated at US\$3-4 per head of population per year.⁴¹ While making the case for increased investment is difficult in the context of a global cost-of-living crisis, this needs to be balanced against the cost of inaction. Indicator B.1.5 looks at the percentage of disability-adjusted life years (DALYs) attributed to mental, neurological and substance use conditions. It estimates 43 countries, the majority of them high-income countries, have percentages of over 15%.

Key insight: The data confirms public expenditure on mental health remains woefully inadequate, with a global median of 2.1% of health expenditure invested in mental health. Where government expenditure is low, the costs of treatment fall on individuals and their families, creating a significant barrier to access. In the poorest countries, neither the government nor individuals can afford to fund mental health care. Increasing government expenditure on mental health is a key priority, and needs to be balanced against the costs of inaction.

Child, adolescent and youth mental health

An estimated one in five children and adolescents have a mental health condition. Suicide is the fourth leading cause of death among 15-29 year-olds,⁴² while mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years.⁴³ Failing to address mental health conditions in young people curtails their chances of leading fulfilling lives as adults.⁴⁴

Countdown GMH 2030 has always included indicators specifically relevant to child and adolescent mental health and the updated indicator set includes the following indicators:

A.1.2 - Violent discipline ⁴⁵

A.3.1 - Proportion of children in school exposed to bullying

A.3.2 - Percentage of children (aged 36-59 months) developmentally on track

A.3.3 - Mean years of schooling

A.3.4 - Primary age children out of school

Data published by UNICEF on 88 countries reveals high percentages of children experiencing violent discipline, ranging from 41.6% in Cuba to 94% in Ghana, with only seven countries for which data is available having percentages below 50%. Violence against women also exposes children to the risk of physical and emotional harm, and UN Statistics Division data shows that in 32 countries, over 20% of women have been subjected to domestic violence from a partner in the last year.

41 Patel V. and others (2016) Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition

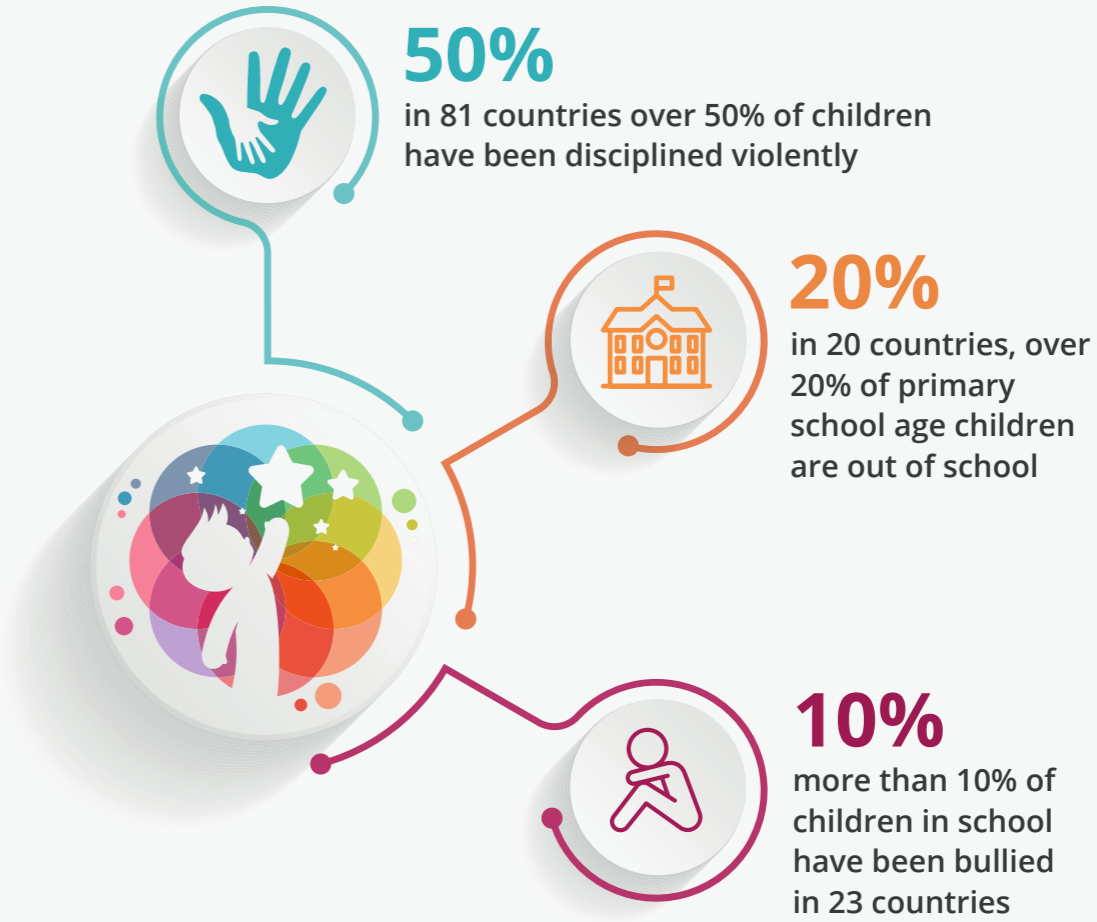
42 Suicide (n.d) World Health Organization. World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/suicide>

43 Adolescent and young adult health (n.d) World Health Organization. World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>

44 Suicide (n.d) World Health Organization. World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/suicide>

45 Percentage of children aged 1 to 14 years who have experienced any violent discipline (psychological aggression and/or physical punishment) in the past month

Early years experiences can impact mental health in later life



Education can help protect children’s mental health, so it is concerning that, in 20 countries, over 20% of primary school age children are out of school, according to UNESCO data. At the same time, the school environment can present risks to children’s mental health. Data shows that the proportion of children in school exposed to bullying varies from 1% in Tajikistan to 18% in Egypt, with 23 countries reporting proportions of over 10%.

Globally, data on the mental health of children and adolescents is limited, especially in LMICs. For example, prevalence estimates are based on less than 5% of the population of interest.⁴⁶ Good data is the starting point for good political and programmatic decisions. Without it, child and adolescent mental health remains a largely unrecognised and unaddressed public health issue. Initiatives that seek to address this include UNICEF’s Measurement of Mental Health Among Adolescents at the Population Level (MMAAP) (see Box 1) and the National Adolescent Mental Health Surveys (NAMHS) (see Box 4)

46 Erskine, H and others (2017) The global coverage of prevalence data for mental disorders in children and adolescents

Box 4: The National Adolescent Mental Health Surveys

The National Adolescent Mental Health Surveys (NAMHS) process aims to address 'data deserts'. It pioneers nationally representative surveys of mental disorders among adolescents in three LMICs: Kenya, Indonesia and Vietnam. Developed by the University of Queensland, partnering with Johns Hopkins Bloomberg School of Public Health, in-country organisations with expertise in adolescent health led the NAMHS process in their respective countries:

- Kenya: K-NAMHS led by the African Population and Health Research Center
- Indonesia: I-NAMHS led by Universitas Gadjah Mada
- Vietnam: V-NAMHS led by the Institute for Sociology

In 2021, between 5,000 and 6,000 pairs of adolescents and their primary caregivers were interviewed in each country. Mental disorders were measured using an instrument designed to diagnose six mental disorders. Meanwhile, each adolescent and their primary caregiver were asked about a range of risk and protective factors linked to mental health, along with their service use and the impact of COVID-19 on their lives.

Results of these surveys can be accessed [here](#).

UNICEF and WHO have formed a joint programme on mental health and the psychosocial wellbeing and development of children and adolescents. Addressing the lack of good data is a key part of its work.

Looking forward, the best approaches to addressing the mental health of young people need to involve those young people from the beginning. This approach is part of the new Being Initiative launched by Fondation Botnar, Grand Challenges Canada and UnitedGMH in 2021.

Key insight: More investment is needed in producing data on child and adolescent mental health, and it should be standardised in worldwide surveys such as Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and the Global School-based Student Health Survey. Involving young people in decisions about the future design and delivery of child and adolescent mental health services is likely to greatly increase their effectiveness.

Box 5: Using data to make the case for integrating mental health into UHC

As part of the political declaration of the UN high level meeting on Universal Health Coverage (UHC) in 2019, member states committed to implement measures to promote mental health and wellbeing as an essential component of UHC. They also recognised primary health care (PHC) as the most inclusive, effective and efficient approach to enhance people's physical and mental health and wellbeing.

The relevant Countdown 2030 indicator is C.6.1 on the functional integration of mental health into primary care. The data, which is based on the WHO's Mental Health Atlas, shows that out of 159 countries for which data is available, only 48 have achieved functional integration, compared to the WHO Comprehensive Mental Health Action Plan 2013-2030 target of 80%.

An overwhelming majority of LMICs have not achieved functional integration into primary health care, with only three and six countries respectively meeting the threshold. But the problem is not confined to the developing world – there are still 19 high-income countries yet to meet the same threshold.

To address this, governments must go beyond the health sector and adopt an all-of-government approach to integrating mental health into UHC and primary health care, and regularly collect data to monitor progress. Commitments to this effect were made at the 2019 UN high level meeting on UHC and as part of the WHO Comprehensive Mental Health Action Plan 2013-2030. But they must be reinforced at the UN General Assembly high-level meeting on UHC in 2023, and then, crucially, implemented at national level.

Box 6: Using data to highlight the impact of climate change on mental health

The link between mental health and climate change is increasingly recognised. The WHO produced a policy brief in 2022, [Mental Health and Climate Change](#), detailing the impact of climate change on mental health and what needs to be done to address it. The brief cites the IPCC 6th assessment report which states, with very high confidence, that climate-related threats to mental health and wellbeing are increasing.

The Countdown GMH 2030 dataset includes two relevant indicators:

- **A.5.1 - Average share of urban population with access to an open space for public use for all, with data from Habitat available on 91 countries**
- **A.5.2 - Mortality rate attributed to household and ambient air pollution, age-standardised (per 100,000 population), with data from the WHO available on 183 countries**

According to the WHO policy brief, “Urban design that is environmentally friendly can provide green spaces for communities, with mental health benefits and stress reduction in different settings.”



According to the WHO policy brief, “Urban design that is environmentally friendly can provide green spaces for communities, with mental health benefits and stress reduction in different settings.” The dashboard data shows that access to open space varies hugely across countries – from as low as 13% for urban populations in Israel to as high as 92% in the Netherlands and 98% in the Maldives. For half the countries with data, it is less than 50%.

The policy brief also outlines the mental health impact of air pollution. The data highlights that mortality rates of over 100 per 100,000 exist in 45 countries from all income groups and regions.

The WHO policy brief includes recommendations on the data that needs to be collected and used to inform policy-making on climate change and mental health. This will be an increasingly important area of work as activists and governments seek to better integrate mental health in climate change programmes.

Key findings and recommendations from the analysis above are summarised at the beginning of this report in the Executive Summary.

Key moments

While the findings of the report paint a rather bleak picture, it is vital to have a clear understanding of what the future may hold if we want to change that future.

This year offers mental health activists many opportunities to come together to demand action. These include:

- **The SDG Summit in September, where mental health should be highlighted as a key area of concern in its own right, and as a means of supporting other goals and targets in the health sector and beyond; and where improving data to track and report on the SDGs is likely to be a key discussion topic**
- **The high-level meeting on UHC, also in September, which provides a make-or-break opportunity for pressing the case for integrating mental health into primary care**
- **The Women Deliver Conference in Kigali in July and the Partnership for Maternal, Newborn and Child Health (PMNCH) Global Forum for Adolescents in October, both of which include commitments to fully integrate mental health into their discussions and outputs.**

Looking ahead, work has already started on the Summit of the Future in 2024 where the global community will discuss future challenges and the necessary responses. The recommendations in this report are all relevant to that summit and to the health and wellbeing of future generations. UnitedGMH and its partners will be seeking to make the most of these and other global opportunities. We will use the data provided by Countdown GMH 2030 to support advocacy to drive change.

Next steps

With a robust, holistic and stable set of core indicators on global mental health in place, Countdown GMH 2030 plans to update the dataset on an annual basis and produce regular monitoring reports. The core group partners, advised by the Technical Working Group, also plan to discuss whether to produce a series of country profiles based on the Countdown GMH 2030 data and additional information from national sources.

These discussions will look at what scope there may be for developing a series of composite indicators that could be adopted by other initiatives seeking to track progress on mental health. In future, it is expected that the monitoring exercise will draw on a planned annual survey of people with lived experience, so the quantitative data provided by the Countdown GMH 2030 dashboard can be supplemented by qualitative insights from those with first-hand experience of using mental health services. However, this is subject to funding and the Countdown GMH 2030 partners will be seeking donor support to continue their work.

Annex 1 - Method of selection of Countdown GMH 2030 indicators for the 2023 report

A Technical Working Group (TWG) of Countdown GMH 2030 was tasked with developing the indicator set for the 2023 version of the report and the dashboard. The names of the members of the TWG are given below.

The first step was to assemble the long list of indicators that would be considered for inclusion. This included all indicators of the Countdown GMH Report, 2021 and others that were suggested by TWG members to be relevant to the various components of the Countdown GMH 2030 Framework. The total number of indicators identified at this stage was 140. The research assistant supporting the work of the TWG then collected some basic information on each indicator (source, definition, components in case of composite indicators, availability and recency of the data and level of disaggregation (e.g. for gender).

The TWG developed the following criteria for systematically evaluating each of the indicators:

- **Relevance:** Should this indicator be prioritised? How strongly is this indicator related to mental health?
- **Feasibility:** Is this indicator feasible to include (data availability, recency, accuracy, reliability)?
- **Sensitivity to change.** How much will this indicator be sensitive to change between now and 2030?

Each of the potential indicators was given a score of 0 (low), 1 (medium) or 2 (high) by the TWG, based on the basic data available and further exploration as necessary. Each indicator was evaluated by at least two members of the TWG and an average score was calculated based on their individual scores. The full TWG then discussed each of the indicators and their average scores and excluded those that received a low score on any of the three criteria. The remaining indicators were further discussed for the strength of each of the criteria and for how representative they were for the subcomponent and component that they belonged to. Those deemed the best were retained and the remaining excluded. A few indicators (e.g. those on treatment coverage for psychosis and involuntary hospital admissions) were retained even though their feasibility scores were unsatisfactory, if their relevance was strong. Retention of these indicators was intended to send a message to countries that they need to make additional efforts to collect data on these indicators.

The result of this consensus driven process among the members of the TWG was a core set of 48 indicators from 15 sources including UN agencies, the World Bank, academic institutions, international NGOs and a global polling organisation. Data for all of these indicators can be viewed and downloaded via [the Countdown GMH 2030 dashboard](#). The indicators are divided into four components: A - Determinants of mental health; B - Factors shaping the demand (and need) for mental health care; C - Factors shaping the strength of the mental health system; and D - Wellbeing. The subcomponents within these components, along with detailed descriptions of each indicator, are given in [this table](#).

Names of the Technical Working Group members:

Liliana Carvajal Velez, UNICEF
Dan Chisholm, WHO
Julian Eaton, LSHTM/CBM Global
Alize Ferrari, Queensland Centre for Mental health Research; School of Public Health, University of Queensland; Institute for Health Metrics and Evaluation, University of Washington
Valentina Lemmi, London School of Economics
Sarah Kline, United for Global Mental Health
Antonio Lora, DMHAS, ASST Lecco
Crick Lund, King's College London
James Sale, United for Global Mental Health
Damian Santomauro, Queensland Centre for Mental health Research; School of Public Health, University of Queensland; Institute for Health Metrics and Evaluation, University of Washington
Claudia Sartor, GMHPN
Pratap Sharan, All India Institute of Medical Sciences
Shekhar Saxena, Harvard University
Charlene Sunkel, GMHPN
Daniel Vigo, University of British Columbia

The TWG was supported by:

Tarun Dua, WHO
Rachel Greenley, LSHTM
Zeinab Hijazi, UNICEF
Dévora Kestel, WHO
Rebecca Kunau, Harvard University



MAKING MENTAL HEALTH COUNT

