



The mental health crisis

An urgent call for action

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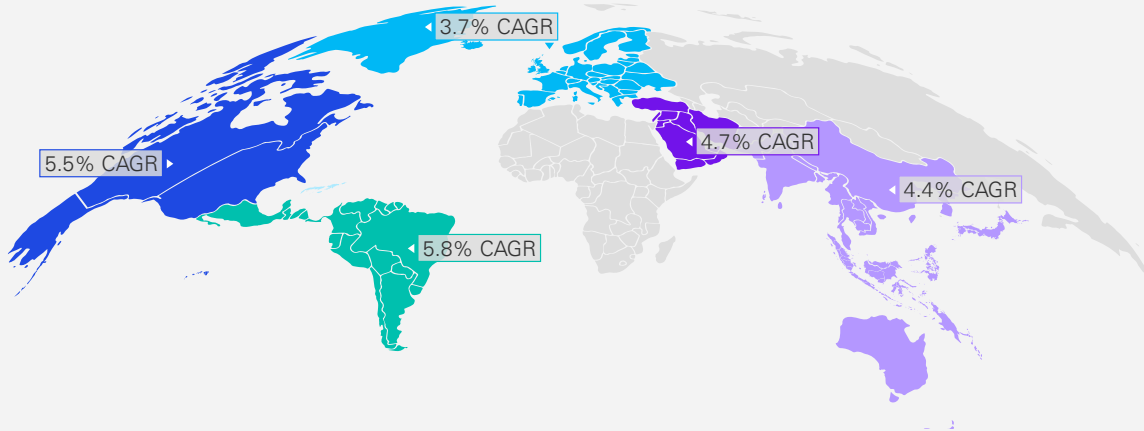


Introduction

Mental health is a global emergency with a dramatically increasing burden on individuals, communities, and economies. About 1 in 8 people worldwide (or about 970 million individuals) are living with mental health disorders, and many go untreated or undiagnosed.¹ In France, for example, it is estimated that only 40 percent to 60 percent of people with mental health disorders are currently treated due to long wait times and low levels of public awareness. And in the United States, the average delay between symptom onset and treatment is estimated to be 11 years.

Over the past two decades, the prevalence of those suffering from mental health diseases has risen significantly. This rise has been exacerbated by global challenges such as the proliferation of social media, the COVID-19 pandemic, and evolving workplace and societal dynamics. The average year-over-year increase in the incidence rate of mental health disorder cases from 2017 to 2021 was 4.6 percent, with the Americas experiencing the highest increase (Figure 1). Despite these challenges, mental health remains significantly underfunded, with an average of only 2 percent of national healthcare budgets

Figure 1: Mental Health Mental Health Disorders: YoY Growth of Cases (2017–2021)³



globally allocated to mental healthcare.² In the US, for example, spending on major depressive disorder in 2019 was 3.3 percent of total US healthcare expenditures compared to 6.8 percent on diabetes in 2022 and 5.2 percent on cardiovascular disease in 2023.^{3,4,5,6}

While progress has been made to improve mental health outcomes in some regions, stark disparities persist between countries. While some nations recognize mental health disorders as medical conditions requiring treatment and care, many still have work to do in order to ensure patients can access innovative treatments. In many places, limited resources, cultural stigmas, and fragmented health systems still hinder access to effective care, leaving many untreated or undiagnosed.

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Certain key themes are emerging around how different countries are developing policies to expand access to mental health services though not necessarily to innovative treatments, including:

1. Increasing overall access

- **United States:** The Protecting Access to Medicare Act established the Certified Community Behavioral Health Clinic (CCBHC) program to define and deliver high-quality, accessible, and comprehensive care. It also introduced two new payment models based on service costs rather than fee schedules.⁴
- **France:** The government prioritized mental health for 2025, emphasizing access to quality public services and support for patients and caregivers.⁵
- **Colombia:** Their 2021 tele-orientation strategy provided early intervention for depression and suicidal behavior, offering psychological first aid with high standards of quality.⁶

2. Legal and policy reforms for equity

- **United States:** The final rules of the Mental Health Parity and Addiction Equity Act (MHPAEA), published in September 2024, ensure that mental health treatment benefits are not more restrictive than those for other medical conditions.⁷

3. National strategic planning

- **Canada:** The Mental Health Commission's Strategic Plan (2021–2031) builds on the 2012 “Changing Directions, Changing Lives” report, addressing cross-jurisdictional challenges with a unified national approach.⁸
- **France:** A 2024 announcement by Prime Minister Michel Barnier included a national call to action with a broad strategic focus on prevention, education, and employment for those affected.⁹

4. Integration with broader social support systems

- **Japan:** Amendments to the Mental Health and Welfare Act in 2024 enhanced community support systems, employment assistance, and services for psychiatric inpatients.¹⁰
- **Saudi Arabia:** Their strategy emphasized integration of mental health into general healthcare and community settings.¹¹

5. Workforce development

- **Australia:** The National Mental Health Workforce Strategy 2022–2032 outlines a roadmap to attract, train, and retain talent, coordinate care based on patient needs, and address systemic workforce challenges.¹²



Despite efforts, challenges remain across the globe



The burden of mental health disorders is increasing:

Beyond the significant burden on patients, mental health disorders impact caregivers and employers, with the scale of productivity loss often underappreciated. Recognizing this burden and educating against public stigmas remains a challenge.



Mental health disorders are highly complex and require tailored care:

Mental health disorders are driven by many factors, including social, biological, genetic, and lifestyle. Understanding the underlying basis of patient disease often requires several interactions with healthcare professionals that can often lead to a “trial-and-error” approach to care.



Support structures are lacking:

Access to care varies widely across countries. Specific patient populations are often left behind, including those with more severe disease, specific disease subtypes, or even those patients in rural locations due to a lack of infrastructure.

KPMG, sponsored by Johnson & Johnson, developed this whitepaper to examine the mental health landscape in depth across 19 countries in five key regions: North America, Latin America, Western Europe, the Middle East, and Asia-Pacific. Through 62 consultations with key opinion leaders, clinicians (psychiatrists, psychologists, and academics), and patient advocacy groups as well as a robust literature search, this paper identifies existing challenges, evaluates policy progress, and proposes actionable solutions to advance mental health outcomes globally.

Addressing the mental health crisis and advancing equitable, patient-centered care requires urgent and coordinated action across policy, healthcare and society. The findings of this study aim to inform targeted strategies that will help.



The growing burden of mental health disorders

The global incidence of mental health disorders is on the rise, with significant societal and economic implications. In 2021, mental health disorders accounted for approximately 4.4 percent of total Disability-Adjusted Life Years (DALYs).¹³ Notably, depressive disorders saw the second-highest growth rate among non-communicable diseases, increasing by 2.9 percent between 2010 and 2021. The COVID-19 pandemic further exacerbated this trend, accelerating the prevalence of anxiety and depression by 25 percent in just the first year,¹⁴ leading to an 11 percent increase in DALYs from 2019 to 2021.¹⁵

Key insights

Economic Impact: A 2011 report from the World Economic Forum and Harvard School of Public Health estimated that the global cost of mental health disorders is projected to reach \$6 trillion by 2030 (Figure 2). This cost is primarily driven by lost productivity and income from disability or death, which make up about two-thirds of the total economic burden. The same report also projected that mental health disorders were anticipated to be the largest cause of economic burden across the top 5 non-communicable diseases from 2010–2030 (Figure 3), more than cardiovascular disease.¹⁶

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Figure 2: Projected global cost of mental health disorders in 2030 (\$US billions)¹⁷

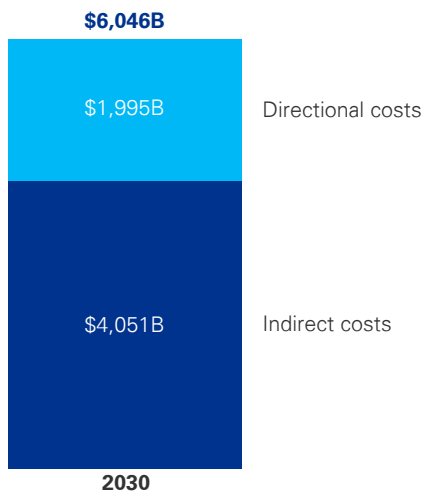
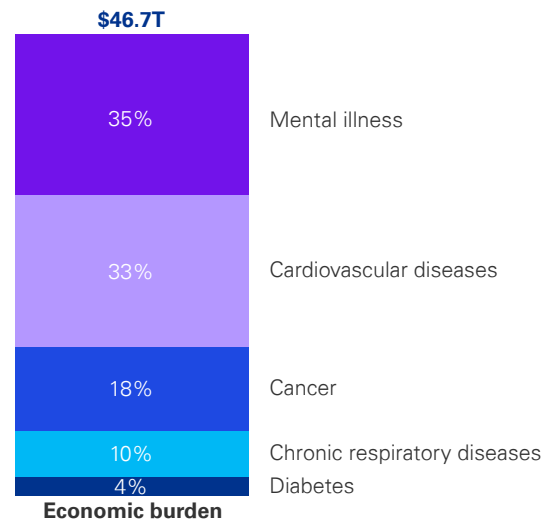


Figure 3: Cumulative economic burden of non-communicable diseases, 2011–2030 (trillions of US\$ 2010)¹⁸



Regional trends

- **United States/Canada:** In these countries, mental health disorders account for 5.8 percent of total health-condition related DALYs, higher than the global average of 4.0 percent.¹⁹ The DALYs rate for mental health disorders in the United States increased by 6.4 percent between 2000 and 2021, with a significant impact from the COVID-19 pandemic.²⁰ In Canada, the rate increased by 16.7 percent over the same period.
- **Western Europe:** In Germany, France, Spain, and Italy, mental health disorders account for 6.7 percent of total health-condition related DALYs, also above the global average.²¹ The DALYs rate increased by 6.7 percent in France, 18.6 percent in Germany, 31.0 percent in Spain, and 14.6 percent in Italy between 2000 and 2021, with notable impacts from COVID-19.²²
- **Middle East/North Africa:** In Saudi Arabia, Israel, and Türkiye, mental health disorders account for 7.2 percent of total health-condition related DALYs, surpassing the global average.²³ Israel saw a 9.7 percent increase in DALYs rate from 2000 to 2021, driven by the pandemic.²⁴ Saudi Arabia and Türkiye experienced significant pre-COVID increases, with rates rising by 31.9 percent and 24.4 percent, respectively.
- **Latin America:** In Brazil, Colombia, and Mexico, mental health disorders account for 5.8 percent of total health-condition related DALYs, above the global average.²⁵ Mexico saw the most significant increase, with a 47.6 percent rise in DALYs rate from 2000 to 2021, followed by Colombia (13.6 percent) and Brazil (17.4 percent).²⁶
- **APAC:** With more than 60 percent of the world's population, the APAC region accounts for about 50 percent of global DALYs related to mental health.²⁷ In Australia, China, and Japan, mental health disorders account for 4.5 percent of total health-condition related DALYs, slightly above the global average.²⁸ Australia saw a 6.0 percent increase in DALYs rate from 2000 to 2021, while China and Japan experienced 7.0 percent and 6.5 percent increases, respectively.²⁹



Drivers of complexity

- **Prevalence Growth:** The rapid increase in the prevalence of mental health disorders, particularly depressive and anxiety disorders, is a major driver of complexity. The global DALYs rate for mental health disorders has been growing steadily, with significant spikes during the COVID-19 pandemic.
- **Economic Burden:** The economic impact of mental

health disorders is substantial, with costs related to lost productivity and income from disability or death making up a significant portion of the total burden.

A 2022 study estimated the value associated with the burden of mental health disorders in 2019 to be \$5 trillion.³⁰

Access to barriers

- **Treatment Delay:** The average delay between the onset of mental illness symptoms and treatment is 11 years in the United States.³¹ According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2021 survey, only 47 percent of U.S. adults with mental illness were receiving treatment.³²
- **Global Treatment Gap:** Globally, less than 50 percent

of patients with mental health disorders are seeking care, even in countries where mental health is comparatively well understood.³³ For example, the 2019 Saudi National Mental Health Survey found that only 11.7 percent of patients with mental health disorders were seeking medical treatment.³⁴

Conclusion

The increasing burden of mental health disorders is a pressing global issue, with significant economic and societal costs. Regional trends highlight the varying impacts, but the overall picture is clear: mental health disorders are growing in both prevalence and economic burden. Addressing the complexity of these disorders and overcoming access barriers are crucial steps in mitigating their impact.





Key global challenge:

Education to combat public stigma is still needed to improve perceptions of mental health disorders and enable appropriate care

Tackling stigma and public perception in mental health

Root cause: What drive stigma?

Stigma around mental health disorders is deeply rooted in cultural, social, and institutional beliefs. In many regions, mental health is still not universally recognized as a legitimate medical condition—even among healthcare professionals.³⁵ This perception gap leads to underfunding, limited infrastructure, and a lack of prioritization in policy and training. Misconceptions about the causes and treatability of mental illness, fear of dangerousness (especially for severe disorders like schizophrenia), and lack of mental health literacy further reinforce public stigma.³⁶ This stigma is compounded by skepticism toward pharmacological treatments—particularly compounds targeting brain circuits such as stimulants and psychedelics—as well as by ideological divides within the psychiatric community, where some schools, like psychoanalysis, can oppose medication altogether. These diverse convictions about the origins of mental illness and appropriate interventions exist even among professionals tasked with providing care. These dynamics can discourage individuals from seeking care, delay diagnosis, and isolate patients socially and economically.



Even some healthcare professionals don't see [mental health disorders] as a disease. Even at the top level, where decisions are made, they don't perceive mental health disorders as real and are less willing to provide funding and create infrastructure to take care of these patients."

Psychiatrist, Mexico

Country case studies: Where has progress been made?

- **United States and Canada:** Over the past 15 years, public education campaigns, workplace policies, and advocacy efforts have improved mental health literacy.^{37,38,39,40,41,42,43} A U.S. study (2006–2018) showed reduced stigma toward depression but persistent fear and avoidance of individuals with schizophrenia.⁴⁴ In Canada, 75 percent of people still hesitate to disclose mental health issues at work, citing fear of judgment and job insecurity.⁴⁵
- **Latin America:** In Mexico, Colombia, and Brazil, stigma remains high. Studies show mental illness is often associated with dangerousness, and mental health literacy is low.^{46,47} Rural populations face additional barriers due to limited access to accurate information and care.
- **Middle East:** Cultural, religious, and educational factors contribute to persistent stigma. In Türkiye and Israel, schizophrenia is perceived as dangerous,^{48,49} and in Saudi Arabia, only 11.7 percent of individuals with mental illness seek treatment.⁵⁰
- **Western Europe:** France has declared mental health a national priority for 2025. While advocacy groups have raised awareness, regional fragmentation limits national impact. Italy's Emilia-Romagna region has seen local success, but other areas lag due to decentralized healthcare budgets.

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Actionable levers: What should stakeholders do?

1. Public education campaigns

Launch broad awareness efforts using social media, traditional media, and community outreach to normalize mental health conversations. Tailor messaging to cultural and societal contexts.

4. Engage religious leaders

In regions where trusted societal influencers hold influence, equip them with accurate mental health information and training to guide communities toward care.

2. Targeted anti-stigma programs

Design campaigns for specific populations (e.g., youth, rural communities, community groups) using demographic insights and local influencers to shift perceptions.

5. Workplace inclusion policies

Incentivize employers to adopt mental health-friendly policies, provide training for managers, and ensure parity in insurance coverage for mental health services.

3. Empower advocacy and medical groups

Provide funding and platforms for grassroots and national advocacy organizations to influence policy and public opinion. Encourage collaboration across regions to amplify impact.

6. Integrate mental health into education

Introduce mental health literacy into school curricula to foster early understanding and reduce stigma among future generations.



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Actionable solutions

Through expert KOL and patient advocate discussions, as well as secondary research, multiple solutions were identified to address the challenges related to public stigma across countries, as described in the table below. Based on findings around level of need, and by understanding historical efforts from different countries, each of these solutions is prioritized to various extents based on geography.

Education to combat public stigma:

- » Investing further in broad awareness efforts/informational campaigns. Leveraging social media to address misunderstandings by disseminating evidence-based information to communities.
- » Supporting stigma-reduction campaigns targeted towards specific populations.
- » Empowering advocacy organizations and physician groups to focus efforts and invest in improvements to existing infrastructure.
- » Engaging and equipping trusted societal influencers with resources to disseminate accurate information.
- » Incentivizing employers to accommodate employees with mental health disorders through programmatic adjustments and environment restructuring in the workplace.
- » Integrating mental health education into curricula across grade school levels, ensuring early exposure to the idea of mental health.

1.

Investing further in broad awareness efforts/informational campaigns. Leveraging social media to address misunderstandings disseminating evidence-based information to communities

What challenge(s) does this solve?

To address stigma and misunderstandings around the causes of mental health disorders, re-educating the public can help to combat existing false beliefs. Even in areas where literacy rates and access to information is lower, this can help broadly disseminate more accurate beliefs. This approach can combat beliefs that lead to social distancing and perceived dangerousness amongst those with mental health disorders. With a reduction in negative attitudes, degrees of social integration (e.g., workforce participation) can improve, while treatment-seeking behaviors can also improve using accurate information on disease symptoms, treatment options, and resulting socialization.

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Which regions could this be a priority to implement?

Latin America, Middle East, APAC

What will this approach look like?

A comprehensive approach can leverage components of the following activities to help educate the public through traditional and social media channels:

- Utilizing social media applications, online platforms, and television to disseminate advertisements and public service announcements with impactful content (e.g., expert insights, factual content)
- Designing and implementing multi-channel public awareness campaigns: social media, traditional media (e.g., newspapers, television/news channels), and community settings
- Promoting key reports, strategic plans, statistics on mental health impact, treatment, and evidence-based information from leading advocacy organizations, medical societies, and international groups across channels to reach various audiences. Highlight specific considerations around culture and religion, as is appropriate for the audience.
- Creating centralized websites that hold resources at the national level for mental health patients, families, and providers. Attract attention via digital advertisements to heighten awareness and ease access to existing resources
- Leveraging influential figures, inclusive of celebrities who have spoken out on overcoming and managing their struggles. Key political and public health figures should issue statements and clearly message information on mental health care.

Successful examples:

- **Canada:** The #BellLet'sTalk campaign leveraged multi-channel media to disseminate information and facilitate discussions on mental health. Utilizing the hashtag slogan and their existing platform, the organization generates significant annual fundraisers. In partnering with both national and local organizations (e.g., CAMH, grassroots organizations), Bell Let's Talk empowers community voices to reach broader audiences through investing funds raised.
- **Japan:** The "I AM" campaign involved public figures and celebrities sharing their stories and experiences in coping with mental health disorders. The aim was to normalize conversations about mental health, particularly on the topic of depression, and to encourage individuals to seek professional help. The campaign raised awareness about mental health as it was promoted on television, social media, and public forums.
- **UK:** The Time to Change program involves a multipronged approach to fighting stigma at the national level. Headlined by a national, high-profile anti-stigma campaign, the program leverages national advertising, PR, social media, community engagement levers and information resources to drive behavioral changes towards those with mental health disorders. The organization prepared by gaining a deep foundational understanding of where exactly stigma was rooted in UK society by conducting a national survey of those experiencing mental health problems as well as follow-on workshops exploring stigma and discrimination.



2.

Supporting stigma-reduction campaigns targeted towards specific populations

What challenge(s) does this solve?

To effectively target long-held social and cultural values amongst specific populations, an understanding of which groups hold stigmas against patients with mental health disorders is important to maximize impact. Past campaigns addressing public stigma have shown short-term effects but often fail to significantly change long-term public perceptions of mental health disorders.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To target specific populations, the following elements may be leveraged:

- Gathering/evaluating demographic data and holding research discussions with target populations to understand where stigma is rooted. Continuing to evaluate campaign effectiveness/reach through data-driven insights on site visits, views, and engagement metrics.
- Customizing campaign messaging to reflect specific cultural, social, age-related dynamics.
- Leveraging various platforms based on reachability of target audiences (e.g., social media towards youth, multimedia for middle-aged audiences).
- Collaborating with existing leaders and organizations to leverage factual databases, insights on past campaign effectiveness, and amplify reach to audiences through the leaders' platforms (e.g., in the United States: NAMI, SPAA, leading clinicians/KOLs).

Successful examples:

- **US:** The Mental Health Care Works Campaign was rolled out in 2024 through the American Psychiatric Association Foundation. Nationwide public service announcements have garnered 323 million impressions over its first year. Beyond providing disorder-specific information and resources, the campaign centers on personal storytelling to reach the audience.⁵¹
- **UK:** The Time to Change program conducted surveys and dedicated discussions with an identified target audience to uncover which stigmas were held amongst the population being addressed. The target audience for awareness campaigns has been identified as middle to lower socio-economic groups in their mid-20s to mid-40s, based on their potential impact and medium-level proximity to individuals with mental health issues (excluding immediate family, but including those with friends or colleagues with mental health disorders). These "subconscious stigmatizers" were chosen as targets accordingly, and the resulting campaign directly addressed these findings.⁵²



3.

Empowering advocacy organizations and physician groups with increased resources, and where resources are scarce, focus efforts on improvements to existing infrastructure

What challenge(s) does this solve?

In many countries, national advocacy efforts struggle to create change because of regional fragmentation, as well as the national health structure and budgeting process. In other countries, grassroots organizations are just starting to gain influence but are fighting the deprioritization of mental health resources. These organizations need more resources and platforms/partners to reach the ear of policymakers.

Which regions could this be a priority to implement?

Global

What will this approach look like?

Avenues to better equip advocacy organizations and physician groups to drive change include:

- Focusing local advocacy groups and/or psychiatric associations on partnering with regional groups (e.g., European Psychiatric Association) to bolster their voice.
- Partnering with patient advocacy groups in other diseases to learn best practices for increasing influence.
- Coordinating local efforts through creation of a centralized national advocacy group (e.g., NAMI in the United States) to share lessons, set precedents for local change, and increase efficiency of resources.
- Focusing on enhancements to the existing system, rather than an overhaul of the mental health care system in areas with slim resources.
- Focusing on creating economic and outcomes data and making these results public.
- Leveraging evidence, including what specific countries have implemented into their mental health care systems, to make the economic and outcomes-based case to implement pilot programs.

Successful examples:

- **United States:** NAMI leverages a local/national approach to driving change and raising awareness, including from a policy standpoint. While state organizations push to promote legislative changes and drive awareness locally, they also collaborate through the national organization in aligning advocacy efforts to amplify their efforts.
- **France:** UNAFAM operates local support groups for families and friends of individuals with various mental health disorders (e.g., Profamille for Schizophrenia). Additionally, they collaborate at the national level to drive advocacy efforts and raise awareness, as well as influencing mental health disorders policy.



4.

Educating and equipping religious leaders with resources to disseminate accurate information

What challenge(s) does this solve?

Public stigma shaped by deeply rooted societal beliefs and norms is often difficult to address through traditional anti-stigma campaigns. Instead, close collaboration with trusted societal influencers and healthcare professionals can help drive more effective outcomes. Equipping these influencers with accurate information can help guide individuals toward appropriate care and reduce stigma at the community level.

Which regions could this be a priority to implement?

Middle East

What will this approach look like?

To appropriately equip religious leaders and healthcare providers with the ability to inform and provide mental health care, the following approaches are important to leverage:

- Educating providers on how to incorporate cultural and societal considerations into care, starting at the earliest level of medical education. Primary care physicians are also key to engage, as they handle a significant volume of mental health care in countries such as Saudi Arabia
- Engaging trusted societal influencers and community leaders early on the importance of mental health care to overall health and quality of life
- Encouraging educational reform for both healthcare providers and influential community figures, and fostering collaboration between societal institutions and the healthcare system
- Providing resources, tools, and training to community leaders and local organizations to support mental health awareness and guide individuals toward appropriate care



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5.

Incentivizing employers to accommodate employees with mental health disorders through programmatic adjustments and environment restructuring in the workplace

What challenge(s) does this solve?

Individuals with mental health disorders in the workplace face challenges around reduced productivity and increased absenteeism. As a set of diseases that do not typically present with obvious physical signs, protecting patients with mental health disorders in the workplace can be challenging. By enforcing the right policies and offering ample resources, companies can improve their own financial performance while contributing to the growth and development of their employees.⁵³

Which regions could this be a priority to implement?

Global

What will this approach look like?

- Incentivizing voluntary workplace mental health programs for companies to adopt.
- Establishing financial disability benefits for individuals with mental health disorders that reduce their ability to work continuously or productively.
- Providing clear referral programs to direct those facing mental health challenges to the appropriate care, resources and tools.
- Implementing policies to prevent discrimination against persons with mental health disorders in the hiring process, as well as in performance evaluation.
- Implementing legislation requiring health benefit programs to treat mental health benefits as equal to those for medical, surgical benefits (e.g., the Mental Health Parity and Addiction Equity Act [MHPAEA] in the United States).
- Providing employers and management with guidelines and training on how to support employees with mental health disorders.

Successful examples:

- **Japan:** According to Japanese law, certain employers are required to provide employees with the opportunity to undergo a “Stress Check” aimed at early identification of work-related mental health issues. If a doctor recommends measures to improve an employee’s mental health after reviewing the results, the employer will be obligated to implement reasonable adjustments including reducing working hours and overtime, limiting business trips, or easing the employee’s workload.⁵⁴
- **United States:** The Americans with Disabilities Act (1990) prohibits discrimination against individuals with disabilities, including those with mental health disorders in areas such as employment. Employers are required to provide reasonable accommodations to employees with disabilities in terms of work scheduling, responsibility restructuring, and modifications to working environments. The act prohibits employers from asking disability-related questions and enables confidentiality for those with various health concerns. MHPAEA (2008) requires health benefit plans to treat mental health and substance use benefits the same as medical or surgical benefits.

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- **UK:** The Equality Act (2010) strengthens anti-discrimination laws, including those related to mental health disorders. It prohibits various forms of discrimination and requires employers to make reasonable adjustments for those with disabilities. Patients with fluctuating symptoms and chronic disorders (e.g., depression vs. schizophrenia) are protected regardless of their medical status. The act also puts into place hiring protections around what can or cannot be asked during an interview process.⁵⁵

6.

Integrating mental health education into curricula across grade school levels, ensuring early exposure to the idea of mental health

What challenge(s) does this solve?

Education on mental health from a young age helps to instill the importance of mental well-being as a cultural priority. This can foster emotional well-being and prevent future mental health issues. It can also create an understanding that it's okay to seek help, speak about mental health, and show where one can do so. The potential to impact cultural and social values related to mental health is highest in younger age groups, paving a pathway for broader acceptance and awareness.

Which regions could this be a priority to implement?

Latin America, Middle East, APAC

What will this approach look like?

The following considerations can help implement effective educational programs:

- It is best to integrate mental health education into grade school curricula starting from an early age, and continuing through later levels of learning. Leverage mental health providers (e.g., social workers, psychologists and child/adult psychiatrists) in developing specific classroom initiatives to effectively educate students. Train and equip teachers with the appropriate lesson plans and activities to confidently deliver engaging content.
- Establishing partnerships between the Ministries of Health and Education, as well as socially focused state entities to develop effective messaging and prioritization of topics based on country-specific cultural and social nuances.
- Including the involvement of student caregivers and teacher training to create a system of support and positive reinforcement.
- Continuously assessing the performance of educational initiatives through feedback from various stakeholders.



Successful examples:

- **Australia:** The Australian government introduced the National Children's Mental Health and Wellbeing Strategy in 2023. One key focus area is the education setting, where schools and early childhood centers are encouraged to integrate discussions about mental health and wellbeing into their daily routines, ensuring staff and students have opportunities to participate in these conversations. The MindMatters program was also implemented in secondary schools via funding from the Australian Government Dept. of Health and Ageing, and ~65 percent of Australian secondary schools use this program.⁵⁶
- **United States, Canada:** Sources of Strength, founded in 1998, is currently implemented in thousands of middle and high schools throughout the United States and Canada. With a focus on suicide prevention and mental health promotion, the program has shown through evidence-based results that it can positively change behaviors and attitudes amongst youth towards mental health. By leveraging "Peer Leaders" to promote help-seeking, coping behaviors, and appropriate identification of adult resources to provide guidance, they seek to change community-based behaviors.^{57,58}
- **Greece:** The Living and Learning Together program aimed to increase the level of awareness and reduce dropouts related to mental health issues in schools. The program, implemented to cover over 6,000 students, teachers and parents, showed improved knowledge on both mental health and awareness surrounding stigma.⁵⁹

Conclusions: The burden of mental health disorders

Based on current data and global expert insights, there is still a high level of need—as well as a high potential impact—that comes with investing in education to address public stigma. It is crucial to have an evidence-backed understanding of this need, and historical examples that demonstrate the potential to shape the public's perceptions around mental health disorders. Governments should consider investing resources to advance these initiatives, while patient advocacy groups, physician groups, international organizations, and NGOs should collaborate to progress and amplify awareness efforts. Medical educational institutions and school systems should also play central roles in driving awareness of the social burden of mental health disorders and enhancing implementation of educational and anti-stigma efforts to support patients getting the right care.

Addressing stigma will not mitigate all the economic burden caused by mental health disorders. That said, by implementing some of these solutions, patients may seek care earlier and start treating their disorder earlier. Better diagnosis and better treatment would certainly help patients progress, and may reduce long-term medical and social consequences.



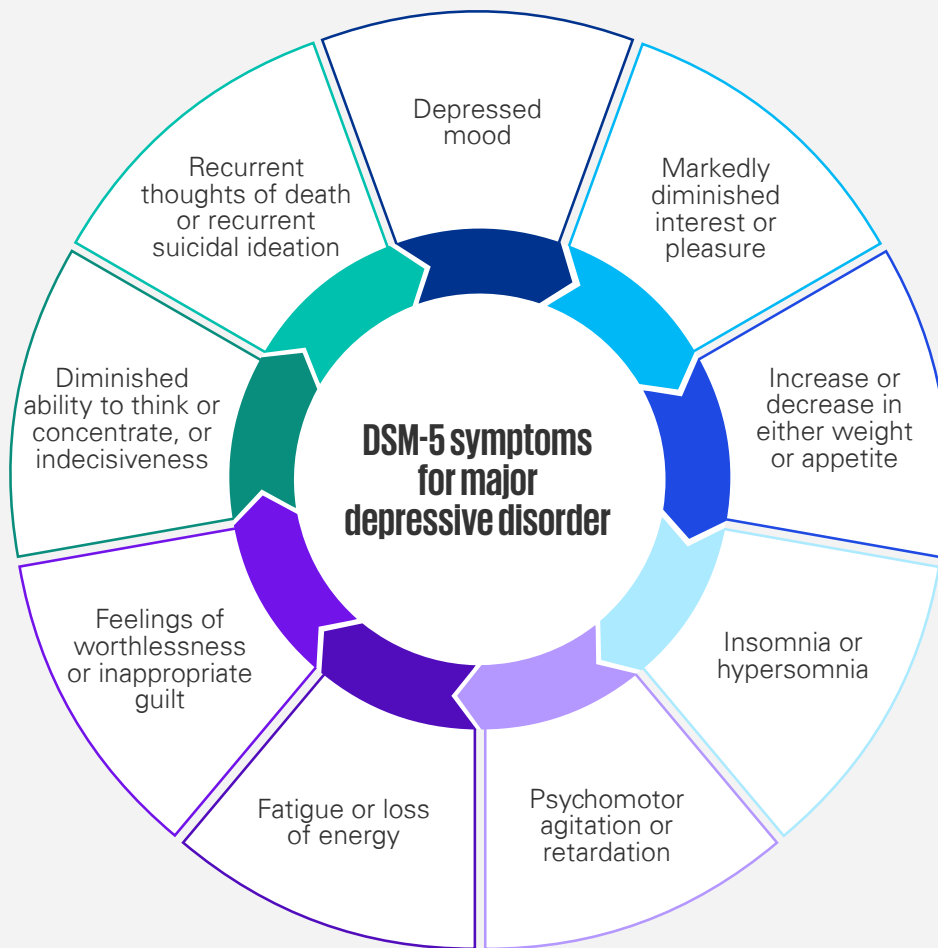


Mental health disorders are highly complex and require tailored care and access to innovation

Mental health disorders are complex and can be impacted by a combination of biological (e.g., physical health, genetics, diet, sleep, age), psychological (e.g., beliefs, perception) and social (e.g., relationships, family, culture, housing) factors. The heterogeneity of these disorders can make diagnosis, as characterized from the Diagnostic and Statistical Manual of Mental Disorders (DSM), extremely difficult. For example, the most recent DSM, DSM-5, for major depressive disorder (MDD) is comprised of nine different symptoms (Figure 4) with the presence of five or more symptoms necessary for a positive MDD diagnosis. When accounting for the different sub-symptoms, there are ~1,000 combinations of symptoms that can qualify for an MDD diagnosis.⁶⁰ Indirect costs, as noted earlier, are expected to reach \$4T, primarily driven by lost productivity and lost income due to disability or death.⁶¹



Figure 4: DSM-5 symptoms for major depressive disorder⁶²



The manifestation of mood disorders can differ across patients. For example, in depression some patients may have decreased appetite and lose weight; others may overeat and gain weight. Not only are there nine symptoms for MDD, but many of the drugs that are prescribed to treat MDD have side effects that may overlap with some of the symptoms used to diagnose MDD (Figure 5). Additionally, patients have different outcomes with different medications.



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Figure 5: DSM-5 Criterion Symptoms v. Antidepressant Side Effects⁶³

Symptom	DSM-5 Criterion Symptom	Antidepressant Side Effect
Depressed mood	Symptom is part of DSM-5 Criterion but	not Antidepressant Side Effect
Markedly diminished interest or pleasure	Symptom is part of DSM-5 Criterion but	not Antidepressant Side Effect
Increase or decrease in either weight or appetite	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Insomnia or hypersomnia	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Psychomotor agitation or retardation	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Fatigue or loss of energy	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Feelings of worthlessness or inappropriate guilt	Symptom is part of DSM-5 Criterion but	not Antidepressant Side Effect
Diminished ability to think or concentrate, or indecisiveness	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Recurrent thoughts of death or recurrent suicidal ideation	Symptom is both part of DSM-5 Criterion and an Antidepressant Side Effect	
Anxiety	Symptom is not part of DSM-5 Criterion	but is an Antidepressant Side Effect
Sexual dysfunction	Symptom is not part of DSM-5 Criterion	but is an Antidepressant Side Effect



We need for general practitioners to better understand mental health in terms of medication and orientation. There is a lack of information for patients on the availability of services in their local settings. GPs/PCPs can also have a strong impact on giving info and orienting people to relevant services."

Patient Advocacy Group Leader, France



The complexity and diversity of patients with mental health disorders would point towards the need for more tailored care. In an ideal situation, clinicians could draw on a data-driven approach for personalized predictions to identify which therapeutic approach would be most beneficial for their patient, however, this does not exist today.⁶⁴ To strengthen the ecosystem, there are a number of unmet needs that should be addressed, including:

- Improved integration across healthcare practitioners: Leveraging a team of health care providers including general practitioners, mental health specialists, and nurses to enable the appropriate diagnosis, triage, and treatment of patients.
- Sufficient time with physicians: The ability for physicians to spend more time with patients may allow them to better identify a unique blueprint.
- Better trained primary care physicians: Physicians equipped with a better understanding of mental health disorders, and the ability to identify patients who need help.
- Better therapeutics: Innovative therapeutics with improved efficacy or reduced side effects can help patients maintain their treatment regimen or target specific patient populations.



Currently, efforts are ongoing to connect primary care to community mental health care. The current disconnect between primary care and mental health care often means patients seek PCP care for mental health first. This sometimes leads to misdiagnosis and symptom deterioration in the interim prior to seeing a specialist.”

Psychiatry KOL, Canada

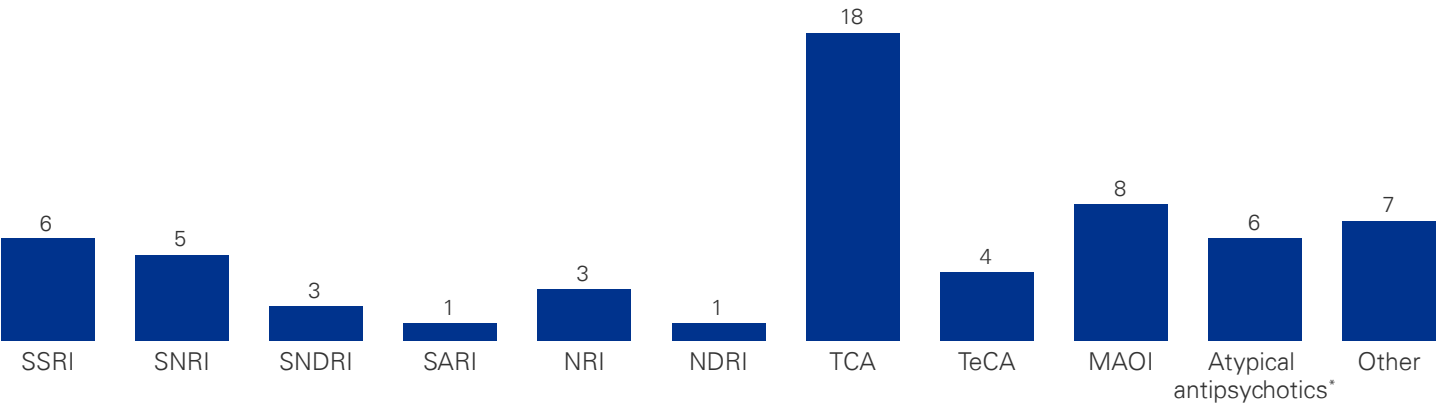




Globally, a large proportion of populations are restricted in their access to quality mental health care due to the lack of providers and support teams. In the United States, where significant mental health workforce investments have been made, about 122 million Americans (~36 percent of the population) still live in mental health provider shortage areas. And the workforce supply of adult psychiatrists is projected to meet less than half of expected demand by 2036 due to both patient population growth and professional burnout and retention.^{65,66,67} In many other countries, the ratio of mental health providers and support care teams is much lower than those in the United States.⁶⁸ WHO data suggests that while high-income countries have about one mental health worker per 2,000 people, low-to-middle income countries may have fewer than one per 100,000 people.⁶⁹ Even in areas where mental health care resources are greater, KOLs cite the need for new therapies to effectively treat patients with resistance to treatment standard of care. They also see access constraints limiting effective treatments to clinical setting administration (e.g., novel therapeutics, transcranial magnetic stimulation [TMS], electroconvulsive therapy [ECT]).

Treatment options are plentiful, with more than 30 therapeutics approved for depressive disorders in the United States across over 10 different drug classes (Figure 6). Even with those options, suboptimal efficacy and tolerability can lead patients to cycle through multiple therapeutics, often without success.

Figure 6: Number of approved molecules for depressive disorders in United States⁷⁰



1. *Excludes atypical antipsychotics indicated only for bipolar depression

“ We are able to manage most of the patients with the current therapies but it isn't perfect. After some time with the drug, the body develops tolerance or new side effects, so it complicates issues down the road. Personalized psychiatry has been a dream for a long time, but we are currently just doing trial and error.”
Psychiatrist, United States





Key global challenge:

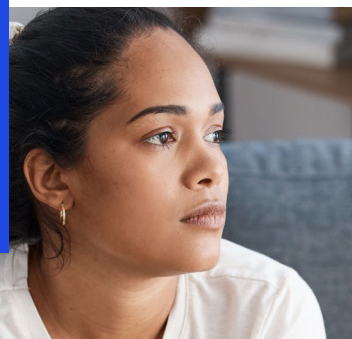
Lack of, and limited access to innovative medicine

The existence of and accessibility to new treatments for specific patient populations is another critical gap. Innovative treatments for mental health disorders have certainly advanced over the past decade, however neuropsychiatry is inherently complex, making treatment highly challenging and making the need for investment that much more crucial, especially from public/private collaborations. The heterogeneity of mental health disorders requires the development and distribution of highly tailored and targeted treatments that can more effectively treat the underlying causes of these very different diseases. Additionally, access to innovative medicines from health technology assessment (HTA) agencies to treat mental health disorders has been considerably lower than innovative medicines that treat physical conditions. For example, in cost-effectiveness HTA countries, negative HTA outcomes in major depressive disorder was more than four times higher than the basket of hepatitis C, melanoma, AMD, psoriasis, COPD, schizophrenia, and bipolar disorder.⁷¹ Furthermore, over the past 10 years, there have been 31 FDA-approved indications from 21 products within the mood and psychiatry space. Comparatively, in EMA, over the same time period, only seven indications in seven products were approved.⁷²



We need more options with better efficacy. We see about 60 percent of patients respond to the first antidepressant, but what about the other 40 percent? Then there is the issue of repeated onset. This is an issue with all of the antidepressants."

Psychiatrist, United States



Regional insights

North America

In North America, efforts to advance access to innovative treatments have been led through innovation and investment in research, with interviewed experts citing improved access to neurotech solutions and medicines. In Canada, the Centre for Addiction and Mental Health was created to drive funding and resources for mental health research projects,⁷³ while in the United States innovation through new interventions and novel therapeutics have opened up avenues for treatment where patients previously had few or no effective treatment options.^{74,75,76}

Still, several barriers are cited by interviewed experts. In the United States, step therapy requirements for novel therapeutic access may delay access to urgent treatment for Treatment-Resistant Depression (TRD) patients. Nearly half of patients experience access issues in obtaining their first treatment session. In Canada, less than half of provinces and territories fund rTMS through the public system as of 2020.^{77,78,79,80,81,82,83,84}



Western Europe

Similar to the United States, European countries have helped advance the pool of new medicines by bringing new products to market, and strengthening access to effective treatments—including TMS, ECT, and CBT.^{85,86} Research projects such as those funded by the Fondation de France and leading medical institution collaborations have contributed to innovation efforts as well including leading Europe-wide platform studies and supporting biomarker discovery.^{87, 88} The health technology assessment (HTA) used to help countries decide on how to use, price, and reimburse new medicines is a barrier for innovative medications to reach the European market as it often references generic drugs as the benchmark price. This leads to fewer innovative drugs being introduced into Europe compared to the United States and impacts the number of newer options physicians have available to treat different patient segments. While experts cite a need for continual investment in research for medicines targeting difficult-to-treat populations, as well as collaboration between countries to improve implementation of innovative solutions (e.g., facilitating access to treatments restricted by hospital-only administration), concerns exist around innovative medicines being available in the market. Interviewed experts cited a need for embedding innovative new medicines and technologies into the patient treatment paradigm as a driver towards improving market availability.^{89,90}



Innovation is ongoing, but implementation is the main hurdle. Treatments like novel therapeutics and TMS are great, but hard to use in daily practice because of their locational and step-through restrictions.”

Psychiatry KOL, Spain

Latin America

Broad adoption of new medicines has been limited due to resource constraints within Latin America. Interviewed experts report overall resourcing constraints that result in research efforts being limited to major institutions with better funding, with regional studies highlighting significant access restrictions. With limited local data and more pressing infrastructural concerns for public provision of mental health care services, access to innovative treatments is not cited as a top priority by interviewed experts. In Brazil, even older ECT services through the public system have been found to be limited to a small number of academic service settings, while in Mexico, for the ~40 percent of the population that is uninsured, drug shortages owing to budgetary restrictions in the public setting mean that even the more basic medications for mental health are subject to significant out-of-pocket expenses. Regional experts cite limited availability of innovative medicines, but even greater concerns regarding accessibility of standard mental health pharmacotherapeutics.^{91,92,93}



Even with standard mental health medicine, pharmacies often run out of supply, forcing patients to drop out of their regular therapy.”

KOL, Brazil



Middle East

Similar to Latin America, the Middle East faces limitations facilitating access to newer, expensive medicines requiring clinical administration based on geographic barriers in particular—primarily in Türkiye and in Saudi Arabia. Experts in Saudi Arabia and Türkiye cite availability of treatments for severe patient populations like Treatment-Resistant Depression in urban care hubs, but low availability in community mental health settings. In Türkiye, local KOLs cite good coverage for new medicines in the public system, owing in part to an emphasis on pharmaceutical treatment for mental health disorders over psychosocial care and, although good coverage exists, disparate mental health clinic concentration makes it difficult to provide access to these medicines broadly. In Israel, innovation has come by way of considerable improvement in access to treatments such as TMS and ECT.⁹⁴ Access to innovative medicines is still, however, viewed as an area needing major improvements. Mental health competes for medication funds against other therapeutic areas in the “Health Basket” system, making it difficult to grow the funds available according to local KOLs.^{95,96,97}



Minimal local production of drugs, and restrictions on imports contribute to interruptions in treatment courses for patients with mental health disorders.”

KOL, Türkiye

Actionable solutions

Each of the following solutions could be deployed across geographies to address unmet needs for patient populations with difficult-to-treat mental health disorders. Through expert KOL, physician, and patient advocate discussions combined with secondary research, the following solutions were identified as potential areas for regions to prioritize. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Lack of innovative medicine



Increased investment in developing treatments that address the most difficult-to-treat mental health disorders, while also investing in the access to medicine



Invest in expanding access to innovative medicine due to site-of-care limitations, and increase national budgets allocated to mental health drug supply



1.

Increase investment in developing medicines that address the most difficult-to-treat patients, while also investing in the portability of treatments

What challenge(s) does this solve?

To meet the gap in treatment for patients with mental health disorders, research needs to target innovative solutions and delivery for existing solutions not yet widely available. While oral pharmacotherapeutic options for MDD and Schizophrenia are often available and accessible (e.g., traditional antidepressants, clozapine), there are often access restrictions for new and innovative medicines.

Which regions could this be a priority to implement?

United States/Canada, Western Europe, APAC

What will this approach look like?

To establish these capabilities, the following actions may be considered:

- Design and establish networks of professionals and researchers to collaborate on research projects dedicated to specific mental health disorders. Leverage central authority bodies (e.g., NIH in the United States) to convene parties to collaborate.
- Increase levels of federal funding towards research projects on new mental health treatments.
- Continue industry investment from medical technology and pharmaceutical companies in research initiatives targeted at populations with the greatest level of need.
- Fund investigator-led research through leading institutions on new treatments. Many markets lack the resources to fund these studies locally.
- Allocate additional federal funding to bridge research projects into services. Focus on implementation of research initiatives regionally and locally.
- Designate funds to leading academic programs in urban hubs to conduct research on the impact of new mental health treatments on local populations within countries/regions.
- Leverage public mental health campaigns to raise money towards investing in national research programs.

Successful examples:

- **United States:** Since 2008, multiple companies have invested in research and brought new TMS technology to market for major depression, treatment-resistant depression, and anxiety.
- **United States:** Since initial approval in 2019 by the FDA for treatment-resistant depression, novel therapeutics have met a critical need for patients without previous pharmacotherapeutic options to address their symptoms. Additionally, experts cite the rapid onset of relief as a key value-add relative to antidepressant use.⁹⁸

**2.**

- (A) Invest in expanding access to innovative medicines due to site-of-care limitations
- (B) Increase national budgets allocated to mental health drug supply

What challenge(s) does this solve?

While many countries in established markets are continuing to enable better access to innovative treatments, other regions have greater barriers to access for new treatments in the public mental health care setting. Even so, North America, Western Europe and APAC have limited access to newer medications due to site-of-care limitations for innovative medicines. In Latin America and the Middle East, similar site-of-care limitations are cited, but even more concerning are the financial restrictions in obtaining generic medicines for mental health disorders to due supply constraints—often as a result of not having national backstock agreements in place with manufacturing companies.

Which regions could this be a priority to implement?

- (A) United States/Canada, Western Europe, APAC
- (B) Latin America, Middle East

What will this approach look like?

(A)

- Invest in expansion of existing hospital facilities, as well as outpatient mental health clinics to facilitate access to novel medicine and treatments.
- Expand guidelines to include more impactful treatment options. Formularies should reflect these changes, and physicians should be able to prescribe these treatments in the public setting more regularly.
- Update physician association guidelines to include the latest evidence-based practices for academic use, clinical use, and to guide insurance policy decisions.
- Consider easing step-through criteria for patients with the highest level of need in the short-term through public policy statutes or regulatory provision or private policy exceptions.

- Expand public insurance programs to cover broad mental health services, including a wider range of treatment options via pharmacotherapies and tech-based solutions.
- Encourage collaboration between physician associations, patient advocacy groups and international organizations to voice concerns around access for new medicines, especially as it relates to funding in the public setting.

(B)

- Establish stocking agreements with drug manufacturers to ensure a more consistent supply of medicines, including newly approved treatments



Successful examples:

- **Taiwan:** Based on evidence produced demonstrating the benefits of LAIs reducing rehospitalizations for patients with schizophrenia in 2024, the National Health Insurance Department plans to increase the budget for LAIs to NTD 3.1B in 2025. LAI use climbed ~23 percent between 2022 and 2023.^{99,100}
- **United States:** Through Medicare and Medicaid, subsidies for mental health treatment are provided for low-income individuals, those with disabilities, and elderly patients. Beyond care in various settings, they cover psychiatric services inclusive of prescription medicines.¹⁰¹
- **Australia:** As of 2024, Australia's Medicare program chose to incorporate ECT into the benefits schedule, expanding access to effective medication options for severe mental health patients.¹⁰²

Conclusions: Mental health disorders are highly complex and require tailored care

Based on current data and expert insights, there is global concern that quality mental health care needs more investment to overcome current challenges.

Workforce shortages are projected to continue into the foreseeable future. To tackle this issue, investments to grow the mental health workforce need to be amplified by leveraging proven solutions such as care models in the primary care and specialty settings. There is a global call for investment in research to find new medicines and technologies, and to broaden access to the latest treatments. Care delivery may be activated through careful collaboration across mental health ecosystem stakeholders—in particular, with leading efforts from government, industry, physician groups, and medical institutions.





Support structures are needed to drive tailored patient care

Policy-based actions to enable access to mental health care can help ensure the right infrastructure and mechanisms exist to provide tailored treatment across patient sub-populations. This should be done at both the national and local levels. To meet the mental health care needs of populations by jurisdiction, policymakers and public health organizations should enable the resources necessary to plan and implement effective solutions. Other stakeholders, including medical educational institutions, NGOs and advocacy groups also have important roles.

Globally, many patients continue to face basic accessibility challenges in receiving mental health care. In low- and middle-income countries, about 75 percent of people with severe mental health disorders do not receive any treatment,¹⁰³ while in more established markets treatment still does not reach all those in need. Data from 2022 collected by the National Institute of Mental Health showed 59.3 million adults in the US had a mental illness with 30.0 million of these adults receiving mental health treatment over the past year.¹⁰⁴ It's evident that there is a global need for a better distribution of infrastructure and resources to deliver more tailored care. Despite the challenges that exist, countries and their governments continue to work to address mental health care access (see examples in Figure 7).

Figure 7: Example Mental Health Care Access Initiatives^{105,106,107,108,109,110,111,112,113,114,115,116}



United States

- Certified Community Behavioral Health Clinics have facilitated access to community mental health care for over three million people.
- The 2014 Excellence in Mental Health and Addiction Treatment Expansion Act paved the way to the operability of these Certified Community Behavioral Health Clinics.



Canada

- Mental Health Promotion Fund is a long-term strategic funding program created to enable community-based interventions to reduce barriers to mental health care and well-being, for Canadian youth and their families.



Figure 7: Example Mental Health Care Access Initiatives (continued)



France

- Projet Territorial de Sante Mentale focused on improving the local level of accessibility and coordination to mental health care for territories across the country.



Spain

- The Mental Health Strategy of the National Health System 2022-2026 stresses the importance of strengthening mental health care in the primary care setting and prioritizes mental health in childhood and adolescence by emphasizing the importance of schools having health professionals who can promote emotional health and detect problematic signs of mental health or suicide risk.



Australia

- The National Mental Health Workforce Strategy 2022-2032 provides a vision and roadmap towards sustaining the mental health workforce.



Brazil

- Psychosocial care centers (CAPS) have been a focal point of investment in community level outpatient mental health care.



Türkiye

- Policy in 2009 established a plan to implement Community Mental Health Centers. These centers received increasing investment to facilitate local access to mental health care with an emphasis on psychosocial, multidisciplinary support services.
- As of 2024, 184 centers were in operation.



Israel

- National mental health reform in 2015 facilitated expanded access to community mental health care, with dozens of new facilities opening as a result.
- Coupled with reformed social security “health basket” coverage of mental health care services, as of 2020 about 30,000 people were receiving mental health care in the community rehab setting.
- Psychiatric hospital budgets during 2000-2001 reform through the “RMD” law were not reduced, despite a focus on shifting mental health care towards the community setting.



Japan

- In 2024, amendments to the Mental Health and Welfare Act were released that included enhancing systems to support persons and children with disabilities in the community, in particular for those with mental disorders.



Key challenges

Throughout the research conducted, the following key challenges were uncovered. Each represents an opportunity for mental health ecosystem stakeholders—governments most of all—to strengthen the pillars that facilitate access to quality mental health care:

Support structures are needed to drive tailored care



Insufficient community mental health care services



Decreasing inpatient hospital infrastructure for acute mental health care



Lack of community residential mental health care facilities



Insufficient resourcing for psychosocial support programs

To address each of these challenges, resources are required and collaboration between stakeholders is critical. Governments, physician groups and associations, educational institutions, and patient advocacy groups have unique responsibilities to drive these efforts. While there is no singular approach that addresses each challenge, by examining past successful approaches and accounting for country-specific nuances, we can inform future approaches.



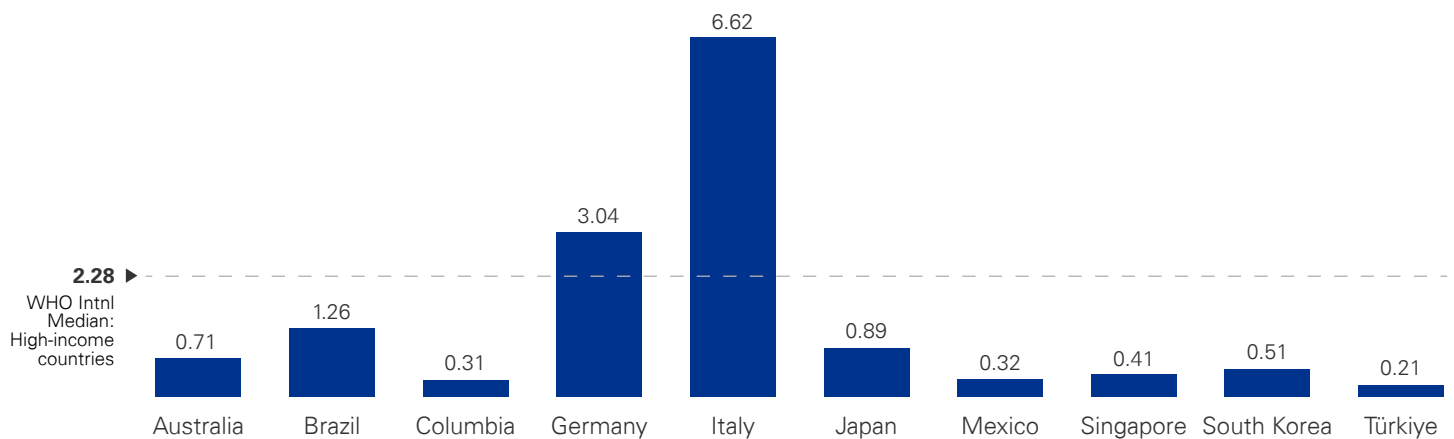
Key global challenge:

Expansion of community mental health care services

Strong community mental health care is essential for early detection and treatment, continuity of care, and supporting mental health in everyday environments like schools and homes. It is particularly vital for rural and underserved populations, where access to specialized services is limited. In addition, it can sometimes be difficult for primary care physicians to provide accurate diagnosis/treatment for less severe cases, and care continuity (follow-ups and referrals) can be low for patients in rural settings. Despite need, the majority of examined countries fall below the WHO median for high-income countries in the number of community-based mental health facilities per 100,000 population (Figure 8). Significant regional and country-specific variability exists in resources dedicated and infrastructure implemented to build-out community mental health care services.



Figure 8: Community-based mental health facilities^{117,118,119}



Regional insights

North America

Approaches to expand access to community mental health care in the United States and Canada have included placement of additional care centers, training primary care physicians to provide mental health care, telehealth incentivization, and guideline standardization. Creative financing has further supported these efforts,^{120,121} however, interviewed experts cite a continued need to invest in community mental health care resources.^{122,123} For example, while only 16 percent of primary care visits included a behavioral health component from 2016-2018 in the United States, integrated care models had yet to be implemented nationally, with issues including technology limitations, reimbursement challenges, and limited training of providers, support staff and community health professionals.¹²⁴ A US study in 2020 found that 60 percent to 80 percent of all primary care visits include a behavioral health component, demonstrating the priority of providing integrated care.¹²⁵



We need more care in place, especially at the community setting. There are some grassroots groups with ideas, and they try to find money to start projects and get funding. When they finally do get things going, they run out of money because they don't have validation. We see this all the time with small community mental health organizations."

Patient Advocacy Group, Canada



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Western Europe

Efforts to implement community health services look different across geographies. In Germany, the existing system revolves around inpatient psychiatric care, so funding for community mental health care is minimal.¹²⁶ And in France, despite the progress the Projet Territorial de Santé Mentale has had on improving outpatient infrastructure, hospitals remain the typical entry point for care for mental health disorders, as PCPs are not well trained for detection or management of mental health disorders.^{127,128,129,130} Significant regional variation in availability of community mental health care was reported across Spain and Italy given differences in territorial budget decisions.^{131,132}



At the community service level, Germany lacks community mental health services. Compared to countries like the United States and Australia, these services are rarely available."

KOL, Germany

Latin America

Across this region, experts cite a critical undersupply of mental care services in the community setting. While CAPS psychosocial centers have been a focal point of investment to expand access to community mental health care in Brazil, these centers are limited in their ability to serve a range of mental health disorders, leaving many patients underserved.^{133,134} Policy priorities in Mexico and Colombia call for early detection, in part through the integration of mental health care into the primary setting, but community resources and infrastructure are inadequate to encourage early detection.^{135,136,137,138,139,140}



From a mental healthcare system standpoint, the best place to start strengthening capabilities is at the primary care community level, providing more options for rehab and treatment."

KOL, Colombia

Middle East

While there are ongoing efforts to build out the community level of mental health care in Israel, Türkiye and Saudi Arabia, each country faces gaps. In Israel, despite the addition of community mental health care infrastructure through 2015 policy reform, studies point to a lack of oversight and incentives to drive this level of care, while in Türkiye, the developing infrastructure of community mental health care services (~186 centers nationally) lacks the geographic footprint needed to service its broad population.^{141,142} In Saudi Arabia, data indicates the ratio of outpatient to inpatient facilities is insufficient to manage demand.^{143,144}



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Actionable solutions

Various solutions should be deployed to effectively address the persisting gap in community mental health care. Through expert KOL, physician, and patient advocate discussions and secondary research, the following solutions were identified. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Expansion of community mental health care services

- » Dedicating additional or reallocating healthcare funding towards outpatient mental health care infrastructure
- » Investing in expansion of and leveraging telemedicine capabilities
- » Investing in the training and placement of mental health care community workers to build capacity in the rural and community setting
- » Increasing the level of integration of outpatient centers to the mental health network (e.g., better referral systems)
- » Incentivizing mental health care providers to administer care to underserved areas
- » Placement of mental health care services and resources in the primary education setting



**1.**

Dedicate additional or reallocate healthcare funding towards outpatient mental health care infrastructure

What challenge(s) does this solve?

To support the appropriate professionals in providing mental health care in the community setting, publicly available clinics need to be created and/or strengthened. Targeted funding needs to be directed toward this infrastructure, in coordination with plans to place the relevant community care professionals (e.g., PCPs, mental health specialists). To date, investments in these services have increased access to care for difficult-to-reach patients and eased the burden on inpatient acute mental health care facilities. Investing in additional community centers alongside the appropriate workforce is key to providing coverage for rural and socioeconomically disadvantaged patients in the public setting—many of whom forego care entirely based on access limitations.

Which regions could this be a priority to implement?

Global

What will this approach look like?

The following levers can be considered to bolster available infrastructure in the community setting:

- Appropriate funding needs to be allocated to building and equipping community mental health care centers in underserved and rural areas (inclusive of integrated primary/mental health care).
- Assess the highest-need communities to prioritize placement of centers based on current service coverage for mental health care and/or primary care. Creation and collection of geography-specific physician supply data should be facilitated by Health Ministries as national initiatives to identify high-need areas.
- Develop strategies to place the appropriate workforce in underserved areas, inclusive of incentives to relocate professionals, plans to leverage telehealth, and expanding educational programs (e.g., rurally based training and rotations).

Successful examples:

- **United States:** Dedicated funding—The United States government provides dedicated funding through HRSA to qualified health centers, enabling more comprehensive outpatient services in the community setting. There are additional grants available to enhance healthcare programs in rural areas. Often, these centers are focused on underserved areas with affordable care payment options. The Substance Abuse and Mental Health Services Administration has focused investment in outpatient mental health services, including the Primary and Behavioral Health Care Integration plan (2009) to fund co-located behavioral health care in the community setting.¹⁴⁵
- **France:** The Projet Territorial de Santé Mentale project has contributed to localized mental health care in the community setting across French territories. National and regional health budgets are drawn upon to foster community-based outpatient mental health care, including creation of the appropriate care centers.



Case study

Category: Community-based care

Subcategory: Integrated primary care teams

Israel: The National Mental Health Insurance Reform has transformed mental health care by integrating it into the national health insurance basket. Since 2015, mental health services have been provided through the country's four public health funds (HMOs), ensuring affordable access to psychiatric and psychological care. This reform shifted focus from hospital-based treatment to community-based outpatient clinics, expanding localized services and embedding mental health professionals within primary care settings to promote early intervention and reduce stigma. This initiative has expanded community-based outpatient mental health services, with over 340 clinics nationwide by 2025. Public investment has grown to NIS 1.4 billion annually, supporting the opening of new clinics and employing clinical staff.

- **Australia:** Youth Support—The Headspace program, funded by the national department of health, offers mental health services at local community centers that target those between the ages of 12 and 25. As of 2023, ~55 percent of the services in operation are in towns, villages and small cities. Services are also provided through online platforms.^{146,147}

2.

Invest in expansion of and leverage telemedicine capabilities

What challenge(s) does this solve?

Leveraging telehealth is key to providing convenient, continuous mental health care in rural and underserved communities.¹⁴⁸ By enabling and expanding these capabilities, patients are not forced to travel long distances for less severe mental health care visits, and may be more likely to adhere to treatment plans with better care continuity. The flexibility in these services also expands appointment capacity beyond normal clinic hours.

Which regions could this be a priority to implement?

Global

What will this approach look like?

Various strategies can be considered to facilitate expansion of telemedicine use for mental health care:

- Improving access to telemedicine capabilities should be a part of national strategies. The foundation starts with ensuring proper infrastructure:
 - Investment and partnership to develop, implement and integrate digital health solutions with a national digital health platform or partnered Electronic Health Record (EHR) service.
 - Investing in the baseline technological infrastructure needed in the community mental health setting. PCP and specialist offices in rural settings should have basic access to internet, along with phone and web platforms to facilitate appointment creation at a minimum.
 - If technological infrastructure already exists (or once it

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is created), telehealth resources should be distributed to public community mental health care centers (e.g., computers, telehealth platform access).

- Set-up of telehealth platform connection between community settings and other levels of mental health care to enable collaborative care efforts (e.g., between community PCPs, hospital-based psychiatrists, private-public).
- Improve government-led policies providing quality insurance coverage for telehealth services, including reimbursement multipliers for rural care provided via telehealth.
- Train providers on telehealth as elements of continued

medical education and in medical school programs for psychiatry, general medical practice.

- Increase comfort and patient reception to telehealth services. Promote the importance of these services to patients in initial clinic visits.
- Reduce government restrictions on telehealth compliance for patient privacy (e.g., HIPAA), cross-geographic care coverage (e.g., across state or regional lines).

Successful examples:

- **Canada:** Telehealth incentivization—In British Colombia, physicians are incentivized via a telemedicine reimbursement multiplier, which is specific to covering care provided to rural areas.
- **Germany:** Telehealth requirements—Digital applications for mental health care are federally required to be covered by health insurance.
- **Australia:** Telehealth funding—The National Mental Health Commission funds access to online therapy, digital counseling platforms, and mental health apps. The national e-Mental Health Strategy drives integration for digital health services in the public health setting.

Case study

Category: Community-based care

Subcategory: Telehealth expansion

Colombia: The National Teleorientation Program for Mental Health has expanded access to psychological support nationwide through a free, 24/7 hotline and telehealth platform. Integrated into the public health system, the program provides immediate counseling, crisis intervention, and referrals, reducing geographic and financial barriers. Supported by the MoH and international partners, this initiative strengthens community-based mental health care and ensures timely assistance for vulnerable populations. By early 2024, over 6,400 individuals accessed counseling sessions, with coverage in all 32 departments, contributing to early identification of suicidal behavior and supporting underserved populations.



3.

Invest in the training and placement of mental health care community workers to build capacity in the rural and community setting

What challenge(s) does this solve?

To amplify the efforts of psychiatrists providing care in the community setting, it's necessary to invest in the training, education and placement of community mental health workers. Not only can these workers help to supplement access to care in underserved/rural communities, but also they can also help patients with social rehabilitation efforts through continuous care efforts.

Which regions could this be a priority to implement?

Global

What will this approach look like?

Investment in the training, education, and placement of community mental health support staff to supplement psychiatrist care provided in the community setting can be considered through a number of initiatives:

- Invest in the training and placement of mental health extenders (e.g., nurses, social workers, psychologists or psychotherapists) in the primary care setting.
- Invest in dedicated staff to structure treatment management plans for patients based on unique individual needs (e.g., nurse managers).
- Create a workforce plan to facilitate implementation of community mental health care support staff across primary care and specialist settings, inclusive of funding dedicated to education and training programs across mental health care support staff role types.
- Develop and implement training for certification of support staff in curriculums and as continued medical education. Incentivize these credentials and emphasize definition of career pathways for support staff roles in the educational setting.
- Enable insurance coverage policies that expand the settings in which mental healthcare can be administered economically, and the types of providers that can administer covered care. Allow the legal provision of mental health care from properly trained support staff.
- Train community members to support care provision (e.g., psychoeducation certification) in rural settings.

Successful examples:

- **United States:** Multidisciplinary teams in some primary care settings include mental health extenders—often licensed clinical social workers, psychologists, or nurses to provide lower-touch therapeutic care, patient education, and care coordination. Psychotherapy (e.g., Cognitive Behavioral Therapy) may also be offered in this setting. Mental healthcare in the primary care setting from various provider types has been a focus of expanded insurance coverage, while the Substance Abuse and Mental Health Services Administration has provided grants to support integrating primary care and mental health care services in the community setting.^{149,150}
- **The Improving Mood – Providing Access to Collaborative Treatment (IMPACT Model)** program integrates mental health treatment into primary care settings by combining the efforts of PCPs, care managers, and mental health professionals to deliver comprehensive patient care. This model has been shown in some cases to double the effectiveness of care for depression at 12 months.¹⁵¹



- **United Kingdom:** Integrated community care—Community Mental Health teams consisting of healthcare professionals, such as psychiatrists, social workers, and psychologists provide mental health services in local communities. The NHS Talking Therapies program for Anxiety and Depression services a large volume of lower-touch mental health care patients in the community setting, and outlines a comprehensive implementation plan for the mental health workforce across care settings and by staff/provider type, inclusive of community mental health care.¹⁵²
- **Australia:** Co-location—Integrated behavioral health care in the primary care setting enables support staff such as psychologists and nurses to co-locate in primary care clinics with PCPs. If patients are identified as having mental health disorders during their routine check-ups, then they can be referred to see the mental health professionals on-site for timely care. The Integrated Model for Primary Care Settings has shown to be an effective mental healthcare model in the rural setting in Australia, including increased communication effectiveness, cost savings, and patient adherence to treatment plans.¹⁵³
- **Mexico:** Non-profit and government partnership—Organizations such as Compañeros en Salud (CES) partner with local governments to provide care to highly underserved mental health care geographies. In Chiapas, CES trains community health personnel on an ongoing basis to enable diagnosis and treatment of various mental health disorders. The approach is multi-pronged: Nurses, doctors and supervisors are trained to provide quality care. Community members receive EP+ (Coping Problems Plus) training to teach psychoeducation groups and conduct home visits.¹⁵⁴

Case study

Category: Community-based care

Subcategory: Infrastructure investment

Brazil: The Psychosocial Care Centers (CAPS) reform transitioned Brazil's mental health care from an asylum-based model to a community-focused system. Central to this reform, CAPS provides multidisciplinary care for mental health and substance abuse disorders at the community level. Federal investment, alongside state and municipal contributions, facilitated the establishment of over 2,300 CAPS, significantly expanding access to mental health services nationwide. By reducing psychiatric beds and promoting community care, the reform has enhanced clinical outcomes and social integration for individuals with mental illnesses, marking a profound shift in Brazil's approach to mental health.



4.

Increase level of integration of outpatient centers to the mental health network (e.g., better referral systems)

What challenge(s) does this solve?

Community care centers can be limited in terms of their connectivity to the mental health network. The ability to refer patients to mental health specialty care from the primary care setting in a clear, easy-to-understand fashion is important to help patients receive higher-touch care. In many areas where PCPs are backlogged, the issue is magnified due to long wait times and concerns about quality of care. Misdiagnosis and mistreatment in the primary care setting can lead to patient symptom exacerbation in between PCP and specialist appointments.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To achieve improved system connectivity between community mental health care and dedicated mental health settings, the following can be considered:

- Establish a chain of care management between providers in various settings.
- Establish communication benchmarks for cross-team care coordination (e.g., periodic meetings between care teams).
- Enable continued education and dissemination of guidelines to PCPs on when, where, and how to refer patients, including equipping patients with resources to find and evaluate care options independently, in the absence of referral systems to specialty care.
- Facilitate access to resources in between primary and specialty care appointments for patients (e.g., connecting peer support groups).
- Enable government to partner with EHR and telemedicine companies to establish national platforms.
- Design a digital health platform and/or partner with existing organizations to provide these services sustainably to digitize community mental health care access. Patient engagement and care coordination will improve with simplification of the appointment-making process for initial visits, follow-ups and care provision at new centers.
- Implement EHRs to facilitate digital platform connectivity and higher levels of care continuity (e.g., record-keeping, telehealth platform, access to patient history).

Successful examples:

- **United States:** Collaborative care with digital—The collaborative care model approach enables PCPs and mental health providers to leverage an organized, digitized system that supports various modes of care (e.g., in-person visits, telehealth) as well as coordination across lines of care (e.g., from primary care centers to the hospital setting).
- **United States:** Digital platform integration—Kaiser Permanente's Mental Health Digital Platform integrates a digital health platform for mental health services across mediums. It bolsters connection and facilitation of communications between patients and healthcare providers, tracking patient's mental health data, and providing access to teletherapy and online resources.

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- **Saudi Arabia:** National digital platform—The national virtual care platform “Seha Virtual Hospital” facilitates free access to health care consultations, including for mental health care. Providers can refer patients to tertiary settings as needed.

5.

Incentivize mental health care providers to administer care to underserved areas

What challenge(s) does this solve?

The incentivization of psychiatrists to provide care in underserved areas is important to establish sustainable care in these settings. A comprehensive approach offering more favorable reimbursement, relocation incentives, and/or reimbursing the costs of mobile care is needed given the overall preference of mental health care practitioners to stay in urban centers. Further, programs can be adopted to dedicate proportional or part-time mental health care service time to rural settings. High resistance to relocating to rural areas to provide care full-time calls for a number of approaches.

Which regions could this be a priority to implement?

United States/Canada, Western Europe, APAC

What will this approach look like?

Various elements of incentivization are important to consider in adopting a successful strategy to sustain improved mental health care workforce supply rurally:

- Raise psychiatry, mental health support staff, and PCP salaries for relocation to rural settings.
- Reimburse telehealth to rural areas at more favorable rates.
- Offer loan repayment and forgiveness programs.
- Require “social service” clinical time as a part-time initiative to provide mental health and primary care to high-need areas as part of medical training programs. Earlier exposure to these programs to allow medical students time to reconsider specialization based on experiences.
- Offer favorable reimbursement for mobile/home-based care: covering costs of travel for providers to visit patients, reimbursement multipliers or compensation boosts.
- Eliminate restrictions that inhibit mental health care providers from practicing in both private and public settings and incentivize existing private practice providers to practice in the public setting.



Successful examples:

- **United States:** Loan repayment—The NHSC loan repayment program offers physicians, including mental health providers and select support staff practicing in health professional shortage areas, loan repayment for educational debt.¹⁵⁵
- **Canada:** Incentivization program—The NITAOP program provides funding for approved physicians who visit rural and isolated communities to provide medical services in British Columbia. Other dedicated programs to provisioning rural care (including mental health care) include the Rural Retention Program, which pays a premium on MSP billing/service contracts, flat fee compensation to physicians in “RSA” rural subsidiary areas, and a business cost modifier flat fee to account for time lost commuting.¹⁵⁶
- **Mexico:** Licensing requirements—One year of social service healthcare is required for medical school graduates prior to receiving professional licensure. Typically, participants are assigned to rural or underserved communities with limited access to health care. In some cases, providers will opt to continue providing care beyond their required time period upon recognizing the high level of unmet need.¹⁵⁷



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6.

Placement of mental health care services and resources in the primary education setting

What challenge(s) does this solve?

To provision better access to care amongst children/adolescents and further emphasize the importance of prioritizing mental health, having care resources available in the school settings, especially public, is key. Fast, easy access to care for these more vulnerable populations can enable early identification and intervention and thus, prevent more severe outcomes. Transportation and financial constraints are eased, along with increased coordination in care capabilities by adding stakeholders in the school setting to collaborate with outside mental health care providers and patient families/caregivers.

Which regions could this be a priority to implement?

Latin America, Middle East

What will this approach look like?

To establish these services, the following actions may be considered:

- Offer co-located services, such as mental health professionals within schools that are either direct employees or are employed by partnered mental health organizations.
- Implement mental health care capabilities into existing school-based health centers. Training existing providers to provide care referrals and handle presenting cases with the appropriate level of urgency and/or hiring additional support staff to serve this function.
- Enable coordination of inter-school professionals: teachers, guidance counselors, coaches, other mentors to have easy access to alert mental health professionals on school grounds.
- Educate students on the local services available through dedicated sessions and curriculum content.

Successful examples:

- **United States:** Training programs—Project AWARE provides training for school personnel and supports the integration of mental health services into school settings by providing grants to state education agencies.
- **United Kingdom:** Access programs—MHST (Mental Health Support Teams) have been established across a growing number of schools and colleges. In addition to providing interventions of mild-to-moderate mental health issues, they advise school staff with situations concerning mental health and liaise with external specialists (e.g., care referrals, enforcing a holistic support network for individuals).¹⁵⁸

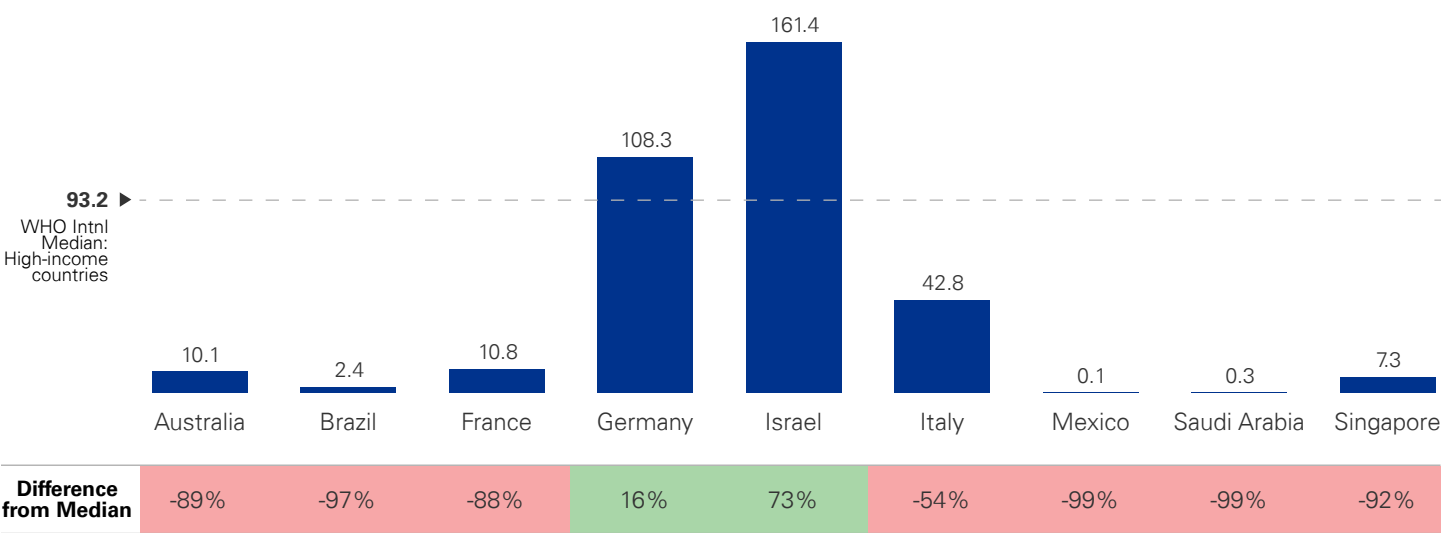


Key global challenge:

Lack of community residential mental health care facilities

Community residential mental health care facilities for long-term inpatient care are crucial but often lacking globally, meaning patients frequently do not have access to much-needed rehabilitation support. Increasing these facilities is essential, as they relieve the burden on acute inpatient and community mental health centers by providing continuous, comprehensive care for high-need patients. This approach prevents high readmission rates and enables individuals to play a more productive role in their life and community.

Figure 9: Community Residential Mental Health Care Facilities^{159,160,161}



Regional insights

North America

Community residential mental health care facilities are cited by experts as a critical missing element of the mental health care system in the United States and Canada.¹⁶² Since deinstitutionalization of psychiatric facilities in the United States, there have been no major, successful efforts to replace their psychosocial inpatient function in the public health care setting according to experts. Instead, diagnosed and treated patients often end up with a mix of some of the support resources, largely in an outpatient setting and rarely to the level that would be possible with long-term, comprehensive inpatient mental health care in the post-acute setting.¹⁶³ As a result of these shortcomings, experts point to patient outcomes suffering: frequent hospital readmittance, unsuccessful social reintegration, and incarceration.¹⁶⁴



Care for schizophrenia is often reactionary. Thus, incarceration follows instead of high-acuity treatment preceding crisis situations—which should be provided in long-term care facilities that are missing.”

Patient Advocacy Group, United States

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Western Europe

WHO data and KOLs noted that Europe has the greatest volume of this level of care out of any region globally.^{165,166} Since 2017, the rate of community residential beds has climbed regionally—a sign of recognition of the importance and investment in this level of care, unlike other geographies.¹⁶⁷ Despite these investments, gaps in residential mental health care remain. Similar to other regions, experts cite leveraging additional outpatient psychosocial support to combat the gaps in availability of these services. The existing infrastructure needs to expand, as evidenced by wait times in Germany, which were approximately 5 months for long-term therapy places of care as of 2020.¹⁶⁸



Often, we don't need all the resources that are invested into the acute care setting. The next level of care in post-acute setting is where resources are most needed."

KOL, Germany

Latin America

In Latin America, there has been a decline in the infrastructure needed for long-stay psychiatric inpatient care. For example, in Brazil, there was a ~40 percent decline in beds ratio for this level of care between 2008 and 2020, while Mexico saw a ~20 percent decline from 2001 to 2020.^{169,170} Similar to the dynamic with declining acute inpatient psychiatric hospital beds infrastructure in Latin America, experts cite the limited resources for this level of care as prohibitive to severe patient care. While other countries are deploying psychosocial programs in place of lacking intermediary post-acute care, experts cite a limited number of these programs available to patients across Latin America as well—with challenges such as existing lack of outpatient mental health care infrastructure limiting ability to effectively provide these services at scale.

Middle East

In Türkiye and Saudi Arabia, the current investments are more focused on acute inpatient and community outpatient mental health care. In Saudi Arabia, residential beds ratios (0.29 per 100,000) are far lower from those seen in most geographies,^{171,172} and while data is not reported in Türkiye, experts point to a lack of this level of care. In contrast, experts point to availability of these facilities as generally accessible in Israel, although expanded capacity is needed, particularly in rural areas. Local reports have noted the lack of inpatient capacity more broadly in the country's peripheral communities.¹⁷³



People can generally get access to intermediary inpatient care following discharge. Rurally, there is still some work to do, but overall, it's quite accessible and covered through social security."

KOL, Israel

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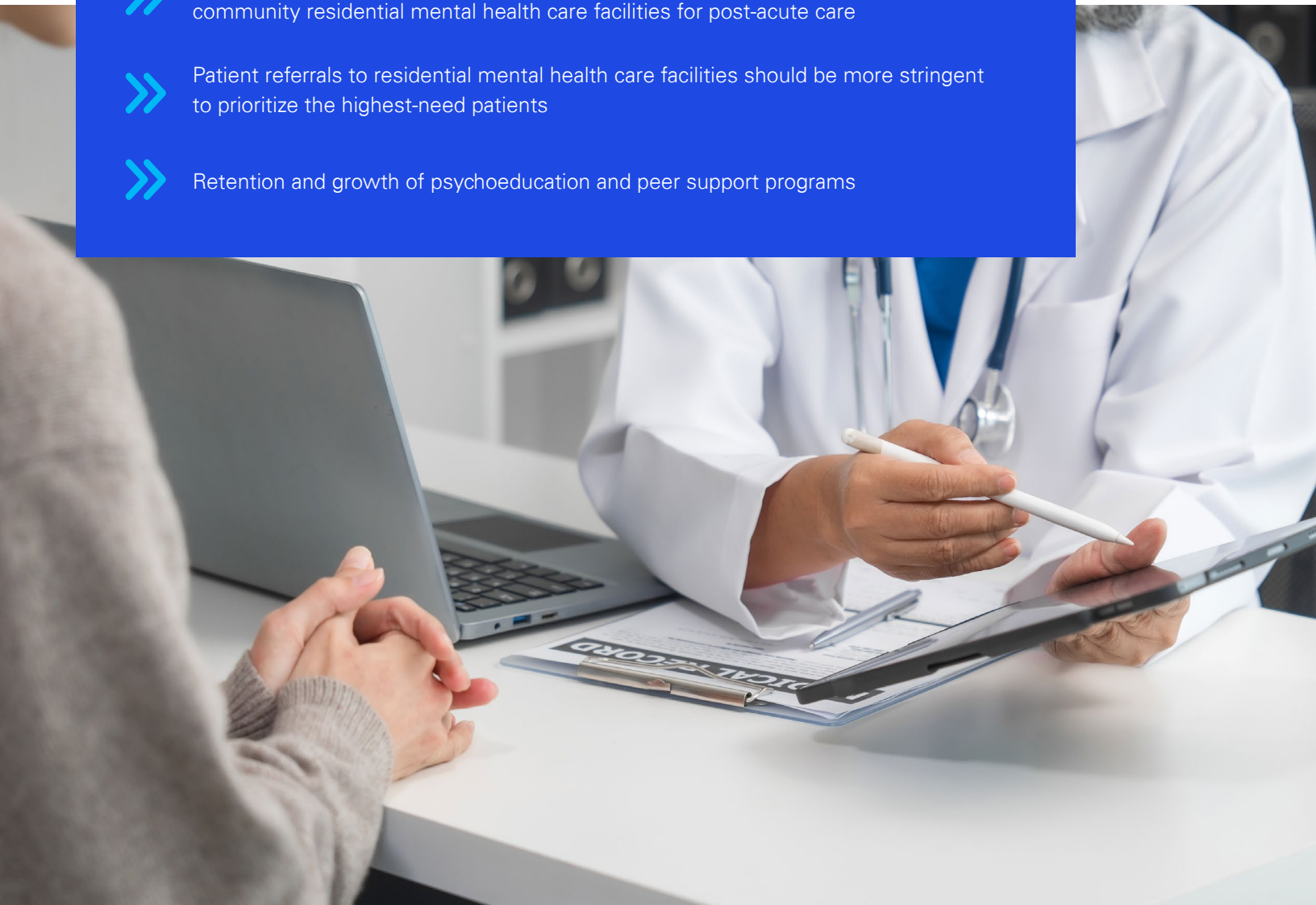


Actionable solutions

To address the need for community residential mental health care facilities, solutions should be considered to bridge existing gaps. Through expert KOL interviews, patient advocate discussions and secondary research, the following solutions were identified as potential areas for regions to leverage. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Lack of community residential mental health care facilities

- » Governments need to consider investing in the creation and/or amplification of community residential mental health care facilities for post-acute care
- » Patient referrals to residential mental health care facilities should be more stringent to prioritize the highest-need patients
- » Retention and growth of psychoeducation and peer support programs



**1.**

Governments need to consider investing in the creation and/or amplification of community residential mental health care facilities for post-acute care

What challenge(s) does this solve?

The right transitional care infrastructure is a key level of care for patients who have recently suffered an acute episode. Having these types of comprehensive care centers can ease the burden on the overall mental health care system by concentrating psychiatric rehabilitation efforts in these settings. In Spain, France and Germany, where these facilities tend to be more integrated into the levels of acute care, existing centers should be amplified to accommodate a greater volume of patients. In the United States and Canada, there's a need for dedicated investment to create these types of care centers and broaden public access. In nations with less developed acute inpatient and outpatient mental health care facilities, this should be a follow-on focus for investment down the line (e.g., many countries in Latin America, Middle East, APAC).

Which regions could this be a priority to implement?

United States/Canada, Western Europe, APAC

What will this approach look like?

To establish these services, the following actions may be considered:

- Direct public investment towards creation and/or amplification of community residential mental health care facilities.
- Offer insurance coverage policies that reflect the need for affordable, long-term care at these types of facilities. Federal funding should cover stays for patients with government-run insurance plans, while commercial insurers should be held accountable for improving existing coverage policies.
- Incorporate intermediary care into the continuum of acute patient care with support from public health officials and professional associations.
- Provide comprehensive and continuous care in these facilities. Patients should receive supported/free housing, workforce training, social support, and access to medicines and therapeutic services.

Successful examples:

- **United States:** Comprehensive care model—While only offered as a self-pay program, programs such as McLean's Appleton program represents a model with the appropriate level of comprehensive, social rehabilitation and care following acute inpatient psychiatric care. An inpatient residential program, services include group therapy (e.g., Cognitive Behavioral Therapy), community-based work and volunteer opportunities accessible via public transit, social skills rehab, emphasis on integrating physical health alongside mental health, and involvement of patient's friends and families with defined roles in "aftercare" planning.¹⁷⁴



2.

Patient referrals to residential mental health care facilities should be more stringent to prioritize the highest-need patients

What challenge(s) does this solve?

To make the most efficient use of resources that exist in public community residential mental health care settings, processes should be established to prioritize spaces available based on level of patient need. Today, in countries where these facilities are in use, often the sickest patients are not able to access the comprehensive care and social support system that they need.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To establish the necessary processes to enable prioritizing the highest-need patients for post-acute transitional care, the following are actions to consider:

- Carry out standardized, comprehensive risk assessments on a consistent basis prior to acute inpatient discharge. These assessments should evaluate the patient's risk profile based on medical history, current patient status, psychosocial needs, comorbidities, etc.
- Utilize triage protocols in a consistent fashion across acute inpatient centers and community residential mental health care centers to guide the allocation of resources based on cumulative patient needs.

Successful examples:

- **Canada:** Non-profit/government partnership—The Mental Health Commission for Canada (MHCC), supported by the Canadian government, promotes peer support as an essential part of the mental health care system. Their strategic plan, first introduced in 2012, included a call for increased funding and the development of guidelines for peer support programming. This was a top strategic priority for national action to improve mental health outcomes. The MHCC released national guidelines for peer support to evaluate the effectiveness of workplace-based peer support programs in 2013.¹⁷⁵
- **France:** Federal program—The national “Housing First” program, which provides housing services to those with mental health disorders, is supported by mobile, multidisciplinary teams of mental health professionals. There is a requirement that two peer support workers per team per site be available to program participants. Nationally, peer support programs have been prioritized by the French government through investment in psychosocial centers and mobilized units.¹⁷⁶



Key global challenge:

Mental health care provider shortage

A healthy supply of providers and care teams—inclusive of specialists, primary care physicians, clinical support staff, and community health workers—allows the mental health care system to address patient needs across various levels of care. Sufficient provider availability is foundational to begin addressing the unmet needs required for more tailored patient care. Today, however, most countries are facing critical professional shortages in the field of mental health care. In many areas, the mismatch between care demand and care capacity has been prioritized. That said, the field of mental health still faces major hurdles to overcome the compensation gaps and negative perceptions on the type of work within psychiatry (e.g., idea of dealing with difficult patients, lower medical professional prestige).

Table 1: Mental health care provider supply¹⁷⁷

Example global markets	Psychiatrists per 100,000 pop.	Difference from international median high-income level	Psychologists per 100,000 pop.	Difference from international median high-income level
WHO International Median: High-income countries	8.6	0%	10.7	0%
Australia	16 ¹⁷⁸	+86%	104.4	+876%
Brazil ¹⁷⁹	3.69	-57%	13.7	+28%
Canada ¹⁸⁰	14.4	+67%	50.2	+369%
China	3.4	-60%	0.4	-96%
Colombia ¹⁸¹	2.5	-71%	-	-
France ¹⁸²	23.6	+174%	11.7	+9%
Germany ¹⁸³	14.2	+65%	55.1	+415%
Hong Kong SAR ¹⁸⁴	7.55 ¹⁸⁵	-12%	-	-
Israel ¹⁸⁶	9.9	+15%	88.1	+723%
Italy ¹⁸⁷	6.4	-26%	3.9	-64%
Japan ¹⁸⁸	13.13 ¹⁸⁹	+53%	27.8	+160%
Mexico ¹⁹⁰	1.6	-81%	5.9	-45%
Saudi Arabia ¹⁹¹	3.4	-60%	3.3	-69%
Singapore ¹⁹²	5.03 ¹⁹³	-42%	-	-
South Korea	9 ¹⁹⁴	+5%	1.9	-82%
Spain	8.6 ¹⁹⁵	0%	-	-
Taiwan	8.9 ¹⁹⁶	+3%	-	-
Türkiye ¹⁹⁷	2.2	-74%	3.2	-70%
United States ^{198,199}	14.4	+67%	29.7	+178%
EU Cardiologist Benchmark ²⁰⁰	9.5	-	-	-

1. Note: Data taken from latest WHO reports between 2015 and 2024

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Regional insights: Addressing the global mental health workforce and innovation gap

1. Workforce expansion: Incentives, training, and distribution

North America: The U.S. and Canada have made notable strides in expanding the mental health workforce. Initiatives like Certified Community Behavioral Health Clinics (CCBHCs) have added more than 11,000 new staff, and early intervention programs like RAISE have helped distribute care more efficiently.^{201,202,203,204} However, workforce shortages persist, with the U.S. projected to meet only 45 percent of adult psychiatrist demand by 2036.²⁰⁵ Burnout and low recruitment into psychiatry remain critical challenges.



Even if the entire wait list was magically erased today, it wouldn't take long for us to start falling behind again because we can't even keep up with the ongoing demand."

Psychiatrist, Canada

Western Europe: Despite having the highest workforce density globally, Western Europe still faces regional disparities and recruitment challenges.^{206,207,208} For example, psychiatrist density in Spain varies by over 400 percent between regions.²⁰⁹ Low compensation and administrative burdens can deter new entrants into the field, and even stigma within the profession itself continues to be a barrier.



There is not a healthy supply of psychiatrists. Elements that scare off medical students include administrative burdens, lack of prestige, and even laws against perceived discrimination that can result in legal rulings against psychiatrists."

Psychiatry KOL, France

Latin America: Workforce shortages are acute. Brazil's "More Doctors" and "Doctors Around Brazil" programs have strived to redistribute providers to underserved areas, but gaps remain—especially in rural regions.²¹⁰ Colombia, as an example, has only 900 psychiatrists for the entire country, and 90 percent of those practitioners are concentrated in major cities.²¹¹



The supply of psychiatrists is actively growing, but a lot more effort is needed to train and place ancillary support teams. Having them go to places where specialists aren't present, including centralizing them in rural communities is important."

Psychiatry KOL, Colombia



Middle East: Severe shortages persist in Türkiye and Saudi Arabia, where educational infrastructure has not kept pace with demand. Saudi Arabia faces a shortfall of more than 10,000 full-time mental health professionals.²¹² Israel fares better but still struggles with regulatory barriers that limit practice flexibility for psychologists.^{213,214,215}

2. Task shifting: Leveraging non-MD providers

- **North America:** Task shifting is actively being implemented. Programs like RAISE and integrated care models are enabling clinical support staff—including nurse practitioners and social workers—to take on greater roles in diagnosis, treatment, and care coordination.^{216,217,218,219} However, experts emphasize the need for more formal licensing and upskilling pathways to sustain this shift.^{220,221,222,223}
- **Western Europe:** While task shifting is less formalized, there is growing recognition of its potential. Some regions are beginning to integrate psychologists and social workers more deeply into care teams, but systemic barriers and lack of standardized training pathways limit broader adoption.
- **Latin America:** The need for task shifting is high, but implementation is limited. Experts in Colombia and Brazil stress the importance of training and deploying ancillary support teams, especially in rural areas where psychiatrists are scarce. However, formal programs to support this shift are still in the early stages.
- **Middle East:** Task shifting is emerging as a necessity due to workforce shortages. In Türkiye, shortened psychiatry appointments and staff outflows have prompted interest in expanding the roles of non-MD providers.²²⁴ Saudi Arabia has begun exploring international recruitment and training programs, but local capacity-building efforts remain underdeveloped.^{225,226}

3. R&D and access to new therapeutics

- **North America:** The U.S. is the leader in mental health innovation, with significant investment in neurotechnology and novel therapeutics. However, access remains uneven due to insurance barriers and step therapy requirements. Canada has made strides in research but faces challenges in public reimbursement for advanced treatments.^{227,228,229,230,231,232,233,234}
- **Western Europe:** Europe has contributed to innovation through research consortia and biomarker discovery. Yet, health technology assessment (HTA) processes often delay or limit access to new treatments. Experts call for better integration of innovative therapies into national formularies and care pathways.
- **Latin America:** Innovation is constrained by limited funding and infrastructure. Even access to standard medications is inconsistent, particularly for those populations that are uninsured. Experts highlight the need for basic supply chain improvements before broader adoption of novel therapies can be considered.^{235,236,237}
- **Middle East:** Access to innovative treatments is highly centralized in urban hubs. In Saudi Arabia and Türkiye, newer therapies are available in select hospitals but remain inaccessible to most due to cost and geographic barriers. Israel has made progress in expanding access to treatments like TMS, but budget constraints continue to limit broader rollout.²³⁸



Actionable solutions

Each of the following solutions should be deployed to various extents across geographies to address the current and projected shortages in mental health care provider supply. Through KOL, physician, and patient advocate discussions and secondary research, the following solutions were identified as potential areas for regions to prioritize. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Mental health care provider shortages

- » Leveraging various levels of care settings, integrated care models, and value-based healthcare to provide mental health care
- » Expanding capacities of existing educational programs: medical school seats, clinical psychologist training programs
- » Equipping PCPs with the tools and training to provide quality mental health care for lower-severity cases
- » Focusing on upskilling non-MD specialists in education programs and continuing professional education, with compensatory incentives attached

1.

Leverage various levels of care settings and integrated care models to provide mental health care

What challenge(s) does this solve?

To decrease the burden on the mental health workforce, workforce planning and investment efforts should be complemented with optimizing the use of care settings of different intensity levels, as well as periodically refreshing care models with evidence-based solutions. A comprehensive workforce plan to meet future projected patient needs is key to combating the burden in the long term. In the short to medium term, care models should be optimized within country-specific mental health care systems. Integrated care and various care levels should be utilized to manage patients with mental health disorders, potentially through a value-based healthcare model. Doing so will enable the global burden on mental health specialist providers to be shared, and patients can receive diagnosis and treatment earlier at a potentially lower cost. By catching patients earlier, the funnel of severe patients coming into the specialty mental health setting can be slowed. With multi-disciplinary, well-trained clinical providers and social support teams providing individualized care, patients can lead more successful lives with fewer emergencies.

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Which regions could this be a priority to implement?

Global

What will this approach look like?

To successfully leverage various levels of care and care models to reduce the mental health care burden, the following actions should be considered:

- Create a workforce plan to facilitate implementing psychiatric care teams across specialist and primary care settings (e.g., inpatient acute, intermediary residential, outpatient).
 - Include funding dedicated to education and training programs across mental health care support staff role types, for both providers (e.g., psychiatrists, psychologists, psychotherapists, NPs, PAs) and social support teams (e.g., social workers, peer support workers, case managers, supportive education and employment specialists).
- Invest in more training and placement of community mental health clinic providers to bolster care continuity (e.g., NPs, PAs), especially in underserved areas.
 - Develop and implement trainings for certification of clinical provider support staff in curriculums and as continued professional education. Incentivize credentials and emphasize definition of career pathways for clinical provider support staff roles in the educational setting.
 - Enable improved provider workforce retention by placing locally trained staff in community mental health clinics.
- Capitalize on successful care pilot program models to provide more efficient care with better outcomes by dedicating additional investment, inclusive of integrating mental health care into primary care, and psychosocial team-based approaches to care.
- Target, in tandem with upskill training programs, legal reform to allow multiple levels of trained professionals to administer covered care across setting type.
 - Change insurance coverage policies to legally allow reimbursed mental health care provision from properly trained support staff and community health workers.
- Enable availability of quality psychotherapy services from psychologists.
 - Incentivize and/or require part-time work for psychotherapists in the public setting.
 - Invest more towards paid psychotherapist positions in the public setting.
 - Establish licensing requirements for psychotherapists to provide mental health care where existing regulation is not in place.
- Support implementation of value-based healthcare for the treatment of patients with mental health disorders.

Successful examples:

- **United States:** With the implementation of Certified Community Behavioral Health Clinics through 2024 in the United States, over 11,000 new staff positions were created in the mental health workforce. Some 50 percent of these centers also offer primary care services on-site, further decreasing the burden on the broader healthcare ecosystem and improving overall care access.²³⁹



- **Australia:** The Mental Health Nurse Incentive Program, established in 2007, funds community practices to employ mental health nurses. The program showed patient outcome improvement and had positive feedback from patients and medical practitioners. Hospital admission rates were reduced, level of employment for patients increased, and PCP workload decreased. Cost savings from decreased hospital admissions were about \$2,600 per patient yearly—approximately equal to the average subsidy of providing the program.²⁴⁰
- **United States:** Certain states have made efforts to localize mental health care providers through incentives. In Tennessee, SB 298, enacted in 2021, requires state medical colleges to create resident training programs for mental health care services in underserved and rural counties. Washington has implemented a mental health workforce initiative to cover education costs for Master's students who commit to work in the community health setting.²⁴¹

2.

Expand capacities of existing educational programs: medical school seats, clinical psychologist training programs

What challenge(s) does this solve?

To enable greater patient care capacities and reduce the existing burden on the undersupply of mental health providers, educational initiatives should be boosted and reshaped. Currently, public university medical programs in developing countries are well short of having the residency or training seats to educate a sufficient volume of psychiatrists, psychologists/psychotherapists, or psychiatric nurses. By expanding these programs at a greater pace, the mental health workforce of the future can be better resourced to deal with growing populations.

Which regions could this be a priority to implement?

Latin America, Middle East, APAC

What will this approach look like?

To expand program capacities to educate more providers, consider the following actions:

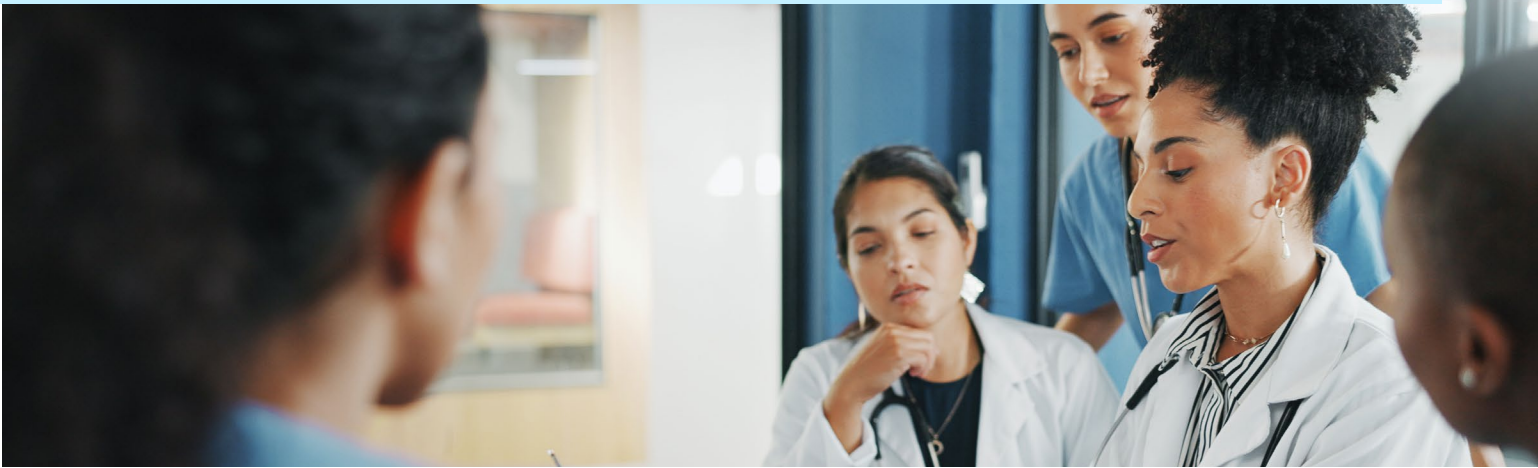
- Target investment in the public education system towards expanding the number of total programs and seats within existing programs to accommodate interest—especially where current demand outweighs educational capacity (e.g., Latin America, Middle East).
- Consider enabling private/public practice mix where it is currently not allowed in order to boost the supply of public university professors available to teach residents.
- Emphasize the use of e-learning and tele-training within residency programs to allow students and professors to connect across geographical distances and reduce barriers to education.
- Establish national councils that meet on an ongoing basis to report on staffing situations and advise policies and investments required to address needs.

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Successful examples:

- **Australia:** The Royal Australian and New Zealand College of Psychiatrists has created a rural psychiatry roadmap for 2021 to 2031, with Commonwealth funding secured for its implementation. This roadmap promotes collaboration among various stakeholders, including the government, universities, regional training hubs, and health services. Key action areas include: (1) ensuring high-quality psychiatry training in rural regions, (2) developing pathways to attract rural medical students and doctor candidates, (3) expanding education programs for all rural psychiatry training, (4) offering expanded rural clinical rotations, and (5) creating support packages to make training and working in rural areas more appealing.²⁴²
- **Iceland:** To broaden access to care nationally, working groups for health care professions including general nurses, practice nurses, and medical doctors were formed in 2019. In 2021, the Ministry of Health established a council, including leaders from the workforce, government, higher education, industry and other national institutions, to address staffing and educational issues.



3.

Equip PCPs with the tools and training to provide quality mental health care for lower-severity cases

What challenge(s) does this solve?

Training and continuous support to PCPs can make an important difference towards easing the burden of mental health disorders. In particular, in areas where community mental health services are not available, these physicians can provide lower-touch care. Local residents, who would typically be restricted to accessing mental health care due to travel and cost barriers, could seek treatment and diagnosis earlier. Governments and local authorities should invest in strategic plans to train and educate existing PCPs and medical students on the path to becoming a PCP.



Which regions could this be a priority to implement?

Global

What will this approach look like?

The following methods can be considered to train PCPs to administer quality mental health care in the community setting:

- Integrate mental health training into the medical school curriculum, particularly for those on track towards general practice (e.g., primary care trainees).
- Offer and encourage pursuit of mental health certifications for continued education in medical school programs.
- Continue medical education: Provide the most up-to-date guidelines on a continuous basis. Offer refresher educational sessions to PCPs on mental health care best practices.
- Deploy dedicated mental health “extenders” (i.e., clinical provider support staff) in the primary care setting.
- Create decision support tools to assist PCPs in making evidence-based treatment and diagnosis decisions (e.g., algorithms, flowcharts).
- Use of validated scales to diagnose, treat, and follow up with patients such as those from the ICHOM Set of Patient-Centered Outcome Measures for Depression & Anxiety.²⁴³

Successful examples:

- **United States:** Medical school training—Some family doctors often screen for common mental health disorders during check-ups, utilizing tools such as PHQ-9 (for Major Depression Disorder evaluation) and they can often prescribe medications for common mental health disorders (e.g., antidepressants, anxiolytics). Investments such as those from the Health Resources and Services Administration emphasize the importance of funding the training of primary care residents during medical school to provide quality mental health care.²⁴⁴
- **Saudi Arabia (ongoing program):** Primary care education—WHO mhGAP implementation is in process, focused on integrating mental health care into the primary health care setting. Trainings have been conducted for the relevant physicians and care professionals, enabling them to provide baseline care in diagnosing and treating common mental health disorders.²⁴⁵
- **Singapore:** Their integrated healthcare model fosters collaboration between PCPs, secondary level care, and social services. The Mental Health PCP Partnership Program enables primary care setting management of mental health walk-ins, including treatment and referral to the inpatient acute setting and case management in coordination with other care levels. A complementary Community Intervention Team supports PCP pharmacological treatment and helps facilitate social services.²⁴⁶



4.

Focus on upskilling non-MD specialists in education programs and continuing professional education, with compensatory incentives attached

What challenge(s) does this solve?

To reduce the burden of care on all providers, shifting responsibilities to support staff is paramount. By trusting trained, credentialed nurses, psychologists, and other staff with more influential care, the quality and continuity of care can expand. Additional hands to diagnose and prescribe may be available, more therapeutic services may be administered, and social/peer support services may be offered in the clinic and out in the community. Building these capabilities not only requires standardized training and licensing programs but also asks psychiatrists leading mental health practices to enable staff to take on more clinical responsibility.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To upskill support staff and community mental health workers, the following actions may be considered:

- Implement a higher degree of clinical training requirements as part of standard licensure in public and private mental health nursing and psychologist curricula.
- Advertise psychologist training to provide psychotherapy services and integrate into more educational programs.
- Dedicate funding towards programs and compensatory awards for support staff willing to participate in training programs for licensure to upskill their responsibilities—as part of standard academic programs, as well as continuing professional education.
- Create standardized training and education materials for caregivers and community mental health workers to use as resources to streamline patient-support efforts.
- Offer regular training programs for community mental health workers (e.g., social workers) and caregivers to stay up to date on best practices.
- Consult leading psychiatrists in crafting upskill training programs for clinical staff.
- Disseminate training materials based on evidence-proven approaches to care in social service programs and in psychoeducation.
- Train peer support workers to help administer psychoeducation programs for patients and their families.

Successful example:

- **United States:** Psychiatric mental health nurse practitioner (PMHNP) programs have evolved beyond psychotherapy education to include pathophysiology, health assessment, and pharmacology. Certified PMHNPs through The American Nurses Credentialing Center can provide direct mental health services to patients, including assessment, diagnosis, and treatment planning.²⁴⁷



Key global challenge:

Insufficient resourcing for psychosocial support programs

Psychosocial support programming—including social support, employment and housing support, patient case management, peer support, and psychotherapy—is critical to providing effective care. Access to psychotherapy from trained psychologists and pharmacologic intervention is also key. Psychotherapy services may be provided by licensed social workers, further adding to the importance of social support program availability. Despite the importance of the social elements of psychosocial care, resources are often insufficiently available to patients—both in and beyond the walls of care centers (Table 2). These services enable patients to manage their disorders, connect socially, and avoid isolation. Social workers and vocational rehabilitation programs provide essential support in housing, job searches, and resource access. Comprehensive psychosocial support programs improve long-term outcomes and offer a critical safety net for vulnerable patients.

Table 2: Percentage of responding countries with availability and provision of pharmacological and psychosocial interventions in >75 percent of primary care centers, World Bank income group²⁴⁸

	Percentage of countries with pharmacological and psychosocial interventions in >75 percent of primary care centers	
	Pharmacological interventions	Psychosocial interventions
Global	39%	11 %
Low	9%	8%
Lower-middle	13%	8%
Upper-middle	41%	25%
High	71%	34%

Regional insights

North America

In the United States and Canada, experts cite evolving approaches to psychosocial programs and increasing adoption—especially in urban hubs. For example, the RAISE early treatment program has yielded overwhelmingly positive results in providing comprehensive levels of psychosocial programming for patients suffering from first-episode psychosis (FEP) in the United States.²⁴⁹ In Canada, multifaceted FEP programming has been implemented more broadly.²⁵⁰ Still, experts in both countries cite continued barriers in accessing psychosocial care, especially for comprehensive services. Resources, including staff—both social and mental health care providers—as well as funding and infrastructure need bolstering to implement scalable programming.²⁵¹



Psychosocial programs are a top challenge. The concept today is often a band-aid approach, but most patients need comprehensive psychosocial care instead.”

Psychiatry KOL, United States

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Western Europe

Experts point to initial progression in psychosocial care efforts in recent years (e.g., France’s “Housing First” program and Projet Territorial de Santé Mentale), but emphasize that there is a long way to go. In the private sector, for example, where many patients seek psychotherapy care, costs can be prohibitive. In addition to financial barriers, psychologist availability can be a challenge. In Germany, wait times—even in urban treatment hubs such as Berlin—can range from one to six months for public psychotherapy. Across the region, experts cite a lack of available resourcing to support psychosocial approaches to mental health care.



Psychosocial and occupational areas are where greatest shortages lie today—resources are scarce for those in need. These activities rely a lot on family support today. They’ve expanded since the ‘90s, but there is a long road ahead. Still, models exist that have shown to be effective although the resources required are expensive.”

Psychiatry KOL, Spain

Latin America

There is consensus among regional experts that the existing infrastructure has limitations making it difficult to facilitate scaled psychosocial care. Social worker supply, for example, is viewed as a constraint—in Brazil and Mexico, 7.6 and 1.4 social workers exist per 100,000 population, which is well short of international peer countries. Despite Brazil’s CAPS psychosocial system, which has enabled access and utilization of psychosocial centers in the outpatient setting, studies suggest that the infrastructure may not be effective in provisioning quality care.²⁵² In Colombia and Mexico, experts indicate limited investment to scale psychosocial approaches to care, contributing to widespread access limitations.



Despite investment in psychosocial centers, this approach isn’t always great. Patients sometimes need a lot more comprehensive care and can’t get it at these facilities. We even try to leverage multi-specialty approaches to care in these settings, but sometimes doctors just raise the medication levels, which creates a chemical barrier to block a patient’s behaviors.”

Psychiatry KOL, Brazil

Middle East

In this region, there are significant barriers limiting access to psychosocial care. In Israel, services have been put in place in care settings but are bottlenecked by volume of resources: social workers, psychosocial care centers, psychotherapy, and sheltered employment initiatives exist, yet require amplification.



Actionable solutions

To address psychosocial care needs, solutions should be based on specific fit to local mental health care systems. Through expert KOL interviews, patient advocate discussions and secondary research, the following solutions were identified as potential areas for regions to prioritize. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Insufficient resourcing for psychosocial support programs

- » Dedicated government funding to develop, expand, and improve existing psychosocial programs
- » Policies and guidelines to solidify and protect the roles of psychosocial support teams
- » Training and placement of social support teams to support comprehensive psychosocial care efforts

1.

Dedicated government funding to develop, expand, and improve existing psychosocial programs

What challenge(s) does this solve?

The availability of psychosocial programs is an important element of patient recovery, especially for the most severe patients. By enabling the availability of psychosocial programs, patient rehabilitation can be expedited, and then patients can avoid readmittance and lead more stable lives.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To enable broader access to psychosocial programs, the following actions may be considered:

- Establish pilot programs to test various psychosocial programs and evaluate their effectiveness. If successful, programs should extend beyond the pilot phase.
- Sustain funding to support programming by enabling policy adjustments (e.g., reimbursement changes).
- Educate mental health disorder ecosystem stakeholders

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on the economic and patient benefits upsides of leveraging psychosocial programs.

- Implement progress tracking systems and structure to understand return on resources invested—both in terms of patient outcomes, and economic impact.
- Leverage insights from evidence-based programs
- internationally, incorporating elements of other successful psychosocial care models on a local level (e.g., housing-first style programs).
- Partner with existing local organizations as “boots on the ground” to connect patient populations to support resources.

Successful examples:

- **United States:** Coordinated programming—Coordinated specialty care programming for first-episode psychosis early intervention through the RAISE program has demonstrated success in improving patient outcomes and generating systemic cost savings. Education and employment rates amongst patients increased from 40 percent to 80 percent over a six-month period, and hospitalization rates dropped from 70 percent to 10 percent in a three-month window. Projecting out program success at scale, potential system savings of \$115B+ over a 10-year span in the United States alone were estimated. A combination of clinical staff and community health workers are leveraged in this comprehensive psychosocial approach to care.^{253,254}
- **United Kingdom:** Employment support model—The individual placement and support (IPS) evidence-based supported employment model can outperform other tested forms of employment support for those with severe mental health disorders. As a part of the ongoing community mental health (CMH) services transformation, it has been embedded into integrated care models for primary care and CMH for patients. Today, supported employment is recognized by the National Institute for Health and Care Excellence (NICE) as an essential element of mental health care.²⁵⁵
- **Australia:** Youth model—The EPICC model for youths with mental health disorders provides those experiencing early psychosis with a clinical pathway catered to specific criteria, aimed to catch and treat youths early to limit psychosocial and functional disruption resulting from psychosis. Services such as case management, family and caregiver support, therapy, medication management, vocational and educational services are offered to provide comprehensive care.²⁵⁶



2.

Policies and guidelines to solidify and protect the roles of psychosocial support teams

What challenge(s) does this solve?

To establish consistency in the presence of psychosocial resources, programmatic psychosocial support should be integrated into existing care centers with the relevant staffing and resources available for patients, in a policy-enforced manner. Doing so will enable patients to more regularly receive the well-rounded elements of support needed with higher continuity. When met with day-to-day challenges, they can consistently turn to team members to tackle ongoing efforts to manage economic, social, and psychological aspects of life. With contextualized, continuous care, patients can achieve better disease management and socioeconomic outcomes.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To establish the roles of psychosocial support teams, the following actions may be considered:

- Establish regulatory frameworks to enforce the quality and accessibility of psychosocial support services in various care settings, including quality assurance standards and licensing requirements.
- Provide support to allow coverage through federal/ social security insurance for care provisioned by social workers, peer support workers, psychotherapists, and for psychoeducation sessions. Hold private insurers accountable for coverage at the federal and local levels through guidelines and legislation based on evidence-driven standards of care.
- Establish dedicated spaces for psychosocial programming in acute inpatient and outpatient mental health treatment centers, incorporating the presence of these resources as quality standards. Similarly, incorporate standards for social workers to enforce higher levels of patient follow-up communications.

Successful examples:

- **United States:** Federal reimbursement recognition—CMS has established code creation to enable care provision by psychologists and social workers in the primary care setting, incentivizing their adoption into the early care settings.²⁵⁷
- **United States:** State reimbursement—In Wisconsin, AB 650 legislation as of 2020 enables Medicaid reimbursement for supervised peer coaching as part of mental health treatment plans.²⁵⁸
- **France:** National requirements—Through the government health authority, HAS, psychosocial spaces are required at acute inpatient psychiatric facilities. This allows high-need patients to access psychotherapy, social and peer worker support teams on a basis that is enforced through national quality standards.



3.

Training and placement of social support teams to support comprehensive psychosocial care efforts

What challenge(s) does this solve?

Without the proper workforce to meet patient needs, providing psychosocial care is not possible. Lack of adequate compensation and positional openings is restricting the supply of social support workers, in particular. While there are often efforts from nonprofits to train and place peer support staff, there should be better-organized governmental initiatives to train and place the relevant professionals. Workforce planning and implementation for the elements of “psychosocial care” beyond medication management should account for social workers, peer support workers, psychotherapists, case managers, and supportive education and employment specialists to enable comprehensive care for patients with high-touch needs.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To establish improved availability to social support teams as part of psychosocial care, the following actions may be considered:

- Invest in planning and implementation of social programming staff supply. This should be inclusive of social workers, peer support staff, case managers, psychotherapists and supportive education and employment specialists as part of broader workforce planning efforts.
- Invest in workforce compensation and training for social/medico-social workers. Provide government salary support and free training programs to upskill and certify (e.g., for psychotherapy certification).
- Leverage telebehavioral health platforms to provide social support services and facilitate access to information (e.g., housing programs and workforce training) to alleviate workforce shortages.
- Invest in more training and placement of community mental health social workers to bolster care continuity. Especially in underserved areas:
 - Develop and implement trainings for certification of social support staff in curriculums and as continued professional education—especially with promotion of psychotherapy training. Incentivize credentials and emphasize definition of career pathways for social support staff roles in the educational setting.
 - Enable improved social workforce retention through placing locally trained staff in clinics and communities.

Successful examples:

- **France:** Federal funding—As part of the national Projet Territorial de Santé Mentale, the French government dedicated a significant subsidy towards salaries of social and medico-social workers. In doing so, the government helps enable a stronger dedicated community mental health workforce to deliver care through their local care centers.

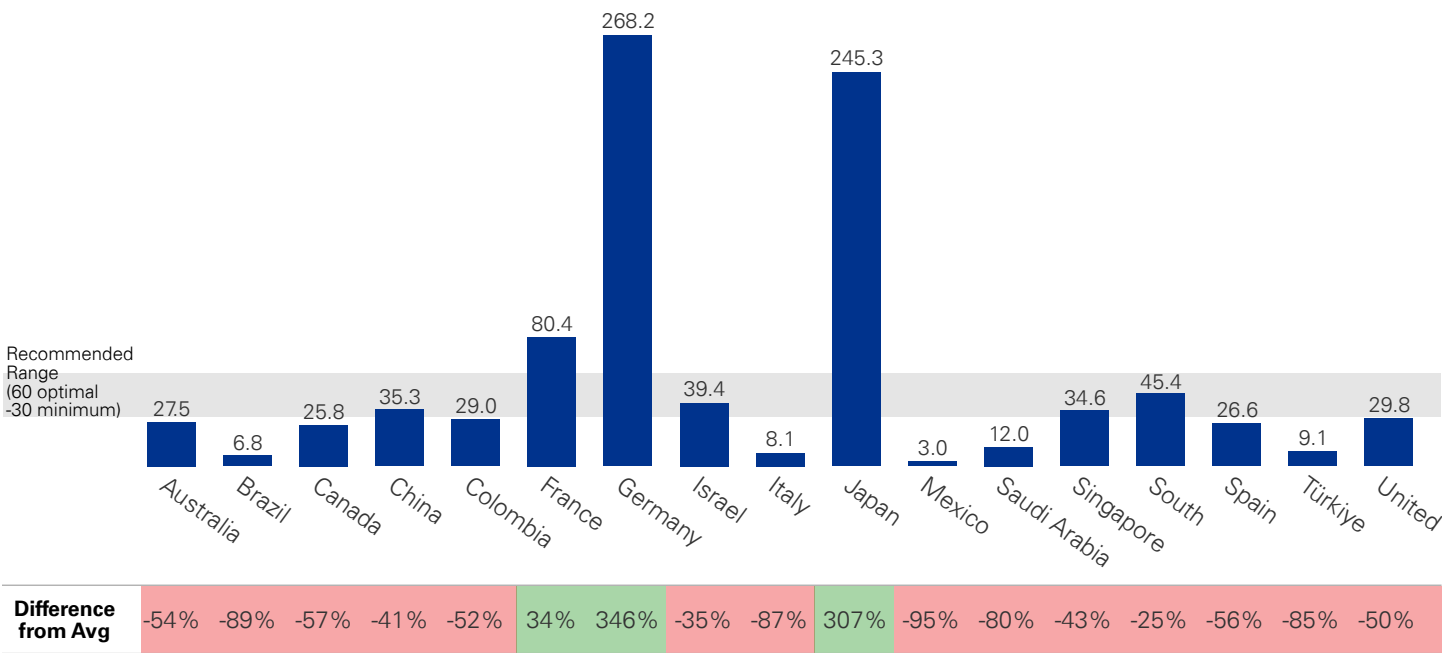


Key global challenge:

Decreasing inpatient hospital bed infrastructure for acute mental health care

Acute inpatient hospital bed infrastructure in psychiatric and general hospitals is crucial for comprehensive mental health care, particularly for severe cases. However, interviewed experts cite how many countries have shifted funds from inpatient to outpatient services, leading to the closure of acute inpatient facilities and reduced capacity to treat acute conditions. This is especially concerning in places like Türkiye, Brazil, Mexico and Colombia, where acute inpatient capacity was already insufficient. Many countries fail to meet international mental health bed-to-population standards based on key studies and WHO findings (Figure 10). Adequate acute inpatient mental health capacity is essential for providing quality, continuous care in high-acuity situations and robust services enable timely recovery and rehabilitation, leading to better mental health outcomes and successful reintegration into society.

Figure 10: Inpatient Hospital Infrastructure for Acute Mental Health Care^{259,260,261, 262}





Regional insights

North America

Both the United States and Canada have taken actions to combat the decrease in acute inpatient mental health infrastructure. In the United States, Institutions for Mental Diseases (IMD) exclusion waivers have enhanced insurance coverage enabling longer acute inpatient mental health stays and multidisciplinary mobile crisis teams have been implemented through the American Rescue Plan Act.^{263,264,265} However, in the United States and Canada, back-ups to meet demand in acute inpatient care demand are evident today and both countries sit below the OECD average of ~60 acute inpatient psychiatric beds per 100,000 population.^{266,267,268,269}



Today, we don't have enough beds to treat our sickest patients. The issue is worsening as facilities close without the funding to operate."

Patient Advocacy Group Leader, United States



The pendulum has swung too far—the reduction of inpatient beds needs to stop, because not every person can be treated in the community setting."

Psychiatry KOL, Canada



Western Europe

In Western Europe, ongoing national public health system budget cuts have meant limited investment in expanding acute inpatient psychiatric beds. Across the region, Germany was the only country that saw a material increase in the number of psychiatric beds from 2013 to 2022 (7 percent rise).²⁷⁰ In comparison, the number of psychiatric hospital beds decreased in France and Italy by 8 percent and 18 percent, respectively, between 2013 and 2022.^{271,272,273} France has tried to leverage alternative efforts, like mobile crisis units to combat the infrastructure shortage. Still, experts in France, Italy and Spain cite an ongoing gap in acute inpatient mental health care that requires additional resources, with significant regional disparity (especially in Italy and Spain).²⁷⁴



With less beds, patients are being admitted for shorter periods. Patients don't have the time to recover properly, and readmittance rates go up."

Psychiatrist, France

Latin America

Across Latin America, acute inpatient mental health care services have been reduced or closed in favor of outpatient mental health investments. Based on most recently available data in 2024, psychiatric bed prevalence was more than fifteen times lower than international standards, and lower than other middle-income regions, such as Eastern Europe and Central Asia. In Brazil, acute mental health care centers have seen major backlogs as a result of the shift of resources to CAPS psychosocial centers, while in Mexico and Colombia, recent closures of psychiatric hospitals and other public health infrastructure is likely to exacerbate challenges facing acute mental health care.^{275,276,277,278,279} The remaining facilities that do exist are highly concentrated in urban hubs and often face major backlogs.



Today, there's a lack of hospital capacity to meet demand. A lot of hospitals are closing due to a lack of financing and the overall economic situation."

Psychiatry KOL, Colombia

Middle East

In the Middle East, while Türkiye has decreased psychiatric inpatient bed supply in favor of a shift of resourcing toward outpatient mental health care settings, Saudi Arabia and Israel are taking a different approach. In Saudi Arabia, new psychiatric hospital builds in recent years have improved levels of available care, with reform to decentralize mental health services leading to the establishment of 21 regional psychiatric hospitals since 2014.²⁸⁰ Despite these efforts, Saudi Arabia continues to face significant acute inpatient mental health infrastructural shortages compared to Israel, which has built up capacity over time and held on to its infrastructure while other countries have closed facilities.^{281,282,283,284,285,286}



There's a general trend towards decreasing the number of hospital beds. However, in Türkiye, there were never enough hospitals to care for acute patients in the first place."

Psychiatry KOL, Türkiye

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Actionable solutions

Through expert KOL interviews, patient advocate discussions, and secondary research, the following solutions were identified. Based on findings around level of need and by understanding historical efforts from different countries, each of the following solutions is prioritized by geography to maximize impact:

Decreasing inpatient hospital bed infrastructure for acute mental health care

- » Increase the number of acute inpatient beds and psychiatric acute inpatient facilities
- » Enable flexibility for providers to lengthen patient stays in special circumstances to provide appropriate treatment and care
- » Ensure that acute inpatient settings have a comprehensive suite of services available and accessible for proper care





1.

Increase the number of acute inpatient beds and psychiatric acute inpatient facilities

What challenge(s) does this solve?

Currently, there is a shortage of beds (based on bed-to-patient ratios) across many countries, with ongoing decreases in inpatient acute infrastructure. Interviewed experts cite patients sometimes needing to wait months for care, a devastating proposition for those with complex conditions.²⁸⁷ Inpatient hospitals and beds in regions such as Latin America, the Middle East, and APAC have been under-developed historically due to limited resources and investment from national authorities, with these factors contributing to increased patient wait times, exacerbation of severe symptoms, and higher readmission rates—leading to a significant gap in care quality for the highest-need mental health cases.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To establish greater acute inpatient infrastructures, the following actions should be considered:

- Increase acute beds and psychiatric facility resources in public acute inpatient hospitals/departments to align with international levels through additional resource allocations from the government. Public funds allocated to mental health should increase materially to build the appropriate psychiatric hospitals and wards in the public setting.
- Prioritize investment dollars to improve accessibility of acute mental health care. This will likely consist of both upgrading facilities in current centers, as well as de novo builds to serve areas with the greatest barriers to care.
- Leverage mobile crisis units to provide short-to-medium-term care in place of traditional inpatient services in areas with highly restricted access to acute inpatient psychiatric facilities.

Real world examples:

- **Singapore:** Increase acute care investment—To meet growing service demand, the main psychiatric hospital, the Institute of Mental Health (IMH), increased the number of psychiatric beds with the opening of a new psychiatric rehabilitation ward in 2021. Additionally, the National Mental Health Strategy has also committed to expanding psychiatric wards.



2.

Enable flexibility for providers to lengthen patient stays in special circumstances to provide appropriate treatment and care

What challenge(s) does this solve?

In many countries, the existing laws and insurance policies restrict physicians' ability to keep acute mental health patients in the inpatient setting long enough for recovery. Many patients do not receive sufficient treatment and rehab to socially reintegrate following discharge. Providers need to exercise judgment for patients to stay for longer than the standard covered or allowed period for high-need cases. In doing so, readmissions for repeated acute episodes or mental health crisis can be mitigated.

Which regions could this be a priority to implement?

United States/Canada

What will this approach look like?

To enable providers with greater decision-making power, the following actions may be considered:

- Repeal laws or add exclusions to existing laws to enable coverage for extended acute inpatient psychiatric stays.
- Reduce the administrative burden to grant exclusions on a timely basis (e.g., less paperwork, more automated processes to minimize lead times on decisions).
- Empower state and provincial authorities to enforce regulations on coverage policies for acute inpatient psychiatric care.

Successful examples:

- **United States:** State policy changes—In some states, local law defines clinical standards or criteria for coverage decisions on mental health care—holding insurance companies responsible for violations. In 2020, California passed a law requiring insurers to follow generally accepted standards of care for mental health/substance abuse disorders. This involves following evidence-based criteria stemming from nonprofit professional organizations and high-quality, peer-reviewed studies. Fines have been imposed for violating these laws (e.g., Kaiser Permanente in 2023).²⁸⁸



3.

Ensure that acute inpatient settings have a comprehensive suite of services available and accessible for proper care

What challenge(s) does this solve?

To provide the appropriate elements of care to high-need patients in crisis situations, acute inpatient settings should be equipped with a range of resources to support these patients, inclusive of drug supply, psychotherapeutic services, and social support—supported by policies that enable appropriate insurance coverage and consider patient out-of-pocket costs. In areas where this is a major concern, the various types of acute inpatient facilities (general public hospitals, social service covered hospitals, and private hospitals) providing mental health care should have solutions to meet ongoing needs. By having these resources available at an affordable cost, it can drastically improve patient care, thereby generating better outcomes following discharge, and reduce re-admissions.

Which regions could this be a priority to implement?

Global

What will this approach look like?

To establish accessibility of these resources in the acute inpatient setting, the following actions may be considered:

- Invest in dedicated spaces and availability of psychotherapeutic services and personnel in the hospital setting to enable comprehensive services in the acute inpatient setting.
- Focus on reimbursement (whether public or private) and availability of the range of services and treatments needed to ensure sufficient supply is available to acute inpatient facilities.
- Initiate peer support program enrollment for acute inpatients during inpatient stays. Public and private facilities should coordinate with advocacy groups and volunteer organizations to set up these partnerships.

Successful examples:

- France:** National requirement—Government health authorities require most hospitals to have dedicated space for patients to access psychotherapy, receive social worker support, and peer support resources. Hospital quality standards through the French National Authority for Health (HAS) account for levels of patient engagement in care through these resources.
- United States:** Public coverage—Government programs such as Medicare and Medicaid cover a significant percentage of patients with mental health disorders, including the inpatient setting where Medicare Part A covers inpatient mental health services at both general hospitals and psychiatric hospitals (limited to 190 total days per lifetime).²⁸⁹
- Germany, France:** Public coverage—Cost of drugs and treatment services (e.g., psychotherapy) are covered in the public setting for inpatient psychiatric care through federal health coverage policies. In Germany, around 90 percent of the population is covered through statutory health insurance. Patients typically have low co-pays for treatment. In France, a majority of the population has accessible, covered care for inpatient psychiatric services through social security health plans.^{290,291}

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Conclusions: Support structures are needed to drive tailored patient care

Based on current data and global expert insights, the various levels of mental health care face major gaps to meet growing patient demand. Ongoing efforts are beginning to progress some mental health care systems towards more mature care continuums, but the needs of some of the most severe patients remain underserved.

To support the early detection and tailored treatment of mental health disorders, countries must strive to provide high care continuity and foster an accurate understanding of the importance of prioritizing mental health. Community mental health care services are critical to implement this more broadly across global mental health care systems. Successful programs to date should expand in geographic reach and patient volume, backed by the necessary resources to support quality, sustainable care.

To support crisis care for the most severe patients with mental health disorders, the availability of acute inpatient hospital mental health beds should be standardized through policy measures and private investment. Countries that are removing inpatient acute mental health beds should recognize that a baseline of these services are needed to provide timely, quality mental health care for the most vulnerable patients.

Similarly to inpatient acute mental health beds, community residential mental health care facilities should be recognized as a needed level of care—in this case, for patients needing post-acute treatment. This care setting is important to drive better long-term patient outcomes, higher patient societal functionality, and reduce the care burden on families. Countries should understand how available mental health care resources may allow them to integrate this level of care, while other areas are also prioritized for investment.

To provide proper, well-rounded care for patients with mental health disorders across care settings, psychosocial care and programming need to be utilized more broadly. Well-rounded care teams extending beyond psychiatrists



and psychologists—including social workers, counsellors, vocational specialists, peers and case managers—have proven, positive impacts on long-term patient outcomes and cost of care effectiveness. Current progress should be expedited through enhanced resourcing and placement of comprehensive support teams.

Each area should be considered by countries in their approach to tackling mental health disorders through policy-based measures and infrastructural investment. Based on country-specific nuances, investment in each level of care should be prioritized—considering existing systemic strengths and weaknesses while keeping in mind international standards and past successful efforts. Governments need to invest the necessary resources to meet existing gaps in the mental health care system, and groups such as patient advocates and physician associations should collaborate with international forces to push for action. In doing so, patients' mental health disorders can be appropriately addressed with better outcomes so they can live as productive members of society.



Call to action

As we consider the impact of mental health disorders on the patient, the community, and society as a whole, it is clear that mental health is not a peripheral issue. It must be addressed globally and collaboratively. The rising prevalence of mental health disorders, the significant economic toll, and the persistent inequities in access demand a bold, coordinated response, and elevating mental health to a national priority means establishing it as a core pillar of public health.

A collective global effort, supported by multi-stakeholder partnerships, is essential to improving patient outcomes and building resilient mental healthcare systems. Government, industry, educational institutions, physician groups and providers, medical institutions, patient advocacy groups, KOLs, employers, international groups, and NGOs all have roles to play in driving towards improved care for patients with mental health disorders.

Final conclusion

Mental health is no longer a peripheral concern—it is a defining challenge of our time. The data and expert insights presented in this paper underscore the urgent need for coordinated, cross-sectoral action to address the rising burden of mental health disorders. From stigma reduction and tailored care to infrastructure expansion and innovation access, the path forward demands bold investment and policy reform. As countries begin to make progress, the opportunity to build resilient, equitable, and patient-centered mental health systems is within reach. The time to act is now—because improving mental health outcomes is not just a healthcare imperative, but a societal one.



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Case studies: What change looks like in practice

Around the world, governments, providers, and communities are experimenting with new ways to expand access, reduce stigma, and deliver more effective mental health care. The case studies that follow highlight tangible examples of solutions that are working—demonstrating how targeted action can reshape systems and improve lives.

Canada: “Bell Let’s Talk” National anti-stigma campaign

Objective: Initiated by Bell Canada, the campaign’s goal is to stimulate a nationwide dialogue on mental health, reduce stigma, and elevate funding for mental health services.¹ Bell originally pledged 5 cents per interaction on Bell Let’s Talk Day, and in 2023 revised the model to a \$10 million lump-sum donation for the day.^{2,3,4}

Duration: Launched in 2010–2011 as a multiyear program and continued annually every January as “Bell Let’s Talk Day” (now in its 15th year, with releases confirming continuing campaigns through at least 2025).^{5,6}

Investment: Bell’s corporate contributions have grown substantially: Press updates show cumulative commitments surpassing \$129 million by early 2022, and the corporate goal increased to \$155 million.^{3,7} The official Bell Let’s Talk site now cites a total funding goal of \$184 million by 2025 and summarizes giving across pillars, including \$9.7 million invested in mental health research.⁸

Hoped-for outcomes: The campaign intends to reshape cultural attitudes towards mental health by normalizing conversations about it, thus reducing stigma and encouraging individuals to seek help. Vision includes substantial funding increase for mental health care and research, aiming for a “stigma-free Canada.”^{9,10}

Implementation: The program has been executed through a robust multichannel marketing approach, utilizing TV commercials, radio, billboard ads, and social media challenges. Celebrity ambassadors and partnerships with schools, workplaces, and sports teams amplify the message. On Bell Let’s Talk Day, interactions are tracked across platforms and tied to donations. Community grants are awarded to local mental health projects.

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Traction/campaigns: Gained rapid and widespread traction nationally, becoming Canada's top trending topic on Twitter yearly. The effort has become a major annual event, with records such as 154,387,425 interactions in 2020 and 164,298,820 in 2022, and frequent status as a top trend on Twitter in Canada and worldwide on campaign day.^{13,7,14}

Key performance indicators (KPIs):

- Over 1.3 billion interactions since 2011 (e.g., 154 million interactions in one day in 2020)^{15,16}
- Over C\$121 million committed by early 2022; cumulative totals continued rising thereafter under the \$155 million target.^{7,3}
- Community funding via the Bell Let's Talk Community Fund has issued 1,000+ grants (by 2022) and 1,100+ grants overall per the initiative page; Bell's research investment is \$9.7 million to date.^{8,17,18}

Stakeholders: Stakeholders encompass Canadian citizens impacted by stigma, Bell Canada's leadership and staff, celebrities, athletes, mental health nonprofits, hospitals like CAMH, schools, workplaces, and the federal government as endorsers.

Outcome/results:

- The campaign is widely credited with expanding national conversation around mental health; official releases document year-over-year record engagement and cumulative funding that enabled programs across more than 1,500 organizations.^{8,13}
- The Community Fund alone has provided more than 1,000 grants by 2022 and over 1,100 grants overall per Bell's initiative page.^{17,11}
- Approximately 6.96 million Canadians have been supported with access to mental health services through programs funded by Bell Let's Talk.²⁰
- Half (50 percent) of Canadians say they have taken action related to mental health since Bell Let's Talk Day began.²⁰
- This campaign has become a global exemplar for corporate social responsibility, normalizing mental health conversations and providing needed funding.

US: CCBHC expansion (Workforce and access initiative)

Objective: The initiative aims to boost the mental health workforce and expand comprehensive community care by scaling up Certified Community Behavioral Health Clinics (CCBHCs) nationwide. It seeks to establish clinics serving anyone in need, with robust staffing and integrated services, addressing chronic workforce shortages and gaps in US mental health access. A core goal includes rapidly hiring more mental health professionals and improving care quality.^{1,2,3}

Duration: Launched in 2017 as an eight-state Medicaid demonstration authorized by the 2014 Excellence in Mental Health Act (Protecting Access to Medicare Act), the program expanded massively from 2018. By 2022, CCBHC status became a permanent option with over 500 CCBHCs across 46 states, DC, and Puerto Rico. As of 2024, it continues with bipartisan backing and is ongoing with no set end date.^{4,5,6}

Investment: Supported by significant federal and state funding—initial demo funding was \$1.1 billion over two years.^{7, 8} Federal grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) released more than \$200 million annually (2018–2021),^{9, 10} and the 2022 Bipartisan Safer Communities Act allocated \$300 million for expansion.^{11,12} By 2024, several billion dollars were cumulatively invested, enabling the hiring of over 11,000 mental health workers.¹³

Hoped-for outcomes: Aims include improving access, staffing, and integrated care. Seeks to reduce wait times for same-day services, to serve more uninsured/underinsured individuals, and integrate mental health with primary care—50 percent of CCBHCs colocate primary care. The program intends to alleviate burden on ERs/jails by offering 24/7 crisis services and demonstrate that funding and standards can elevate the community behavioral health system, resulting in better recovery and stability.^{14,15}



Implementation: CCBHCs must offer nine core services, including crisis care, outpatient treatment, and care coordination with strict quality mandates. Clinics hire additional staff—clinicians, case managers, peer specialists, addiction counselors—reimbursed through a Medicaid Prospective Payment System rate. Expansion grants from SAMHSA facilitate adoption. Technical assistance ensures evidence-based practices.^{16,17}

Traction/campaigns: The initiative gained traction through bipartisan political support due to early success addressing the opioid crisis and veteran suicide. Advocacy from the National Council and “Mental Health Care Works” framing emphasize workforce and care improvements. Advocacy highlighting results (workforce more than 11,000 staff, integrated care, reduced hospital use) to secure bipartisan support for expansion.¹⁸

KPIs:

- Geographic expansion—serving 55.7 percent of US counties (over 1,430 counties)—and workforce expansion with more than 11,000 new positions.¹⁹
- Access metrics report tens of thousands of new clients served (approximately 2.1 million/year), substantially reduced wait times, and clinical outcomes like 36 percent fewer hospital admissions and 17 percent fewer Emergency Department visits in states like Missouri and New York.^{20,21,22}

Stakeholders: Stakeholders include community behavioral health clinics, federal agencies SAMHSA and Centers for Medicare & Medicaid Services, state mental health authorities, patients and families, law enforcement, hospitals, and the mental health workforce—all benefit from expanded services and workforce opportunities.^{16,23}

Outcome/results:

- By 2024, approximately 40 percent of US counties have a CCBHC, which serve an estimated 3 million people, with 125 CCBHCs (25 percent) serving in rural areas.^{4,24}
- The CCBHC program has successfully expanded access and staffing nationwide. States in the initial demo saw more than 25 percent more individuals served and reductions in wait times from months to days.²⁵
- It demonstrates improved outcomes with examples of reduced unmet needs and enhanced patient care, validated by Congressional support and funding as part of US mental health policy.²⁶





Mexico (Chiapas): Compañeros en Salud community mental health partnership

Objective: Compañeros en Salud (CES), the local sister organization of Partners In Health (PIH) in Mexico, works in rural Chiapas to integrate quality mental health care into primary care via task-sharing with generalist clinicians and trained community health workers. The program is designed to address common conditions like depression, anxiety, and psychosis in communities that previously had little or no access to care.^{1,2,3} A key aim is to build capacity in Ministry of Health (MOH) clinics so they can reliably recognize and treat mental illnesses, while linking patients to social support and follow-up by local “accompaniment” workers (acompañantes/ community mental health workers).^{1,3}

Duration: CES began operations in 2011 in the Sierra Madre region of Chiapas and subsequently embedded mental health services into its primary care program; formalized community-based mental health activities were underway by 2014, with ongoing expansion through the 2010s and 2020s.^{2,3,4}

Today, CES operates approximately 10 rural public clinics in partnership with the MOH (plus a community hospital and maternity homes) and continues without a set end date as a long-term, system-strengthening model.^{2,5,6}

Investment: CES runs on a nonprofit model with philanthropic funding and government in-kind support. PIH supports additional staff and training programs, operating on a low-cost, high-impact model. Government provides space, basic medications due to CES advocacy, and primary care doctors’ salaries. Exact budget figures aren’t public, but CES’s annual budget is a few million USD, supporting low-cost care for villagers.^{1,7,8}

Hoped-for outcomes: Goals include early identification and treatment of mental illness, reducing suffering and disability. CES aims to drastically increase care for depression. Key outcomes include improved remission rates, better daily functioning, and community empowerment through education and stigma reduction. A systemic goal is to create a replicable model for the MOH.

Implementation:

- Primary care integration: Mental health screening, diagnosis (e.g., PHQ-2/PHQ-9), basic pharmacologic

care, and brief psychological interventions are delivered at CES-supported MOH primary care clinics, with specialist supervision (psychologists/ psychiatrists) provided in person and remotely.^{2,3,13,14}

- Community health workers (acompañantes/ cuidadoras de salud mental): Trained locals provide regular home visits, individual brief therapies (e.g., PM+, single-session therapy, psychological first aid), group psychoeducation, and adherence/return-to-function support.^{2,3,15}
- Holistic supports: The model explicitly addresses social determinants (transport barriers, poverty, nutrition, gender-based violence), pairs mental health care with primary care, and facilitates referrals to secondary/tertiary services when needed.^{2,3,11}
- CES integrates mental health care into 11 rural clinics, training generalist doctors to manage common mental illnesses, and employing local community health workers as “mental health acompañantes” for follow-up care and education.

Traction/campaigns: CES emphasizes grassroots engagement—CHW home visits, community talks, and collaboration with local public entities—rather than mass media campaigns. This task-sharing approach builds trust and help-seeking among historically underserved populations.^{2,3,16}

KPIs:

- In a recent year (July 2021–June 2022), approximately 9,500 people were screened for depression and anxiety and more than 700 people received treatment across approximately 11 facilities.²⁰
- Clinical improvement: On average, 67.7 percent of patients receiving care had improved depression symptoms.²⁰
- Validated tools: CES research validated the use of PHQ-2/PHQ-9 for depression screening/diagnosis in rural Chiapas.¹³
- More than 3,000 patients have been reached with outreach and treatment. Reduction in severe outcomes, such as eliminating physical restraints on patients, and regular CHW visits demonstrate community support reach.²⁰



Stakeholders: Primary stakeholders are patients and families in rural Chiapas; MOH clinics and public health staff; CES/PIH clinicians and supervisors; community health workers; and collaborating academic partners conducting program evaluation.^{21,22,23}

Outcome/results:

The program has significantly improved access and outcomes for mental health care in Chiapas:

- 68 percent of those treated showed symptom improvement.²⁰
- Approximately 9,500 people were screened for depression and anxiety, and more than 700 people received treatment across approximately 11 facilities.²⁰
- More than 200 women were newly enrolled for mental health services for depression, anxiety, psychosis, and epilepsy.²⁰
- The CES programming has attended to more than 3,000 patients, providing outreach and treatment services.²⁰
- Stigmatized conditions are now actively treated, reducing discrimination, and patients are reintegrated into daily life. Diagnosis timelines for serious illnesses have decreased, with stigma significantly reduced locally.
- CES's model has influenced policy, contributing to Mexico's national mental health strategy focusing on community-based care.
- CES has transformed mental health care in its reach, providing a functioning system where hundreds are cared for annually, illustrating effective community healthcare delivery in low-resource settings.

United Kingdom: "Time to Change" national anti-stigma campaign

Objective: Time to Change (TtC) was England's largest evidence-based national anti-stigma campaign led by Mind and Rethink Mental Illness, designed to end stigma and discrimination around mental illness and to help people speak openly and seek help without fear.¹ The program's early, explicit goals included at least a 5 percent positive shift in public attitudes and at least a 5 percent reduction in reported discrimination, alongside mass reach objectives.²

Duration: TtC operated from 2007 until 31 March 2021, with Mind and Rethink confirming the closure in March 2021 following the end of government funding; both charities continue the work and legacy.³ Its legacy persists through annual Time to Talk Day and ongoing use of its educational materials by local groups.

Investment: The campaign secured approximately £115 million over 15 years. Funding came from Big Lottery

Fund/National Lottery Community Fund, Comic Relief, and the Department of Health (later DHSC) across multiple phases: for example, the first phase was funded with £16 million (Big Lottery Fund) and £4.5 million (Comic Relief), and in 2016 the program secured a further £20 million from DH, Comic Relief, and the Big Lottery Fund to continue into its third phase.⁴ (Official communications emphasize these major tranches rather than a single cumulative total.⁵)

Hoped-for outcomes: Key objectives included measurable stigma reduction:

- TtC's published outcomes included measurable stigma reduction (e.g., at least a 5 percent improvement in attitudes; at least a 5 percent reduction in discrimination) and broad public reach, alongside behavior change outcomes such as increased willingness to live, work, and maintain



relationships with people experiencing mental health problems.⁶

- More openness about mental health issues—aiming to reach at least 50 million people through media and millions of initiated conversations. By its final phase, targets included improving attitudes of an additional 5 million people and securing over 1,000 employer pledges.

Implementation: TtC combined multipronged social marketing (mass media, PR, digital, social contact calls-to-action) with community programs and a nationwide network of Time to Change Champions—people with lived experience who shared stories publicly.⁷ A major workplace initiative, the Employer Pledge (introduced in 2011), supported organizations with a 12-month action plan; by June 2020, over 1,500 organizations employing over 4 million people had signed.⁸ Schools and local hubs were also mobilized to embed anti-stigma work at community level.⁹

Traction/campaigns: National visibility was driven by repeated mass-media bursts and targeted efforts; independent evaluation reported prompted campaign awareness of 38 percent to 64 percent during 2009–2011.¹⁰ Time to Talk Day, initiated by TtC and continued annually by Mind/Rethink (with UK partners), remains the campaign's signature public engagement day encouraging open conversations nationwide.¹¹

KPIs: The campaign tracked national attitudes to mental illness, with:

- Attitudes: National surveys show a 9.6 percent improvement in public attitudes (2008–2016), equating to approximately 4.1 million adults with improved attitudes; improvements continued into later years.¹²
- Willingness/behavior: From 2009 through 2016, willingness to live/work/maintain relationships with someone with a mental health problem improved by approximately 11 percent.¹³
- Discrimination (service-user reports): Between 2008 and 2014, those reporting no discrimination increased

by 5.6 percentage points, and average discrimination across life areas fell substantially.¹⁴

- Recognition/awareness: Evaluations of early social marketing bursts found prompted awareness between 38 percent and 64 percent.¹⁵ The Employer Pledge program encompassed over 4 million employees by 2020.⁹

Stakeholders: Led by Mind and Rethink Mental Illness, integrated extensive involvement from staff and volunteers with lived experience. The UK government and Big Lottery Fund ensured accountability. More than 8,000 Champions spread stories locally, influencing general public attitudes. Employers, schools, community groups, media, healthcare providers, and academics partnered to amplify the campaign's scope, while grassroots organizations deployed minigrants for regional projects.¹⁷

Outcome/results:

- Willingness to work with someone with mental health issues improved approximately 11 percent since 2007. Discrimination instances reduced, with thousands fewer annually shunned or dismissed due to mental illness.
- National surveys show a 3.1 percent improvement in attitudes in 2018–2019 versus 2016–2017, leading to overall 12.7 percent change in attitudes, i.e., 5.4 million people with improved attitudes since the campaign began.
- Independent and program evaluations attribute meaningful stigma reduction to TtC, evidenced by attitude and behavior improvements and declines in reported discrimination among service users.¹⁸ The campaign's legacy continues through Time to Talk Day and ongoing anti-stigma work embedded by Mind and Rethink after TtC's closure in March 2021.



France: “Un chez soi d’abord” Housing first program (with peer support)

Objective: Provide stable housing and community support for homeless individuals with severe mental illness, following the Housing First model that prioritizes housing without preconditions and then offers wraparound treatment and social support. The French “Un chez soi d’abord” (UCSD) program was launched by the state to serve people with schizophrenia or bipolar disorder living long term without housing, combining immediate access to ordinary housing with intensive, multidisciplinary support (including peer workers) oriented to recovery.^{1,2}

Duration: The pilot was launched in 2011 and evaluated through a multisite randomized controlled trial (RCT) from 2011 through 2016 across Paris, Lille, Marseille, and Toulouse; follow-up continued into 2018. Based on positive results, national scale-up was initiated and the program was integrated into national policy and the Code of Social Action and Families (post-2016), then embedded within the national “Logement d’abord” (Housing First) strategy.^{2,3,4} Based on positive results, a national scale-up began in 2017; by 2018, it expanded to 16 new departments aiming for 2,000 housing slots by 2023. As of 2025, the program is ongoing and continues expanding, becoming a permanent strategy in France’s homelessness and mental health policy.

Investment: France’s broader Logement d’abord plan 2018–2022 helped approximately 440,000 people access permanent housing; funding was increased by €160 million for 2023–2027 (“Logement d’abord 2”). UCSD sits within this national strategy.^{5,6} Within UCSD specifically, the program expanded beyond the four pilot cities; government and technical notes report more than 40 cities and more than 3,000 places by 2022–2023.⁷ National expansion received a budget commitment of €60 million over 2018–2022. Funding is collaborative between health and housing ministries. By 2023, investment surpassed €100 million, with net savings demonstrated, strengthening political will.

Hoped-for outcomes:

- Aim for more than 80 percent of participants to remain housed long-term.

- Reduce psychiatric hospital admissions and emergency visits, increase participant satisfaction and autonomy, and foster social integration. On a system level, demonstrate feasibility and broader adoption, aiming to reduce national chronic homelessness and showcase peer support enhancement in engagement and recovery.^{1,8}

Implementation: Mobile multidisciplinary teams (psychiatrists, nurses, social workers, psychologists, peer workers) support tenants in scattered-site ordinary housing. The UCSD model combines assertive community treatment (ACT) with recovery-oriented practice; separates housing management from support; and emphasizes choice, harm reduction, and noncoercive engagement.^{2,9,10}

Traction/campaigns: UCSD’s positive trial results prompted permanence and national scaling via Logement d’abord. Official briefs and health-public reports defined targets of 20 UCSD sites (approximately 2,000 places) by 2023, aligning with metropolitan rollouts (Bordeaux, Dijon, Lyon, Grenoble in 2018; Montpellier, Nantes, Nice, Strasbourg in 2019).¹¹

KPIs:

- Housing retention: In the first year of support, more than 80 percent of participants remained housed; four-year follow-up shows housing stability advantages for UCSD versus usual care.^{1,12,13}
- Hospital use: The RCT found significantly fewer inpatient days for UCSD (RR approximately 0.62) over 24 months; government synthesis notes approximately 50 percent reduction in hospital days for UCSD versus control.^{14,15}
- Cost-effectiveness: Markov model analyses (24 month data extrapolated) show 246 percent more days housed, ICER approximately €5.32 per additional night in independent housing; lifetime modeling supports long-term cost-effectiveness from a societal perspective.^{16,17}
- Quality of life/recovery: The trial reports quality-of-life improvements and recovery gains over time (both arms improved; UCSD’s main differential benefits were housing stability and reduced inpatient days).^{13,14}



- Clinical outcomes: Improved quality-of-life scales; 50 percent fewer hospital days indicated, showing notable reduction in service utilization costs and improved functioning.
- Peer worker integration: more than 300 peer support workers trained by 2023.
- Housing slots: As of 2023, more than 3,000 individuals housed, targeting 10,000 slots by 2027. Employment and social relationships improved;

10 percent to 20 percent gained employment within a couple of years.

- **Stakeholders:** The Ministry of Health and Ministry for Housing (France) launched UCSD; DIHAL coordinates scale-up. Delivery involves public health/psychiatry teams, social landlords/private landlords, NGOs, and peer workers integrated within ACT teams; research partners (e.g., Aix-Marseille University/CEReSS) led independent evaluation.^{2,18}

Outcome/results:

- National strategy performance: Across the Logement d'abord plan, DIHAL/Anah document structural gains (e.g., 49,500 affordable private rentals via Anah conventions 2018–2022; growth in social housing allocations for homeless households).^{6,21}
- With more than 2,000 places opened in five years, for a total of 2,570 places by the end of 2022,³² towns now host a “Un chez-soi d'abord” scheme.²²
- Housing retention: In the first year of support, more than 80 percent of participants remained housed.^{1, 12,13}
- Service transformation: Scaled up from four cities to over 40 cities, with 3,000 individuals housed by 2022. Future expansion plans aim for 10,000 slots nationwide by 2027.²²
- Embedded in policy: “Logement d'abord” is now the standard approach, reorganizing shelter systems to prioritize quick housing for those with severe mental illness. Pilot served as an European Union-cited example of successful Housing First integration.

United Kingdom: Individual Placement and Support

Program objective: Individual Placement and Support (IPS) is an evidence-based supported employment model for people with severe mental illness (SMI). It uses a “place then train” approach (rapid placement into competitive employment with ongoing individualized support), integrated within mental health teams, and is endorsed in England as part of community mental health transformation and NICE guidance sets (QS80, QS95, CG178, CG185).^{1,2} IPS consistently outperforms traditional vocational services in helping people with SMI achieve competitive jobs, with meta-analyses showing IPS participants are approximately twice as likely to gain employment than controls (pooled risk ratios 2.40 and 1.63 across RCTs).^{3,4}

Duration: Introduced through trials in the 2000s, notably the 2006–2007 UK IPS demonstration projects. By the 2010s, pilot successes led to policy integration:

- In 2016, NHS inventory found approximately 10,000 IPS places in England.
- The Five Year Forward View for Mental Health (2016) and NHS Long-Term Plan (2019) aimed to double IPS reach by 2020–2021 and again by 2023–2024, targeting 55,000 people annually by 2023–2024 via IPS.
- As of 2023, IPS is ongoing and scaling, with funding extended into 2024–2025, embedded in community mental health transformation.⁵

Investment: Substantial funds invested:

- IPS scale-up has been financed via LTP transformation funding and then mainstreamed into CCG/ICS baselines. Guidance for commissioners states IPS services moved from transformation funding to local commissioning from April 2021, with the adult SMI



budget uplift worth $\geq$ £975m per year by 2023–2024 (for broader community mental health improvements in which IPS is embedded).

- NHS England has contracted national IPS expansion support (2024–2029) valued at £26.7 million, indicating ongoing central investment in implementation support and fidelity.¹⁰
- NHS allocated tens of millions of pounds for IPS expansion, about £40 million between 2018–2021 for team growth across trusts.
- Additional funds from DWP and local councils supplementing IPS. NHS England launched IPS Grow in partnership with Social Finance UK to support scale-up.
- Estimation by 2023 is roughly £100 million cumulative investment nationally.
- Extensive savings: Every £1 invested in IPS yields more than £1.50 saved in reduced healthcare/welfare costs.

Implementation approach: IPS operates under eight evidence-based principles: focus on competitive employment, zero exclusion (eligibility by client choice), integration with mental health treatment, attention to preferences, benefits counseling; rapid job search, systematic employer engagement, and time-unlimited individualized support.^{11,12}

Campaigns for traction: To support fidelity and scale, NHS England and partners run IPS Grow, providing fidelity reviews, technical assistance, workforce support, and data tools. Independent evaluation by RAND Europe documents IPS Grow's role in scaling IPS maturity and service performance.¹³

KPIs:

- Employment rates: IPS yields significantly higher competitive employment than alternatives; systematic reviews and meta-analyses across RCT's report pooled RR approximately 2.4 and RR approximately 1.63 favoring IPS.^{3,4} Job retention: Many participants maintain jobs more than six months; 44 percent employed at least half the time over five years. IPS

participants show better job tenure, weeks worked, income, and hours relative to controls across pooled RCTs.^{4,14}

- UK commissioning KPIs: IPS Grow's framework recommends at least 40 percent job starts among unemployed clients and at least 65 percent sustained employment beyond 13 weeks per Employment Specialist.¹⁵
- Fidelity reviews assess IPS model quality, correlating with better program outcomes.
- Nonvocational outcomes: Noted hospital reductions (50 percent fewer hospital days) and improved self-esteem/social inclusion.
- Service reach: By 2023, NHS targets aim for 20,000 new IPS starts annually, scaling to support 55,000 individuals per year.^{5,6}
- Inclusion of underrepresented groups: Ensuring IPS access for diverse demographics.

Stakeholders: NHS England/ICSs (commissioners), Mental Health Trusts (providers), IPS Grow (Social Finance and Centre for Mental Health), DWP/OHID (cofundors for some IPS implementations), and NICE/Royal College of Psychiatrists (practice guidance in mental health care).^{1,7,13}

Outcome/results:

- Improved employment rates: IPS clients were twice as likely to gain employment (55 percent versus 28 percent) and worked longer than controls.¹⁷
- Scaling impact: NHS Long Term Plan target of 55,000 in IPS on track; approximately 14,500 accessed in 2021, increasing with funding.^{5,6,9}
- Economic evaluation: UK Health-led employment trial found mixed return on investment (ROI) at 12 months—some modest financial benefits in one site, but overall insufficient to offset costs in others (underlines that economic impacts can be context-specific).^{18,19}



Japan: “I AM” National Mental Health Awareness Campaign

Objective: Break the silence and stigma around mental health, especially depression, in Japanese society. The “I AM” campaign encourages people to say “I am (depressed/anxious)” without shame, aiming to normalize these conversations through public figures sharing their mental health struggles. The goal is to make it safe for Japanese individuals to acknowledge mental illness like depression, countering the cultural norm of silent suffering.^{1,2}

Duration: Circa 2019–2020, concentrated in a few months of 2020, led by NGO and activities were largely NGO-driven and linked to suicide prevention efforts during COVID-19 and just supported by the Ministry of Health. Planning began in 2019, with TV commercials, online videos, and events rolling out in early-to-mid-2020. Campaign-style efforts with TV commercials and social media hashtags were reported in early 2020, coinciding with rising concern after high-profile suicides.^{1,3,4}

Investment: Moderate investment by nonprofits and corporate sponsors, with government endorsement for high-quality commercials, TV slots, and event organizing. Additionally, there was significant in-kind support with waived fees, donated coverage, and government provision of platforms and credibility.⁵

Hoped-for outcomes: Goal is an increase in help-seeking and public discourse on mental health. The campaign aimed to boost mental health service usage, including more calls to hotlines and increased clinic visits. Long-term goals included reducing Japan’s high stigma—measured by improved willingness to discuss mental illness in surveys. Moreover, the program hoped to influence policy by demonstrating public appetite for mental health services.

Implementation: High-profile individuals (actors, musicians, athletes) publicly state “I am [diagnosis]” to destigmatize condition. Campaign uses TV commercials, social media hashtags (#IAM), and interviews/panels where these figures and experts encourage seeking help and empathy. Resources (helplines, websites) are provided alongside personal stories.⁸

Traction/campaigns: Coordinated around mental health awareness days with hashtags trending. Celebrity ambassadors like musicians and sports heroes engage

youth. Possible tie-ins with companies (e.g., LUSH #IAMWHOLE digital detox campaign mentioned in JP context). Youth challenges to share “I am ____” statements to peers. Gained traction via public figure involvement and timing with high-profile suicides. Wide media coverage and social media momentum saw the hashtag trending in Japan. Support came from celebrity fan groups and media outlets, linking segments to the campaign. The government provided further backing, with discussions about increased mental health funding helped crystallize national focus.^{9,10}

KPIs:

- Media reach and engagement: It is estimated that millions of viewers saw an “I AM” ad.
- Helpline saw an approximately 20 percent increase in calls during the campaign.
- Social media metrics tracked hashtag usage and video views, with the main YouTube video receiving over 5 million views. Public attitude shifts noted an increase in willingness to seek help.
- Participation: Over a dozen celebrities involved, numerous media pieces, packed live events.¹¹

Stakeholders: Mental health NGOs initiated and guided the campaign. Media companies produced and aired content. The Ministry of Health endorsed policy alignment. Celebrities and influencers were key stakeholders; their participation was vital for societal acceptance. The general public, especially those silently struggling, were the target stakeholders. Employers and schools responded with supports, and healthcare providers managed potentially increased demand.¹²

Outcome/results:

- Sparked unprecedented discourse on mental health in Japan.
- Mental health services reported 10 percent to 15 percent increase in new patients during campaign-linked periods.
- Government launched a “Loneliness and isolation” initiative in 2021, signaling policy influence.
- Cultural impact included persistent mental health discussion in media, showing gradual generational stigma shift.¹³



France: Projet Territorial de Santé Mentale

Objective: The Projet Territorial de Santé Mentale (PTSM) framework was created by Article 69 of Law n° 2016-41 (26 January 2016) to transform mental health policy toward community-based, integrated care and to reduce territorial inequalities by organizing accessible, coordinated pathways of care and support at territorial level.^{1,2}

Duration: PTSMs were legally instituted in 2016, then operationalized by decree n° 2017-1200 (27 July 2017) which set priorities, method, and timelines; the 2018 national instruction guided ARS (regional health agencies) and stakeholders to elaborate, contract, and evaluate projects.^{3,4} As of 2024–2025, France is moving to “PTSM 2.0”: the Ministry’s 2024 Tour de France report consolidates lessons learned and the December 1, 2025 instruction launches the update cycle (2025–2027).^{5,6}

Investment: PTSM is a planning framework channeling substantial public health budgets:

- Rather than a single ring fenced PTSM budget, PTSMs operate within the national Feuille de route “Santé mentale et psychiatrie” (launched June 28, 2018, and enriched September 2021) under which €3.3 billion in additional funding is mobilized through 2026 for prevention, care pathways, and social inclusion, with ARS contracting local actions via CTSMs (Contrats Territoriaux de Santé Mentale).⁷
- Concrete regional examples include Normandie’s 7 CTSM (signed December 2021) committing 128 actions with €24 million ARS funding over 2021–2025.⁸
- National funding: €50 million allocated in the 2018–2022 budget.
- ARS budgets: Reallocated funds to bolster community initiatives, increase mental health centers, and enhance local services.

Hoped-for outcomes: The decree prescribes six priorities:

- Early identification/diagnosis and access to care/support
- Coordinated no-break pathways for people with severe disorders/psychiatric disability

- Access to somatic care
- Prevention and management of crisis/urgency
- Rights, empowerment, and anti-stigma
- Action on social/environmental/territorial determinants.^{3,9}

Implementation: Implemented through collaborative territorial governance, convening stakeholders to diagnose local needs and develop action plans. Plans receive approval from regional committees, leading to formal Contrat Territorial de Santé Mentale guiding resource allocation and initiatives across a five-year term, with detailed actions and monitoring protocols.^{3,4}

Traction/campaigns: Politically reinforced as mental health was declared a “Grande Cause Nationale 2021–2022,” enhancing public visibility and support. Efforts included community forums and professional engagement to embrace community work, promoting regional workshops and guidelines showcasing success stories, such as local day center creation enhancing patient outcomes.¹⁴

KPIs:

- National coverage: The first generation of PTSMs now covers the entire territory; the ministry notes “104 PTSM” progressively reaching term since mid-2024.¹⁵
- Earliest approvals: ARS Pays de la Loire reports Vendée’s PTSM as the first in France (December 3, 2018), followed by Sarthe (April 13, 2019), and Loire Atlantique (December 19, 2019)—demonstrating early territorial adoption and five-year cycles.¹⁰
- Regional action portfolios: Normandie’s 7 CTSM (2021–2025) operationalize 128 actions with 140 signatories and €24 million ARS funding to destigmatize and improve pathways in child/adult mental health.¹⁰

Stakeholders: Publics concernés include psychiatric providers, health professionals, social/medico-social services, user/family representatives, psychologues, ARS, and local authorities. The decree explicitly sets out these actors and the ARS role in methodology and approvals.³



Outcome/results:

- New community services established: Dozens of outpatient structures and mobile teams launched, promoting access in previously underserved regions.
- Improved access in underserved areas: Outreach reducing city travel needs and enhancing local consultations.
- Better continuity of care: Formal agreements ensure posthospital community follow-ups, reducing readmission rates.
- Stigma reduction and patient rights: Increased peer support employment and patient involvement in care decisions.
- Focus on social integration: Expanded employment support and housing programs aligned with PTSM priorities.⁵

Australia: Headspace Youth Mental Health Centers (2006 to present)

Objective: Headspace aims to provide early intervention mental health services for young people aged 12–25 in youth-friendly settings. These centers offer a “one-stop shop” for addressing issues like depression, anxiety, drug/alcohol use, and vocational support in a stigma-free environment. The objectives are to reduce barriers to help for young individuals, catch problems early to prevent more severe illness, and ultimately to reduce youth suicide rates in Australia. Headspace also seeks to normalize seeking help among young Australians by embedding these centers within communities.^{1,2}

Duration: Launched in 2006 and ongoing, Headspace has operated for over 19 years. Starting with 10 pilot centers, the network expanded rapidly: the first 10 services opened in 2007, approximately 55 centers by 2014, approximately 100 by 2018, and over 154 centers by 2023. Headspace is a permanent fixture in Australia’s health landscape, funded under successive mental health plans, with additional online services through Headspace launched in 2010.^{3,4}

Investment: Substantial federal funding: Initial funding in 2006 was AU\$54 million, and by 2020, cumulative funding exceeded AU\$700 million. In the 2021 federal budget, approximately AU\$278 million was allocated for expansion and enhancement. Each center operates through lead agencies typically funded AU\$1 million–AU\$2 million annually. State governments occasionally

contribute, but primary funding is federal. Considering the more than 100,000 youth served annually, investment is seen as worthwhile.^{5,6}

Hoped-for outcomes: Improved mental well-being and reduced suicide/self-harm among young Australians. Increase the proportion of young people getting help, reduce psychological distress, improve social and vocational functioning, and high satisfaction with services. Long-term aim: reduce severe mental illness into adulthood, normalize mental health care, and divert youth from hospital-based care. Target is to have at least one Headspace within approximately one-hour drive for all young Australians.⁷

Implementation: Headspace centers follow a hub-and-spoke model in accessible areas, providing four core services: mental health counseling, physical health, alcohol/drug services, and vocational support. Centers employ youth mental health professionals, GPs, and vocational specialists. Services are free or low-cost, emphasizing walk-ins and confidentiality. A Youth Advisory Group ensures youth-centered service, and satellite services extend reach. Integration with universities and Australia’s Medicare system, and specialized programs for early psychosis are notable implementations.⁸



Traction/campaigns:

Headspace benefits from broad political and public support, effectively becoming a trusted youth brand. Recognizable marketing campaigns like “Headspace Day” promote youth well-being. Collaborations with Australian musicians and athletes enhance visibility. Community acceptance is high, with many regions lobbying for centers. Notable traction: over 1 million young people supported since inception. The pandemic increased demand, highlighting tele-mental health services.^{9,10}

KPIs:

- Client improvement: Approximately 70 percent show significant mental health distress improvement, more than 85 percent satisfaction rates.¹¹
- Service reach: Approximately 550,000 sessions delivered in FY2024.¹²
- Accessibility: Centers meet intake target within two weeks; network expansion to 154 centers by 2023 ensures broad reach.³
- Demographic penetration: Headspace serves approximately 11 percent of youth aged 12–25 annually.¹²
- School engagement: More than 75,000 students received mental health education in 2023.¹³
- Stigma reduction: Significant increase in help-seeking attitudes among youth, partly attributed to Headspace’s presence.¹⁴

Stakeholders:

- Young people as primary stakeholders, shaping services through advisory groups.
- Australian Government Department of Health: Key funder and policy driver.

- Headspace National Youth Mental Health Foundation: Manager of model fidelity and center support.
- Local health providers and NGOs: Partners in center operations.
- Schools, universities, community organizations, and families play integral roles in supporting Headspace’s outreach.
- Mental health professionals involved in care delivery. State health systems coordinate with Headspace for comprehensive service coverage.¹⁵

Outcome/results:

- Approximately 70 percent show significant mental health distress improvement, more than 85 percent satisfaction rates.¹¹
- More than 75,000 students received mental health education in 2023.¹³
- Economic evaluations estimate \$450 million annual benefits from improved mental health and productivity.¹⁶
- Headspace is a cornerstone of Australia’s youth mental health strategy, successfully providing services to hundreds of thousands with evidence of reduced psychological distress and high satisfaction rates. Though youth suicide rates remain steady, Headspace’s preventative role is crucial. Reduced stigma and increased mental health literacy among youth are notable cultural shifts. The integrated approach has helped many clients re-engage with education and employment after intake. Systemically, Headspace prompted similar early intervention initiatives, positioning Australia as a leader in youth mental health.¹⁶



Taiwan: Expansion of long-acting injectable antipsychotic treatment access

Objective: Taiwan's National Health Insurance (NHI) introduced a dedicated budget policy for long-acting injectables (LAIs) in 2022 to improve treatment adherence among schizophrenia patients. The goal is to improve outcomes for people with schizophrenia by expanding access to LAI antipsychotics through enhanced insurance coverage and clinical uptake. LAIs, which require injections every one-to-three months, can significantly reduce relapse and rehospitalization, but usage was previously low due to cost and limited awareness. The initiative aims to make LAIs widely available and affordable under NHI, encourage their use by psychiatrists and patients, and ultimately reduce relapse rates and improve patient adherence.^{1,3,8}

Duration: From approximately 2019 through 2025, policy changes and expansions have been underway. Taiwan began enhancing coverage around 2019, with NHI adding newer LAIs to the formulary. A key milestone in 2023 was evidence prompting NHI to propose a significant budget increase for LAI funding starting in 2025. The NT\$3.1 billion earmarked for 2025 marks a major budget increase, with implementation continuing, ensuring LAIs remain a permanent option in treatment guidelines.

Investment:

- 2025 NHI budget: The Ministry of Health and Welfare announced a record increase in the NHI global budget to NT\$928.62 billion, explicitly continuing LAI reimbursement with an additional NT\$3.11 billion.¹
- 2022 launch funding: The LAI-DBP was reported at NT\$2.7 billion on introduction.²
- Previously, usage was limited due to tight budgets. Additional investments include clinician training and patient education, funded by the Ministry of Health and Welfare. LAIs can be costly (NT\$5,000–NT\$10,000 per dose), so NHI funds are crucial for removing cost barriers, with net savings expected from reduced hospitalizations.

Hoped-for outcomes: Better treatment adherence and fewer relapses/hospitalizations for schizophrenia patients. Increase stable schizophrenia patients on LAIs to reduce relapse rates by approximately 20 percent to

30 percent, improve psychotic episode frequency, and enhance quality of life and functional outcomes. System-level aims include lowering hospitalization and ER visits and improving stigma by stabilizing patients' community involvement. Target goal: achieve 30 percent utilization of LAIs among eligible patients by 2025. Ultimately, reduce suicides and improve social outcomes.

Implementation:

- Reimbursement and listing: NHI's third party payment and global budget mechanisms cover medicines via fee schedules; pay-for-performance (P4P) is used across programs to influence treatment behaviors and improve outcomes.³
- Formulary evolution: Reimbursement of monthly (PP1M) and thrice-monthly (PP3M) paliperidone palmitate has been associated with significant increases in LAI prescribing.²

Traction/campaigns: Gained momentum with compelling evidence and psychiatrist advocacy. A pivotal study (2021) showed LAIs led to 23 percent fewer rehospitalizations, shifting narrative to "LAIs save costs by preventing relapses." Although not a mass campaign, the initiative was widely promoted in medical fields. A 2023 Health Ministry press conference highlighted increased LAI funding, boosting visibility. Family support groups endorsed LAIs, noting decreased monitoring stress when patients switched. NHI's funding announcement (NT\$3.1 billion) signaled LAI prioritization, encouraging hospital adoption.

KPIs:

- Budgeted support (2025): NT\$3.11 billion ring fenced within NHI for LAI reimbursement.¹
- Utilization (hospital data set): LAI share approximately 33.2 percent of all antipsychotic prescriptions by September 2024 (postpolicy) at the studied institution; SGA LAI share approximately 27.8 percent.²
- Effect on readmissions: Early discontinuation of LAIs is linked to higher risk of psychotic readmission; continued LAI use following in hospital initiation is protective.⁵



- Relapse/hospitalization metrics: Reduced average inpatient days by 25 annually for LAI patients.

Stakeholders:

- National Health Insurance Administration (NHIA) under MOHW funds and regulates reimbursement and payment models (global budget, P4P).³
- Psychiatric hospitals and clinics deliver LAIs; clinical consensus in Taiwan supports broader uptake to improve outcomes.⁴

Outcome/results:

- NHI global budget 2025: NT\$928.62 billion, with multiple earmarks and expansions; LAI reimbursement explicitly receives more than NT\$3.11 billion in 2025.¹
- Policy impact (2022–2024): Dedicated budget support and broader LAI reimbursement increased LAI utilization and shifted prescribing toward SGA-LAIs in real-world practice.²
- National trend: Over 2010–2019, Taiwan saw greater SGA/LAI use and ongoing efforts to improve adherence and outcomes in schizophrenia care.⁷
- Clinical impact: Early initiation and sustained LAI treatment reduces risk of readmission in Taiwanese cohorts, supporting the policy's adherence and relapse-prevention goals.⁵

Saudi Arabia: Seha Virtual Hospital (Digital Mental Health Access Platform)

Objective: Seha Virtual Hospital (SVH), launched in 2022, is the world's largest virtual hospital, connecting more than 224 hospitals across Saudi Arabia. It provides telehealth consultations, including psychiatry, using AI, AR, and digital twins to overcome geographic barriers and expand access to specialist care, including psychiatry, through a nationwide virtual hospital platform. SVH, launched by Saudi Arabia's Ministry of Health (MOH), aims to enable patients anywhere in the Kingdom to consult specialists remotely. This ensures access to advanced care for those in remote or underserved areas without travel. For mental health, the objective is to provide psychiatric evaluations and follow-ups via telemedicine, integrating mental health services into a cutting-edge digital health system to increase equity in healthcare access, reduce wait times, and improve health outcomes.^{1,2,3,4}

Duration: Launched in February 2022 and rapidly scaling through 2025, SVH started with initial pilot services and became fully operational by mid-2023, connecting more than 130 hospitals, expanding to more than 224 by 2025. As of late 2025, SVH is in the expansion phase, with 166 connected hospitals aiming to integrate every MOH

hospital. Continuously upgraded as part of Saudi Vision 2030's healthcare transformation, SVH has no set end date.^{1,2,5}

Investment: Significant government investment in telehealth infrastructure for telemedicine platforms, data centers, and equipment. SVH employs over 150 doctors across specialties for teleconsults, serving up to 480,000 patients annually, indicating substantial operating costs. Funding comes from the MOH's Health Transformation Program budget, with partnerships for telehealth software and AI tools. Indirect savings from centralizing expertise and reducing the need for local psychiatric coverage are expected.^{1,2,6}

Hoped-for outcomes: Equitable, timely access to high-quality care and improved health outcomes through early specialist intervention. For mental health, the goal is to ensure patients can see psychiatrists within days, reducing the need for transfers and travel costs. Improve clinical outcomes by providing remote expert input to prevent complications. Enhance efficiency: one specialist can cover multiple hospitals virtually. Target numbers: hundreds of thousands of virtual consults **annually**, integrating e-consults as routine care.^{1,2,7}



Implementation: Implemented as a central hub in Riyadh linking hospitals nationwide. Telehealth rooms with high-resolution cameras and diagnostic equipment facilitate consultations. Psychiatric telemedicine includes patient-to-provider and provider-to-provider models. SVH operates 24/7 for urgent specialties, including mental health. Training local staff, ensuring broadband connectivity, and integrating electronic health records are key components. MOH mandates virtual referrals, and the Seha app and call center direct users to SVH services.^{1,2,8}

Traction/campaigns:

SVH gained global attention as the world's largest virtual hospital and a Vision 2030 flagship. COVID-19 accelerated telehealth acceptance. Utilization grew quickly, achieving over 255,000 patients served and 1.6 million virtual consultations via Sehhaty app since launch. MOH mandates hospitals to use SVH, making it part of KPIs for directors. Mental health uptake was strong in underserved provinces.^{1,2,9}

KPIs:

- Consultation volume: Over 100,000 virtual consultations conducted by mid-2023, targeting 500,000 annually at full capacity.
- Coverage: Connecting 224 hospitals, aiming for all 240 MOH hospitals by 2025.
- Patient outcomes: Stroke door-to-needle times reduced to 33 minutes; psychiatric transfers decreased 30 percent.
- Provider participation: Grew from 150 doctors in 2022 to more than 300 by 2025.
- Utilization goals: Achieving at least 60 percent utilization of SVH's capacity by 2025.^{1,2}

Stakeholders:

- Patients and families, especially in remote areas, benefit from easier access.
- MOH and Vision 2030 program office: Funders and advocates of SVH.
- Healthcare providers: Integrate SVH into their workflow, relying on remote support.
- Specialist doctors at SVH: Engage in nationwide care, extending hospital reputation.
- IT and telecom sectors: Provide essential connectivity and platform maintenance.
- Government entities: Use SVH as a showcase, contributing to its success.
- Academic institutions and community leaders: Indirectly support improved local services.^{1,2,8}

Outcome/results:

- Scalability: SVH now serves over 255,000 patients, with capacity for 597,500 annually.
- Quality of care: High patient satisfaction (86 percent) and reduced readmissions (25 percent) indicate strong clinical outcomes.
- SVH has rapidly transformed healthcare delivery, ensuring specialist care accessibility and timeliness.
- Cost savings: Reduced travel and hospitalization costs by 40 percent, improving affordability.
- Global impact: SVH is extending services internationally (e.g., supporting Syrian doctors remotely), positioning Saudi Arabia as a telehealth leader.^{1,2}



Colombia: National Teleorientation Program for Mental Health

Objectives: In 2021, Colombia's government launched a teleorientation mental health program. It was designed to serve as a nationwide mental health hotline and telesupport service to provide free, immediate mental health support remotely to the entire population, especially to prevent suicide and intervene early in depression/anxiety crises. The goal was to reduce barriers of geography, cost, and stigma by offering phone-based psychological first aid, and to link callers to ongoing care or emergency services as needed.¹

Duration: Teleorientation for mental health under the phone number 192-4 began operating April 13, 2020 as a pandemic response.⁶ Subsequently, MinSalud launched the first phase of a national video call teleorientation platform on December 2, 2022, available 24/7, free of charge, and articulated with regional lines (Bogotá, Cali, Valle, Risaralda, Boyacá).^{3,4,5} Planned second phase articulation with "Línea 106" (a widely used crisis/help line) was announced in December 2022; subsequent communications (2024) show MinSalud encouraging territorial authorities to ensure national coverage/enrutamiento of 106 with the telecom regulator.^{3,4,5,12}

Investment: The program is led and funded by MinSalud; national guidance/protocols for territorial lines and national teleorientation were published by MinSalud with USAID (Programa Comunidades Saludables) and Pontificia Universidad Javeriana technical support. The guidance and protocols documented implementation processes, financing options (PIC/regalías/cooperación), and operational standards.^{7,8}

Implementation: Citizens dial 192-4 to reach mental health counselors. The protocol includes triaging the caller's needs and providing psychological first aid, including active listening, coping guidance, and de-escalation of crises. If risk is high (e.g., imminent suicide), then counselors can activate emergency services (CRUE) to dispatch help. They also give information on local mental health clinics and can schedule follow-up calls. The service emphasizes accessibility and is free, 24/7, nationwide. In 2022, a web portal added video-call appointments to expand access for those preferring online scheduling.^{1,3,4,5,9}

Campaigns for traction: The program is accompanied by the awareness campaign #EresPrioridad on social media, radio, and community outreach. It encourages prioritization of mental health, leveraging testimonials to normalize seeking support. Mentes Colectivas team promotes via regular social media content. During World Mental Health Day 2021 and 2022, additional drives in partnership with PAHO publicized the service.

Hoped-for outcomes: Reduce suicide and severe crises by offering immediate help. The initiative hopes to increase help-seeking (especially among youth and rural residents) by providing an anonymous, free channel. By intervening early with professional guidance or referrals, the program aims to prevent self-harm, stabilize individuals, and guide them into follow-up care locally. Ultimately, a reduction in suicide rates and better outcomes for depression are the desired impact.^{7,8}

KPIs:

- Utilization metrics: 18,089 mental health teleorientation requests were handled by 192-4 between April 13, 2020 and April 13, 2021.^{1,2}
- Caller profile: 61 percent women; majority aged 15–39. Approximately 17 percent from vulnerable groups (conflict victims, disabled, migrants).^{1,2}
- Follow-up/Referral: Approximately 4.6 percent of calls led to healthcare referrals (for serious cases). Approximately 40 percent of cases required scheduled follow-up calls (monitoring).^{1,2}
- Coverage: Active in all 32 departments via single line. By end of 2022, integrated with over five regional helplines and a national 106 hotline to ensure 24/7 counselor availability.^{1,2}
- Start and staffing (pandemic phase): Operation began April 13, 2020 with approximately 40 clinical psychologists working in shifts; estimated capacity 300 orientations/day.⁶

Stakeholders: MOH (program owner), departmental health secretariats (coordinate local follow-up), National Center for Mental Health (technical input), and international partners (e.g., UNICEF in integration of psychosocial support for youth). Callers include the general public, often young adults and people in conflict-affected areas. The service is part of the broader public



mental health network, interacting with hospitals and community providers via referrals. MinSalud (owner/implementer); clinical psychologists (service providers); regional health departments and existing hotlines (partners for referrals); PAHO/WHO, IOM (policy

support); general population (end-users); emergency services; and other sectors (referral endpoints in severe cases).^{1,6,78}

Outcome/results:

- Expanded access: By late 2022, the “Línea de Salud Mental” was fielding calls from all 32 departments of Colombia. It has been credited with “contributing to the early identification of suicidal behavior” in callers, even access to remote and underserved populations.^{1,3,4,5}
- Positive user impact: Reduced anxiety/distress after sessions, with approximately 36 percent returning for follow-ups.^{1,3,4,5}
- Geographic distribution (early operation): Bogotá (approximately 26 percent), Antioquia (approximately 12 percent), and Cundinamarca (approximately 10 percent) accounted for the largest shares of early contacts, with cases recorded across multiple departments—demonstrating national reach through the 192 line.⁶
- Timely crisis intervention: Effective at de-escalating crises; coordinates life-saving interventions in acute cases, supporting individuals in dark moments.^{1,3,4,5}
- Integration into health system: Strengthens the mental health continuum, guiding users to follow-up with insurance providers or clinics, easing emergency room pressure.^{1,3,4,5}

Israel: National Mental Health Insurance Reform

Objectives: Integrate and improve access to quality mental health care by including it in the national health insurance basket. The reform aimed to end the separation of mental versus physical health care, reduce stigma, and ensure every citizen can get psychiatric or psychological treatment through their health fund (HMO) with minimal out-of-pocket cost.

Duration: Enacted via government order in 2012, the reform took effect July 1, 2015 when responsibility shifted from the Ministry of Health (MoH) to the four public HMOs. It is ongoing; further enhancements were introduced in 2023–2024 (e.g., new trauma clinics postconflict), and the program continues to expand community services in 2025.

Investment:

- By 2018, the reform budget stood at approximately NIS 2.3 billion, and the State Comptroller noted an additional approximately NIS 400 million supplement to HMOs as part of the reform.⁵

- The 2015 reform reallocated NIS 1.54 billion to HMOs’ budgets for mental health services, including about NIS 300 million in new annual funds (2012 prices).
- In 2024–2025, the government announced major increases to strengthen community mental health services (press and MoH briefings commonly cite approximately NIS 1.4 billion for mental health as part of broader health system reinforcement).^{4,6,7}
- Additional one-time infusions occur for special initiatives. For example, in late 2023, tens of millions of shekels were earmarked for new community programs and wartime trauma support.
- Overall, funding is considered adequate by law to cover basic needs, though experts note it remains only approximately 4 percent of total health spending (below OECD averages), indicating scope to further increase resources.

Implementation: The MoH transferred service provision to HMOs in 2015. Care is delivered via HMO mental health clinics (multidisciplinary teams), public hospital



outpatient clinics, and independent providers contracted by HMOs. The MoH emphasizes low copayments (e.g., a small quarterly copay for psychiatrist visits in public clinics; independent-provider psychotherapy has regulated, modest fees), extended hours, and dozens of new clinics to improve access.^{1,2,8}

Campaigns for traction: Public awareness improved with the reform's rollout and HMO advertising that therapy is covered like any specialist visit, leading to increased utilization. Public communications and HMO guidance helped normalize access. Utilization surged post-October 7, 2023: MoH data cited in national media indicate approximately 400,000 people received mental health care via HMOs in 2024, with sharp increases in short-term care and resilience programming. School and community programs partnering with HMO clinics aided normalization of mental health care.^{9,10}

Hoped-for outcomes: Aims for greater service availability, shorter wait times, and parity of esteem between mental and physical health, encouraging earlier help-seeking and reducing stigma. The reform seeks to reduce psychiatric hospital admissions and lengths of stay by strengthening community care, ensuring equity for underserved communities.^{11,12}

KPIs:

- Availability: Over 50 new clinics opened by 2018, totaling around 340 nationwide by 2025.
- Wait times (historical and recent): The State Comptroller (2020) found average waits in 2018 were approximately 150 days for psychotherapy (adults/children). During 2024–2025, several audits and press reports describe significant demand and, in many areas, multimonth waits—with MoH stating plans to reduce queues.^{5,13,14}
- Utilization: HMOs treated approximately 400,000 people in 2024, and short-term care cases (three sessions) rose approximately 471 percent versus 2022 (from around 3,500 to around 20,000).⁹

- Financial protection: MoH guidance confirms low or no copays for psychiatrist visits in public clinics (small quarterly excess) and regulated modest fees for independent-provider psychotherapy.^{2,8}
- Payment reform details (November 2024): Retrospective bundled episodes (15 encounters/year) for outpatient mental health; higher per-diem inpatient tariffs; P4Q payments for hospitals.¹¹

Stakeholders: Includes the MOH leading policy, Health Funds providing services, and mental health professionals transitioning to HMO contracts. Patients and families play crucial roles, with advocacy groups supporting simplified access. General practitioners facilitate referrals, and the Ministry of Finance influences funding expansions. The Israel Trauma Coalition and international donors contribute, supporting community clinics for trauma.

Outcome/results:

- Service utilization: HMOs treated approximately 400,000 people in 2024, and short-term care cases (three sessions) rose approximately 471 percent versus 2022 (from around 3,500 to around 20,000); increased equity for Arab and Haredi patients.⁹
- Resilience: Participation in community resilience programs surged to 171,000 from 40,000 in 2022, a 327 percent increase. Individual resilience programs also saw a 758 percent jump, with 41,000 participants compared to 4,780 in 2022.⁹
- Stigma reduction: More routine mental health care via clinics aiding destigmatization, with reduced private clinic use.⁹
- Quality of care: Over 80 percent satisfaction reported by patients via HMO, improvement from prereform levels.⁹
- Continuity: Improved holistic management of comorbidities due to integrated care.⁹



Brazil: Psychosocial Care Centers Reform

Objectives: Brazil aimed to transform its mental health system from an asylum-based model to a community-based psychosocial care model. This reform centers around psychosocial care centers (CAPS), designed to deliver multidisciplinary outpatient care for mental health and substance abuse disorders. Goals included deinstitutionalizing psychiatric hospital patients, promoting social reintegration, and ensuring the right to community care as mandated by Law 10.216/2001. Reduction of psychiatric beds and reallocating resources to community services were key strategies, aiming for better clinical outcomes and dignity for mental health patients.

Duration: The reform's legal milestone is Law 10.216 (April 6, 2001). CAPS operation/typologies were formalized by Portaria 336/2002, and national RAPS (Psychosocial Care Network) was instituted in December 2011 to integrate CAPS and other points of care.^{1,2,3} Official MoH time series show 2,546 CAPS by 2018, rising to 2,836 by mid 2022 (and continuing upward thereafter). Earlier snapshots show 848 CAPS (June 2006) and 1,290 (October 2008).^{5,6,14}

Investment:

- RAPS was nationally budgeted and expanded; MoH confirmed first major custeio (operating) increase since 2016 with more than R\$ 383 million annually (October 2024) for CAPS and Residências Terapêuticas and 137 new services; plus R\$ 69.4 million for newly habilitated points.¹²
- MoH also announced RAPS budget additions of R\$ 414 million over 12 months into July 2024 and highlighted strengthening of the Programa de Volta para Casa (PVC).¹⁰
- By 2019, the annual federal mental health budget for community services was about R\$1.6 billion, under 1.5 percent of total health expenditures.¹⁸

Implementation: Guided by federal policy, implementation involved setting CAPS types based on population size—CAPS I for small towns, CAPS II for medium cities, CAPS III for large cities (24-hour centers), CAPS I for children/adolescents, and CAPS AD for substance use. Municipalities apply for CAPS establishment. Multidisciplinary teams staff the centers,

which cooperate with general hospitals and community residences. Significant asylum hospital closures occurred; thousands moved to community living via the “Back Home Program” and Therapeutic Residential Services. CAPS activities foster community involvement. Legal enforcement supports patient rights, with stakeholders actively advancing reforms.^{2,3,4,5}

Campaigns for traction: The “Luta Antimanicomial” (Anti-Asylum Struggle) movement fueled traction, with public support rallying around “Por uma sociedade sem manicômios,” emphasizing a society without asylums. CAPS services witnessed utilization increases—patients treated for depression in CAPS rose 107 percent from 2013 to 2019, indicating substantial uptake. CAPS coverage expanded to meet approximately 87 percent of population needs by 2019, improving geographic equity. Media coverage highlighted success stories, and Brazil received international recognition from the World Health Organization in 2015, validating domestic efforts.

Hoped-for outcomes: The reform envisioned drastically reducing psychiatric hospital populations, creating a society where patients receive community care with dignity. Goals included increasing CAPS treatment points, achieving better clinical outcomes with continuity of care, social integration, and reducing emergency interventions. Social outcomes were paramount—patients regaining rights, living with dignity, and forming societal relationships. On a system level, the aim was cost-effective care over time and compliance with human rights by eliminating asylum abuses.^{1,3,4}

KPIs:

- Number of CAPS: Increased from 848 (2006) and 1,290 (2008) to 2,546 (2018) and 2,836 (mid 2022); independent analyses show approximately 3,343 by 2023, rising 42.7 percent (2013-2023).^{5,6,14,15}
- Psychiatric beds (SUS): Total SUS beds fell approximately 40 percent (2012–2018) from 34,730 to 20,636, with a shift toward general hospital beds; by 2013 to 2023, SUS psychiatric beds dropped from 17.3 to 8 per 100,000 (53.7 percent), while private beds rose.^{6,16}
- Hospitalization metrics: CAPS introduction led to significant reductions in psychiatric admissions,



especially long-term hospitalizations.

- PVC (Back Home Program): Created by Law 10.708/2003; MoH reports more than 8,000 beneficiaries by August 2023; current monthly benefit R\$ 755 (MoH page; MoH news referenced R\$ 500 during 2021–2023 adjustment period).^{8,9,10,11}
- Diversity: Women accounted for 77 percent of the patients, with almost half falling within the age range of 41 to 61 years (49 percent).²⁰

Stakeholders: Includes the MoH guided policy and funding. State and municipal governments operated services with federal financing; psychiatric associations, healthcare professionals, patients, families, civil society, and NGOs drove momentum. Academic institutions contributed research, while human rights bodies enforced patient rights. International organizations like PAHO/WHO provided technical advice, and private psychiatric hospital owners initially opposed reform. Overall, stakeholders encompassed government, healthcare workforce, service users, activists, and academic research, ensuring multisector engagement.^{3,4}

Outcome/results:

- National volume of mental health attendances (SUS): Psychological/psychosocial attendances doubled from 13.1 million (2013) to 26.4 million (2023); approximately 13.9 million psychological attendances were recorded in H1 2024 alone.^{15,17}
- CAPS density (national): MoH 2022 table indicates CAPS/100,000 ratios by state, with national mean approximately 1.33 (weighted measure used by MoH), and 2,836 CAPS across 1,910 municipalities by June 2022.⁵
- Federal funding: Share of federal funding for mental health doubled dedicated to community-based care between 2002 and 2014 (from 24.8 percent to 79.4 percent).¹⁹
- Clinical improvement: 107 percent increase in the number of patients with depression receiving treatment at CAPS between 2013 and 2019. Women accounted for 77 percent of the patients, with almost half falling within the age range of 41 to 61 years (49 percent).²⁰





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