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Advancing Mental Health Worldwide: Five Core Elements for Effective Strategies

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Table of Contents

Introduction

THE GLOBAL IMPACT OF MENTAL HEALTH: BY THE NUMBERS

More than one billion people worldwide live with a mental health condition (MHC).[1] Depression and anxiety disorders are the most common MHCs, affecting 280 million and 359 million people, respectively.[2] An additional 40 million people live with bipolar disorder,[3] and 23.18 million people live with schizophrenia—two MHCs that can cause severe disability.[4] Depending on their severity, depression, anxiety, bipolar disorder, and schizophrenia can all be categorized as serious mental illnesses (SMIs), defined as any MHC that causes severe impairment and impedes one's ability to function.

The individual, family, community, and economic impacts of MHCs are extraordinary. MHCs are the leading cause of years lived with disability (YLDs) around the world, accounting for one in six YLDs, or 155 million of the 907 million total all-cause YLDs in 2021.[5] On average, the life expectancy for people with bipolar disorder is 13 years shorter, and for schizophrenia 9 years shorter, than that of the general population.[6] People with MHCs often experience poorer overall health than the general population and have an increased risk of developing comorbid physical health conditions[7]—resulting in greater, more frequent health-care utilization and, subsequently, higher direct costs for health-care systems.

Furthermore, MHCs impose indirect costs, such as lost productivity and wages and reduced quality of life and life expectancy. Depression and anxiety disorders alone cost an estimated $1 trillion globally in lost productivity each year.[8] By 2030, the total direct and indirect costs of MHCs and their associated consequences are expected to reach $6 trillion globally, a substantial increase from $2.5 trillion in 2010.[9]

SHARED GLOBAL CHALLENGES FACING MENTAL HEALTH-CARE SYSTEMS

Countries and regions around the world rely on mental health-care systems—the interconnected set of services, providers, funding mechanisms, policies, and infrastructures—to deliver prevention, treatment, and social supports for MHCs. These systems face significant shared challenges in providing effective care and support to their communities, although the mix and severity of barriers differ across low-, middle-, and high-income settings. Despite the high prevalence of MHCs and the growing scale of their societal and economic impact, government investment often remains insufficient, particularly for mental health promotion and prevention. Many countries also underinvest in foundational areas required to deliver quality care at scale, including research, workforce development, service infrastructure, and community-based supports, limiting access to prevention, early intervention and treatment, and continuity of care.

In 2024, the median mental health budget was just 2 percent of total government health spending.[10] By contrast, cardiovascular disease, a leading cause of death globally,[11] accounts for 15 percent and 11 percent of total health-care spending in the US and the European Union, respectively.[12]

Spending gaps are exacerbated in low-income countries (LICs). Per capita, LICs spend US$0.04 on mental health, which is only 0.1 percent of the US$40 they spend on health in total. By contrast, high-income countries (HICs) spend US$66 on mental health per capita, which is 10 times more, or 1.2 percent of

the US$5,252 spent on health in total.[13] Yet, even when funding for mental health does exist, it can be misallocated or skewed toward institutions focused on acute care, which deprioritizes community services, prevention, and rehabilitation.

In addition to and in part driven by funding challenges, gaps in equitable access to care exist to some degree in all countries. In some HICs, approximately 50 percent of people with MHCs receive care, while in some low- and middle-income countries, less than 10 percent of people with MHCs receive care.[14] This widespread lack of access across geographic and socioeconomic boundaries means that the majority of people living with MHCs are not receiving the high-quality services they need, with pronounced inequities between HICs and LICs. Gaps in access to care are driven by a combination of factors, including the cost of care, provider shortages and workforce capacity, physical barriers to accessing care (e.g., distance, time, ability to travel), and social and cultural barriers (e.g., stigma).

Integrated care models are one possible solution to mitigate several of these barriers and to deliver quality care at scale. Integrated care is not an "all or nothing" approach. Therefore, countries with funding constraints can start with incremental changes. Although systemic resource gaps in LICs may prevent the full-scale adoption of these models, every small step toward integrating care with social supports is a meaningful move toward improving mental health outcomes.

A primary driver of the current mental health crisis is a shortage of mental health workers, which can include nurses, psychiatrists, psychologists, therapists, primary care physicians, pediatricians, emergency room physicians, crisis intervention teams, and other mental health-care practitioners. For example, Europe has around 80 mental health workers per 100,000 people, while Africa has only 2 mental health workers per 100,000 people.[15] The global median stands at only 13 mental health workers per 100,000 people, and nearly half of the world's population resides in a country with less than one psychiatrist per 100,000 people.[16]

A lack of mental health awareness and education, stigma, and low mental health literacy pose additional challenges to prevention and early intervention of MHCs. Studies have found that greater mental health literacy is associated with a reduction in stigma, can reduce social isolation for individuals living with MHCs, and can encourage help-seeking behavior.[17] Efforts to enhance mental health literacy and increase awareness through education on mental health risk factors, warning signs, and symptoms can help prevent MHCs and support earlier intervention, which will subsequently improve health outcomes and lower the associated social and financial costs of MHCs.

Centralizing data is critical for assessing the impact on mental health outcomes and ensuring accountability. However, mental health data are currently fragmented in many countries, making it challenging for leaders to track outcomes, improve strategies, and rationalize policy decisions and program investments.

To address these and other challenges and to focus attention on mental health, many countries have created national mental health strategies (also called mental health plans or mental health policies), as well as subnational strategies, plans, and programs. These strategies define the countries' identified priorities and guide government and other stakeholder efforts to improve mental health. World Health Organization (WHO) Member States have committed to the WHO Comprehensive Mental Health Action Plan 2013–2030, and according to the 2024 WHO Mental Health Atlas survey, 81 percent (117 out of 144) of countries responding to the survey (117 of 194, or 60 percent of WHO Member States) report that

they have a stand-alone mental health plan or policy. However, only 54 percent report having implemented the plan or policy.[18] Furthermore, the 2025 political declaration following the fourth high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being affirmed Member States' commitment to accelerating action on mental health.[19]

The health and economic costs of the current mental health crisis will continue to rise unless governments and other stakeholders move from commitments to coordinated implementation of action plans that address persistent mental health-care system challenges. To support that shift, Milken Institute Public Health examined mental health strategies and practices from around the world to identify shared challenges, emerging opportunities, and lessons from what is working in real-world settings. Consolidating these insights, this report highlights five core strategy elements, examples of successful case studies, and recommended actions to help government leaders and other stakeholders design, assess, and execute mental health strategies and programs to achieve impact and improve outcomes in their respective countries and regions.

Methodology

Drawing on the Milken Institute's long-standing history in mental health across public health and philanthropy, in 2025, Milken Institute Public Health conducted an extensive landscape analysis of more than 100 articles, studies, policy frameworks, and reports to examine existing mental health strategies, policies, and practices across 22 countries on six continents. Building on this research, the Milken Institute interviewed 13 thought leaders, representing seven countries on five continents, to better understand the practices being employed at the local, state, or national levels to advance mental health. The insights gathered from the interviews were thematically coded and analyzed.

In October 2025, the Milken Institute convened a virtual roundtable, bringing together thought leaders, individuals with lived experience, mental health-care providers, policymakers, researchers, and start-up founders, to discuss practices and policies to bolster mental health in their geographic areas of focus. Ten countries were represented at this roundtable, enabling an examination of diverse approaches to mental health, as well as the unique challenges that leaders face due to cultural, economic, political, or geographic factors.

Five Core Elements Integral to Mental Health Strategies

Insights collected from the landscape analysis, interviews, and virtual roundtable surfaced five elements that are core to a mental health strategy: (1) prevention, education, and early intervention; (2) equitable access to services; (3) integrated care and social supports; (4) funding; and (5) data and measurement.

CORE ELEMENT 1: ENHANCE PREVENTION, EDUCATION, AND EARLY INTERVENTION

The most effective methods to reduce the global burden of MHCs are prevention and education, paired with early intervention when symptoms emerge. Globally, one-third of MHCs develop by age 14 and 62.5 percent by age 25, underscoring the importance of acting sooner, during childhood and early adolescence, before symptom onset.[20]

Public health frameworks describe prevention across three stages: primary, secondary, and tertiary prevention.[21] Primary prevention is defined as intervention before health effects occur, commonly through vaccination and behavior modification to reduce risk. This route is often the most cost-effective because it prevents the onset of disease, thereby mitigating the downstream health care–related costs of screening for, diagnosing, and managing a condition. Secondary prevention involves screening to detect disease in its earliest stages, before symptoms arise, allowing for early intervention. After diagnosis, tertiary prevention focuses on treatment and managing conditions to reduce the burden of disease. Early intervention is known to result in better outcomes for individuals with MHCs,[22] with primary prevention as ideal.

Education supports both primary and secondary prevention by increasing mental health literacy, which is defined by Tulane University's Celia Scott Weatherhead School of Public Health and Tropical Medicine as "the knowledge of and ability to learn about mental health. This includes general knowledge of the signs and symptoms of as well as the treatment resources for mental illnesses, and the ability to recognize, manage, and seek support for mental health issues."[23] Mental health literacy can also reduce stigma and help people recognize early warning signs, enabling them to seek care sooner.

The importance of prevention, education, and early intervention was a recurring theme throughout our research, interviews, and roundtable. We identified 11 specific practices that can be embedded in mental health strategic plans to support prevention, education, and early intervention efforts.

Prevention

- Implement programs to address upstream drivers of health, such as employment, housing, and food and nutrition, to mitigate risk factors associated with the development of new or the worsening of existing MHCs.
- Integrate substance use prevention and harm reduction strategies into mental health prevention initiatives, given the well-established relationship between substance use and MHCs.
- Invest in community infrastructure, such as green spaces, public programs, and initiatives that promote healthier, more connected lifestyles to reduce mental health risks at the population level.

Education

- Embed age-appropriate mental health education in school curricula nationwide to destigmatize mental health and increase mental health literacy, starting at an early age.
- Launch public health campaigns to increase awareness of risk factors for developing MHCs and early warning signs, coupled with clear guidance on how to respond when those signs arise.

Early intervention

- Adopt the evidence-based coordinated specialty care model as the standard of care for individuals experiencing a first episode of psychosis (FEP), which is the gold standard for early intervention with FEP.
- Mandate training for educators to recognize mental health warning signs and to provide mental health first aid, so that they are better equipped to identify and respond to young people in need.

> **A clinical psychologist emphasized the importance of coordinated specialty care for FEP, saying, "You can only improve so much if you know you have first episode psychosis, but your health plan doesn't cover the only clinical intervention that is proven to work, which is coordinated specialty care."**

- Incorporate mental health screenings into primary care settings to facilitate early identification and intervention.
- Expand insurance coverage of mental health screenings to ensure equitable access to those services.
- Train law enforcement and other first responders in mental health first aid so that they can appropriately identify mental health crises and refer individuals to the proper mental health professionals.

> **An internationally recognized psychiatrist shared, "The most effective thing we found, though, was enlisting the aid of law enforcement, who all of this ultimately falls on to manage..." because law enforcement, and other first responders, are often called to respond to mental health crises in the absence of first-line mental health professionals.**

- Increase the availability of crisis intervention services to prevent escalation of MHCs.

Australia's headspace Model for Early Identification and Intervention

In 2006, Australia established headspace National Youth Mental Health Foundation, funded by the Australian Government Department of Health and Aged Care, to support young people and their loved ones as they navigate mental health challenges. The program offers holistic, integrated primary care services to individuals aged 12–25 years, focusing its prevention, education, and early intervention efforts on the critical window in which most MHCs emerge. headspace centers provide youth and their caregivers with comprehensive services—including mental health support, physical and sexual health services, alcohol- and drug-related services, and work and study support—in a welcoming, accessible environment, to address the myriad challenges that young people face.

Specifically, headspace:

- Is designed to engage young people *before* the onset of MHCs, providing them with the tools and education needed to foster resiliency, promote well-being, and navigate life challenges to prevent any mental health challenges from developing into MHCs.
- Makes self-help and guided resources widely available, equipping young people and their caregivers with the tools and information needed to prevent mental health challenges in the first place, but also to recognize and appropriately respond to concerns when they do arise.
- Provides education and increases awareness of early mental health warning signs, leading to earlier recognition and faster intervention, which is proven to result in better long-term health outcomes.
- Employs multidisciplinary care teams consisting of general practitioners, social workers, clinicians, counselors, study specialists, and career mentors to ensure that young people can access the appropriate professional(s) for their individual needs, without having to seek them out separately, which can be a barrier.
- Embraces the importance of community in bolstering mental health by offering resources for parents, families, educators, and other professionals so that they can build their mental health literacy and better support youth as they navigate mental health concerns.
- Partners with local organizations to expand the reach of headspace programs and embed them in the communities where young people live, work, and play.
- Offers young people and their support systems access to headspace services online, over the phone, or in-person at headspace centers. This approach minimizes physical barriers to accessing care, enabling young people to reach out in the manner that feels most comfortable to them.
- Convenes reference groups to collect feedback from young people and their families. Their input is incorporated throughout the design, development, and evaluation processes of programs and initiatives. This approach ensures that the programs are youth-friendly, approachable, and tailored to their specific needs, increasing the likelihood that young people will access the services.

Australia's headspace program stands out for its focus on prevention, education, and early intervention; emphasis on integrated, comprehensive care; and intentionality in centering the client experience.

CORE ELEMENT 2: PRIORITIZE EQUITABLE ACCESS TO CARE

One of the largest barriers for individuals seeking mental health care is a lack of access. As previously discussed, widespread provider shortages and a lack of investment in mental health preclude adequate access to care for all who need it. Gaps in access often fall along socioeconomic lines, meaning care is more accessible to individuals in certain geographic areas or with greater financial resources. To truly tackle the mental health crisis, everyone must be able to access quality care without long wait times or excessive travel times. In other words, access to care must be equitable.

As defined by Robert Wood Johnson, health equity means that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[24]

Many thought leaders engaged in this project underscored the need to prioritize equitable access to care as a key component of mental health strategies. No single right way to address barriers to care exists because they manifest differently for each community and individual. Achieving mental health equity means ensuring that each person has the resources they need to access the services that are appropriate for their unique circumstances. By definition, equity cannot be a one-size-fits-all solution and *must* be customizable and flexible.

> **"Another big barrier is this concept of one-size-fits-all and where the needs of everyone can be determined by very rigid systems," one thought leader explained.**

Efforts to ensure equitable access to care must address all factors that impede care, including financial challenges, insufficient workforce capacity, physical barriers, and social and cultural barriers. Actions to address these factors include the following:

Financial considerations for individuals

- Lower the direct costs of health insurance and out-of-pocket medical expenses.
- Mitigate the indirect costs associated with seeking and receiving care (e.g., unpaid time off from work, transportation costs).
- Strengthen and enforce parity laws to ensure that insurance coverage and reimbursement for mental health are comparable to those for physical health.
- Fully cover preventive mental health services at the point of care.
- Improve the affordability of treatment options.

Workforce capacity

- Offer mental health workforce education and training programs, such as scholarships and/or stipends to recruit and retain human capital, especially in underserved communities, to combat the provider shortage, shorten wait times, and improve the provider–patient ratio.

> **An American public health official lamented, "There's a huge talent deficit in mental health. It's changing slowly, but for years these have been underpaid, undervalued, highly stigmatized jobs that no one really wanted... Now we're seeing more and more young people trying to pursue mental health careers and finding it's not sustainable."**

- Upskill or shift tasks to lay workers, community workers, and others to expand the capacity of the mental health workforce.

> **According to a Singapore-based global mental health expert, "There wouldn't ever be enough psychiatrists anyway, ... [or] enough psychologists anyway, even if we increase the workforce. So we need to find alternatives to deliver mental health care, like task shifting, where you train lay workers, community workers, or frontline workers."**

- Integrate mental health care into other care settings, such as primary care, pediatrics, pharmacies, and specialists, such as OBGYNs, which reduces the burden and expenses of managing multiple providers and appointments and ensures continuity and coordination of care for a holistic approach to mental well-being.
- Implement regular provider check-ins, either in-person or virtually, to assess medication affordability and dosage, thereby supporting adherence to treatment protocols and strengthening patient engagement.

> **In one thought leader's own words, "The most relevant issue for whether or not they're able to maintain their stability in the community and avoid hospitalization is medication adherence, which is not necessarily being willing to take medication. It can be being able to afford medication and being able to access medication. And being able to be properly stabilized so that you have the right dose of the right medication that is being monitored appropriately by medical professionals and psychiatric professionals."**

Physical barriers to care

- Establish mental health service locations in rural areas, not just urban centers, to reduce geographic disparities in access.
- Close the digital divide and expand access to devices and internet connectivity needed for telehealth, especially in rural and underserved areas.

- Expand telehealth offerings to eliminate physical barriers to mental health care and increase access for people who cannot readily access in-person services, such as people in rural or provider-shortage areas or people with physical disabilities or mobility challenges.
- Embed care directly in communities, which allows people to access services without going out of their way, reducing barriers to access. For example, employ dedicated mental health professionals in schools and provide educational information about MHCs and mental health resources at community centers and other gathering places.
- Ensure the availability of evidence-based digital mental health tools, such as mental health support or telehealth services, to individuals and communities in remote or provider-shortage areas.
- Offer students, particularly those who reside in under-resourced settings, access to school-based mental health services, including counselors, psychologists, and social workers.

> **As one psychologist noted, "For a lot of different services, going virtual actually increased the accessibility of the service to certain people... You don't have to do as much coordination around travel and things like that. Families are more able to participate."**

Social and cultural barriers to care

- Offer resources, such as care navigators, translators, or patient advocates, to help individuals navigate their care journeys and make informed decisions about their treatment options.

> **One mental health policy expert expressed, "You cannot expect the average health-care consumer to even be able to stand up for their own rights because they are so hard to fight for, and health plans have such opaque ways of skirting care," underscoring the need for patient advocates to assist in that process.**

- Include people with MHCs and their families in the development and implementation of programs and services to ensure that their lived experiences and needs are reflected and accounted for.
- Ensure that the needs of people with SMI are adequately considered, acknowledging that they may require additional support to navigate the health-care system.

> **As one thought leader, who leads a mental health advocacy nonprofit, noted, "It's very difficult to take a person who is in psychosis and not stable and navigate through a system that is tough to navigate even without those challenges."**

- Tailor services to specific communities and ensure that they are culturally relevant to increase trust in and utilization of mental health services.
- Embed mental health services in communities, which may mitigate stigma by making mental health information and resources more visible, familiar, and normalized.

Singapore's Peer Support Specialists Create a Cycle of Support to Expand Access to Care

Singapore's Tiered Care Model focuses on a patient-centered, community-based approach to meet people where they are and provide an appropriate level of support based on demonstrated needs. A key component of this model is the Peer Support Specialist Programme, which Singapore's National Council of Social Service launched in 2016 to train people with lived experience to support others through their mental health journeys. These peer support specialists (PSSs) become part of the multidisciplinary team of physicians, nurses, psychologists, and other health professionals who provide integrated care to people with mental health challenges. PSSs provide support in three main avenues: education, peer support, and stigma reduction.

Singapore has 4.6 psychiatrists and 9.7 psychologists per 100,000 people,[25] a lower ratio than other Organisation for Economic Co-operation and Development countries. This tiered approach and use of PSSs ensure that resources are deployed effectively to provide Singaporeans with the appropriate level of care.

Drawing from their own lived experience, PSSs share resources and educational materials to support an individual at every stage of recovery. They lead both individual support sessions and peer support groups and workshops, which allows for more personalized support at the individual level while also fostering community through group workshops. In this role, they humanize mental health and may be less intimidating than other providers, offering firsthand insights into the recovery process that complement formal mental health care. In addition, PSSs are mental health advocates, participating in media interviews, public speaking engagements, and conferences to raise awareness and reduce mental health stigma.

PSSs play a vital role in expanding equitable access to mental health care. Through their lived experience and public advocacy, they help individuals dismantle self-stigma while tackling some of the institutional stigma that can deter people from seeking care. They are trained to help individuals navigate the mental health-care system, which supports an integrated care approach and reduces the logistical and administrative hurdles that individuals may face (especially individuals with SMI). Furthermore, in Singapore, PSS services are free, eliminating any financial barriers to access. Because PSSs are embedded within the communities they serve, they offer culturally relevant, locally tailored support and help overcome geographic barriers that often limit access to mental health services.

By training people with lived experience to support others, Singapore's PSS program not only empowers community members but also provides PSSs themselves with purpose, connection, and improved well-being, enforcing a cycle of support that strengthens the entire mental health ecosystem. One PSS detailed his experience for the Singapore-based nonprofit Tapestry Project, remarking that he had experienced that cycle of support for himself, "I believe I will be able to perform my vocation well, to heal not just my peers but myself as well and also the system."[26]

This standout program promotes education and awareness, expands equitable access to care, and adopts an integrated care approach, incorporating three of the core elements outlined in this report to improve mental health outcomes.

CORE ELEMENT 3: EMBRACE INTEGRATED CARE MODELS WITH SOCIAL SUPPORTS

Integrated care models focus on whole-person health, recognizing that MHCs are deeply connected to the conditions and environments in which people are born, live, learn, work, play, and age. Such models deliver coordinated, comprehensive care by embedding mental health services into accessible community-based settings to eliminate barriers to access, reduce stigma, and improve outcomes.

> **Underscoring the need for a more comprehensive, unified approach, one mental and public health leader from the United Arab Emirates shared, "We should take a more holistic, honest approach to health, as in understanding that there are different elements that bring this whole picture together, and then we will stop putting health into small categories of mental and physical and geriatric and children... It's one health, one human health."**

Thought leaders engaged in this project highlighted the importance of social supports and community approaches to mental health. Social supports are the mental, physical, and informational supports that people with MHCs receive from the community and their families as part of their mental health treatment. Models that integrate social supports foster holistic well-being and ensure that mental health treatments are person-centered and sustainable. For example, people recovering from an MHC require a stable environment that fulfills their basic needs, beginning with dignified housing. Once these needs are met, the treatment focus can shift to helping them find community and then purpose.

> **One thought leader so eloquently stated this process as "...people, place, purpose."**

These models are particularly transformative for people living with SMI because they can prevent the worsening of MHCs and associated symptoms and avoid hospitalizations.

A synthesis of our research findings yielded nine key actions to implementing successful integrated care models with social supports:

- Integrate mental health services into primary care to adopt a whole-person approach during routine health care.
- Employ a housing first approach to provide a stable place for people to live safely.

> **One public health official remarked, "We need to put a priority on the idea that we need to stabilize and provide anchor institutions in the community. And those anchor institutions are really health care, housing, and community."**

- Address food insecurity through partnerships with nutrition programs.

- Provide interpersonal or friendship skills training, such as facilitated groups, to allow a safe, controlled environment for navigating conversations in a social setting.
- Provide conflict resolution skills and support (e.g., landlord and tenant disputes).
- Promote a family-first model that encourages family engagement for people with MHCs.

> **When describing family engagement opportunities, a clinical psychologist explained, "Family psychoeducation is where you educate the family about the nature of the mental illness, principles of the treatment... It's not aimed at looking at the past; it's really aimed at bringing the family on board to be members of the extended treatment team, and the client is included."**

- Deliver supportive employment opportunities for people with MHCs, such as vocational training, career preparedness, and interview and resume help.
- Connecting people with MHCs to public assistance programs to provide utility support (e.g., payment of electricity, water, natural gas, and sewage bills).
- Utilize community care models that deploy community health workers (CHWs), "lay counselors," or "community caterers" to provide informal counseling, support, check-ins, reintegration assistance, and more.

> **When discussing care models, one thought leader, who led suicide prevention efforts in Indonesia, added, "(Community) caterers would simply go to people's houses, check them, and spend time with them. They would help them detransition from a mental institution. In the mental health scope, that would be their responsibility."**

The following three case studies demonstrate the diverse application of integrated care. They showcase a blend of primary care, community-based services, the use of lay counselors, and family involvement to provide coordinated care. They also highlight how essential social supports, such as housing, employment, and support groups, function as critical components of this integration.

> **A Canadian mental health leader summarized their perception of social support as "Everyone needs a home, a job, and a friend."**

The Healthy Activity Program in India—Mobilizing Lay Counselors for Mental Health Treatment

Statistics show that the majority of people in need of mental health care do not receive the required treatment.[27] In 2016, India began to adopt an integrated approach to mental health care when Sangath, an Indian mental health company, launched the Healthy Activity Program (HAP). HAP trains lay counselors from the community to counsel, educate, and support people with depression and guide them through a range of activities to refocus their minds on positive behavior modifications and coping mechanisms.[28] These activities consist of the following:

- Supportive counseling
- Psychoeducation
- Problem-solving
- Social support
- Relaxation
- Physical exercise
- Sleep and smoking cessation support
- Addressing interpersonal triggers
- Family involvement
- Treatment engagement29

HAP is delivered over six to eight 30–40-minute sessions during which lay counselors deliver treatment for severe depression in a primary care setting or a person's home. A study found that delivering HAP alongside enhanced usual care (EUC) significantly improved mental health for people with moderately severe to severe depression in India, leading to greater depression reduction, higher remission rates, less disability, better behavioral activation, and fewer suicidal thoughts compared to EUC alone. HAP was found to be an effective, cost-efficient way to close mental health treatment gaps in this setting.[30] This program is a prime illustration of leveraging nontraditional partners who are close to their communities to provide counseling, education, and support to people with MHCs.

YAKKUM Rehabilitation Center's Disability Inclusion Through Strengthening Local to National Capacity and Policy Program in Indonesia

The Disability Inclusion Through Strengthening Local to National Capacity and Policy (DIGNITY) program is a major mental health and disability-inclusion initiative in Indonesia. This multiyear effort is led by the YAKKUM Rehabilitation Center, with support from the Australia-Indonesia partnership, INKLUSI. DIGNITY aims to advance disability inclusion by strengthening local and national capacity and policy frameworks to uphold rights, ensure protection, and expand inclusive participation of people with disabilities, including psychosocial disabilities (its term for "a range of MHCs that significantly impact an individual's ability to function in daily life and participate fully in society"[31]), in all aspects of life.[32]

The program is structured around rights-based services, community-based rehabilitation, economic empowerment, and inclusive employment to achieve its goal of comprehensive inclusion. These activities ensure that individuals receive the services they need by coordinating across sectors and promoting integrated services, such as access to legal aid, vocational training programs, self-help groups, disability services, family capacity-building, and more. Examples of specific actions include the following:

- Capacity building for families and communities by providing training opportunities for community-based rehabilitation
- Anti-violence initiatives to prevent abuse and discrimination, often through collaborations with local legal aid and other programs
- Access to integrated and accessible care through local health and social service departments
- Empowerment of families and communities to collaborate with the government, private sector, and academia to support inclusive employment and entrepreneurship
- Formation and strengthening of self-help groups composed of people living with psychosocial disabilities, their families, and other supportive community members to provide mutual support and social rehabilitation
- Work with employers and vocational training centers to encourage inclusive hiring practices and create more job opportunities for people living with psychosocial disabilities
- Strengthening of the coalition through training, coaching, and facilitated dialogues with government, civil society, and the private sector[33]

Since launching in 2023, DIGNITY has delivered clear, measurable results at the community level:

- 10 community-based self-help groups were established.
- 190 people have accessed the services provided by self-help groups.
- 43 people have received capacity building to participate in public decision-making processes.[34]

Indonesia's DIGNITY program is a shining example of how community-based approaches—combining employment support, self-help groups, and structured engagement opportunities—can strengthen inclusion and empowerment for people living with MHCs.

Fountain House Clubhouse Model Is Uplifting Community as Therapy

The Clubhouse model is a pioneering, community-based approach to psychosocial rehabilitation for people with SMI. Originating with Fountain House in New York City in the 1940s, it is distinct from traditional clinical treatment programs because it views community as therapy and focuses on the individual's strengths and potential. The following fundamental principles guide the Clubhouse model's operation and philosophy:[35]

Community is therapy—The clubhouse model creates an intentional, restorative community where members find a sense of belonging, purpose, and dignity, which helps combat the stigma often experienced by people living with SMI.

Voluntary, lifelong membership—Participants are referred to as "members" to emphasize their ownership and role in the community. Membership is voluntary, free, and without time limits, meaning that members can return for support at any time in their lives.

Work-ordered day—Members and staff work side-by-side as colleagues to run daily operations. This chosen work helps members develop skills and build confidence.

Access to resources—Members are provided access to crisis intervention services and support for their basic needs, including employment, relationship building, education, housing, and daily meals.[36]

Research suggests that the clubhouse model is associated with a reduction in psychiatric hospitalizations, improved employment, better quality of life, and cost savings for the health-care system.[37] The model has grown into a vast global movement and has been replicated with more than 370 local clubhouses across 32 countries.[38] The clubhouse model demonstrates how integrating connection, purpose, and community with access to resources aids people with MHCs.

> **Bridging this concept of community, connection, and integration with mental health systems requires sustainable investment. As one of our thought leaders articulated, "We need to invest more in family. We need to invest more in community."**

CORE ELEMENT 4: MAKE PUBLIC FUNDING THE FULCRUM OF MENTAL HEALTH STRATEGIES

The public sector remains the primary funder of mental health services and treatment, yet median governments spending on mental health accounts for only 2 percent of their total health budgets.[39] This low level of funding and the rising socioeconomic costs associated with MHCs highlight the need for public-sector strategies to prioritize funding for mental health and develop long-term funding plans to ensure sustained support for mental health goals and initiatives. Public-sector funding facilitates advances in population-level health coverage, the integration of mental health into primary care, workforce development, and accountability mechanisms that align with an individual's right to good health.

Although political drivers vary, several funding principles that can be incorporated into a mental health strategy emerged from our research:

- Promote a "whole of government" approach to funding mental health, composed of partnerships between government agencies and the private sector.[40]
- Allocate funds across the care continuum to align prevention, early intervention, treatment, and recovery supports.

> **When describing funding of mental health, one psychiatrist commented, "Redesign the funding mechanisms to support better access and care quality."**

- Commit to a policy model that incorporates full parity between mental health and physical health prevention and treatment, including equity in payment model design and equal reimbursement rates for mental health providers.
- Support sustainable funding mechanisms that are resilient to changes in government leadership.
- Collaborate with private and philanthropic organizations to complement public funding and enhance innovation and services.
- Increase accountability of public-sector funding by enhancing transparent outcome-based reporting.

Taking the Long View—Canada's Publicly Led National Mental Health Strategy

In 2012, the Canadian government created *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The strategy outlines 26 priorities and 109 action recommendations across the six strategic directions of promotion, prevention, access, equity, recovery, and leadership. It proposes the following:

- Increase the proportion of health spending devoted to mental health from 7 to 9 percent over 10 years.
- Increase the proportion of social spending devoted to mental health by 2 percentage points from current levels.
- Identify current mental health spending that should be reallocated to improve efficiency and achieve better mental health outcomes.
- Engage the private and philanthropic sectors in contributing resources to mental health.[41]

Canada has continued to refine its strategy and funding allocations to ensure that Canadians' ever-evolving needs are met. Its updated strategy, *The Mental Health Commission of Canada: Strategic Plan 2017-2022*[42] placed renewed emphasis on mental health promotion, prevention, and early intervention as well as engagement with community partners and people living with MHCs to improve the efficacy of their efforts. Canada's 2017–18 federal budget included a new investment of CA$500 million annually over 10 years, a total of CA$5 billion, to improve access to mental health services.[43] In 2021, Canada also established a new minister of Mental Health and Addictions position, demonstrating a clear commitment to advancing mental health.[44]

In 2023, Canada established the Mental Health Promotion Innovation Fund, modeled after successful approaches to chronic disease prevention.[45] The fund focuses on health promotion–related projects, with a goal of scaling interventions with the potential to address social determinants of health and promote health equity. Since its establishment, the fund has enhanced access to national support tools, including crisis support lines and youth services; provided targeted funding for priority populations; and convened an annual symposium to further mental health learning and innovation.[46]

Sustained financial support from the public sector is critical to the long-term success of any comprehensive mental health strategy. Canada has demonstrated a comprehensive approach to mental health funding that can inform and guide similar efforts in other countries.

> **As one public health official expressed, "To turn the faucet back on, you have to build the plumbing, right? You can turn on the resources; however, you need plumbing. It is really important to make a system that functions, and that 'plumbing' is payment, it's data, it's workforce. It's every effort to both improve performance and reduce fragmentation."**

CORE ELEMENT 5: STREAMLINE MENTAL HEALTH DATA AND MEASUREMENT FOR SYSTEM TRANSFORMATION

To make a measurable impact on mental health outcomes, leaders should prioritize centralized, accurate, and time-sensitive data. Currently, many systems suffer from fragmentation, complicating efforts by leaders to track outcomes, justify policy and financial investments, and ensure oversight and accountability.

> **A mental health expert focused on the Americas noted, "Without knowing what exactly is going on, it's very difficult to make improvements."**

Thought leaders engaged in this project emphasized the importance of including data and measurement as critical elements of a mental health strategy. They recommended tracking three categories of data to evaluate system performance and individual well-being: (1) system capacity, (2) clinical outcomes, and (3) quality of life and psychosocial function.

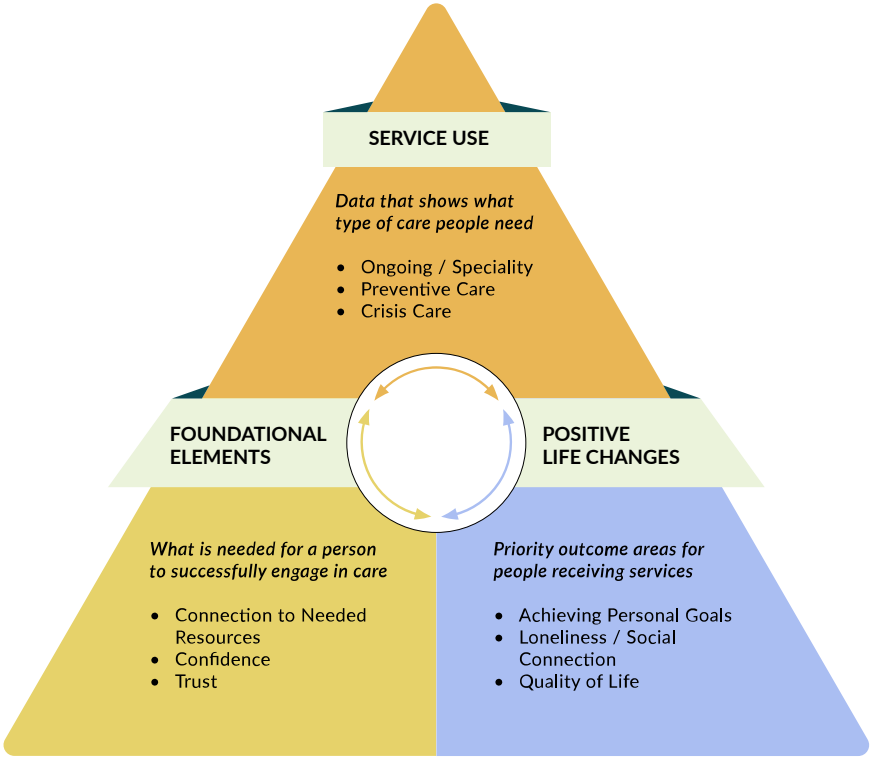
Measures of system capacity provide a broad, aggregated view of the performance, capacity, and overall impact of the mental health system and are often used for policy, planning, resource allocation, and quality monitoring across countries. System capacity measures include suicide rates, mortality rates, treatment bed availability, total cost of health care, and treatment coverage.

Measures of clinical outcomes, quality of life, and psychosocial function focus on the impact of treatment on a person with an MHC's health status, functioning, or well-being. They are often used to assess progress and evaluate treatment efficacy. Clinical outcomes measures include hospitalization/rehospitalization rates, symptom severity scales, and lengths of hospitalizations. Quality-of-life and psychosocial function measures include presenteeism, level of self-care and independent living, life skill interventions, housing stability, and law enforcement contacts.

> **When discussing mental health outcomes and measures, one psychologist explained, "The primary outcomes would be symptom severity. It would be psychosocial functioning, primarily in terms of quality of social relationships, the ability to work or go to school, or if a person is in another role (caregiver or parent), the ability to fulfill that role, and self-care and independent living... There are various measures done at various levels, at the community mental health center level, at the state level, and so on."**

One example of a mental health measurement framework is a new approach by Fountain House that builds on the International Consortium for Health Outcomes Measurement's standard sets of measures in depression and anxiety (2017) and psychotic disorders (2022).[47] Informed by lived experience, this visual framework (see Figure 1) embeds "measures that matter" directly into the mental health-care system—bridging many of the measures referenced above.[48]

Figure 1: Fountain House's "Measures that Matter" Framework



Source: Milken Institute (2026), adapted from Fountain House (2025)

To build a holistic view of mental health within a country, leaders should aim to integrate system capacity, clinical outcomes, and quality-of-life and psychosocial function data from multiple sources. Some of these data may already exist in government sources such as vital statistics, national surveys, and other government reports. Leaders should consider embedding additional mental health–related questions into existing data sources to capture more comprehensive data. Data related to treatment and care may also be available in electronic health records and insurance databases.

In addition, other partners can be a source of third-party mental health data. Academia, nonprofits, and consulting firms often collect mental health data through surveys, questionnaires, opinion polls, and other methods. These data can complement government sources to inform understanding of a country's mental health state and be used to adjust the strategy and funding allocations as needed to maximize impact.

When thinking about designing a strategy that includes measurements, a thought leader voiced, "We should be designing for zero homelessness amongst this population. We should be designing for zero mental health crisis hospitalizations. We should be designing for zero incarcerations… We should be designing for positive factors like employment and purpose, and self-reported things like loneliness and social isolation."

Denmark's Comprehensive National Health Registers Link Mental Health Data to Support Government Decision-Making

Denmark tracks mental health data through comprehensive national health registers, primarily the Danish Psychiatric Central Research Register, the Danish National Patient Register, and the Danish Civil Registration System, which collect mandatory, nationwide data on hospital admissions, outpatient care, diagnoses, treatments, and demographics, linked by a unique personal identifier (CPR number) for population-level planning, decision-making, and research.[49]

The system works as follows:

- Every resident receives a unique 10-digit CPR number, enabling data linkage across various systems.[50]
- Health data are registered when a person visits health-care providers or hospitals, buys a prescription, or receives other health services.
- Data from various sources feed into national registers.[51]

This rich source of mental health data enables study of entire populations. The data available over a lifetime help leaders and providers understand long-term mental health outcomes, disease patterns, treatment effectiveness, and risk factors. This integrated system of registers makes Denmark a leader in leveraging population-level mental health data to improve outcomes. Denmark's system is a prime example of sophisticated data interoperability that enables seamless integration of mental health data to provide a foundation for evidence-based decision-making and national planning.

Position Stakeholders for System-Level Change

> **One thought leader emphasized the need for cross-sector collaboration, saying, "Mental health is everyone's business, being that workplaces have a role to play, communities have a role to play, schools and education systems have a role to play, of course, and the health-care system has a role to play, so does the justice sector. So it includes a vision for every sort of player in the space."**

Each stakeholder within the mental health-care system has an important role in promoting early diagnosis and intervention of MHCs, advancing the national dialogue on MHC prevention, and prioritizing health equity and access to care for people with or at risk for MHCs. Stakeholders need to engage, coordinate, and collaborate meaningfully to achieve impact by assuming leadership and supportive roles to realize this vision. Therefore, people with lived experience, the private sector, community-based partners, and the public sector, including policymakers at local, state, and national levels, ideally must *all* come together and engage in the design, implementation, and continued measurement of mental health strategies for sustained success.

FROM DESIGN THROUGH DELIVERY: CENTERING THE LIVED EXPERIENCE PERSPECTIVE

> **"The only thing is just how important it is for having people with lived experience at the center of a strategy and [those] around them, their circle of influence, whether it be their peers, their family members, their caregivers, and anyone they consider their support mechanism. It's really important for them to be at the center and for them to have a say in what is developed and what is implemented," a Canadian mental health leader shared.**

When developing mental health strategies, incorporating the perspective of people with lived experience, encompassing people with MHCs and their families and mental health advocacy groups, is more than a moral or ethical choice. It is a necessity that ensures that systems work for the people they are intended to serve and treat. Other stakeholders may view mental health-care systems from the top down, while people with MHCs must navigate systems from the inside out, giving them unique perspectives on how things work in practice.

People with lived experience can identify barriers that others may overlook and can actively codesign the strategy with their personal experiences in mind. By treating people with lived experience as partners rather than only recipients, strategies become more inclusive, holistic, and effective. By centering lived experience, resources can be directed toward services that improve the quality of life for people with MHCs.

CATALYZING THE PRIVATE SECTOR TO BOLSTER MENTAL HEALTH INITIATIVES

The private sector, including employers, pharmaceutical companies, private health insurers, private care providers, philanthropic organizations, and technology and digital health companies, has a unique opportunity to bolster mental health because it can often be more agile than the government and other public entities. This agility can enable faster innovation and more creative solutions, maximizing impact through public–private partnerships that leverage the best of both sectors.

ENGAGING COMMUNITY-BASED PARTNERS TO EXTEND REACH AND PROVIDE HOLISTIC SUPPORT

Community-based mental health partners, including schools, media outlets, law enforcement, PSSs, CHWs, housing providers, social services, parks and recreation centers, nonprofit organizations, academia, and more, can bridge funding gaps and provide holistic, accessible, and culturally sensitive support, treatment, and care. These individuals and organizations work across the continuum of whole-person health, early interventions, and community-based approaches to support people with MHCs. These partners are often closest to and have local insights about the communities they serve, and can play a key role in strategy design and implementation.

POSITIONING POLICYMAKERS TO ADVANCE MENTAL HEALTH

Policymakers are uniquely positioned to allocate funding as well as champion policies, laws, and regulations that impact mental health. Each entity—whether local, state, national, or international government official, regulatory agency, or nongovernmental organization—has a distinct role to play in the creation and implementation of mental health strategies depending on a country's systems of governance and health care.

ACTIONS FOR KEY STAKEHOLDERS ACROSS THE CORE ELEMENTS OF A MENTAL HEALTH STRATEGY

Table 1 summarizes actions that each stakeholder group can take to collectively advance mental health, aligning with the five core elements of an effective mental health strategy: Prevention, Education, and Early Intervention; Equitable Access to Services; Integrated Care and Social Supports; Funding; and Data and Measurement.

Table 1: Actions for Key Stakeholders Across the Core Elements of a Mental Health Strategy

		Stakeholder		
		Individuals with Lived Experience Individuals with lived experience should be consulted by all other stakeholders throughout the design, development, implementation, and evaluation phases of each initiative.		
		Private Sector	**Community-Based Partners**	**Policymakers**
Core Element	**Prevention, Education, and Early Intervention**	**Employers:** Provide flexible scheduling options, paid leave, a healthy workplace culture (including workload), and access to mental health support for employees and their families. **Private insurers:** Ensure parity in coverage of mental health prevention and treatment. **Businesses:** Partner with nonprofits and governmental agencies to promote mental health awareness campaigns.	**Schools and education systems:** Provide mental health education and offer school-based mental health services for early intervention. **Media outlets:** Collaborate with the community to increase public awareness and reduce stigma through educational campaigns. **Law enforcement and first responders:** Partner with community mental health providers to increase connections to mental health resources. **Faith-based organizations:** Implement mental health literacy programs in their communities to reduce stigma and promote early interventions.	**Policymakers:** Elevate mental health on local, state, national, and international policy agendas using a "health in all policies" approach. Encourage mental health stakeholders to participate in convenings, coalition meetings, and workgroups.
	Equitable Access to Services	**Technology and digital health companies:** Produce innovative mental health tools and solutions to expand equitable access to mental health care through tele- and digital health services. **Pharmaceutical companies:** Lower the cost of efficacious therapies, thereby reducing some financial barriers to treatment.	**PSSs and CHWs:** "Meet people where they are" through their lived experience and direct community connections.	**Policymakers:** Enact policies that scale promising and/or novel mental health initiatives, including digital health services, to reach all communities, both rural and urban. Employ a rights-based equity framework for care and include people with lived experiences in the policy design and implementation processes.

	Integrated Care Models with Social Supports	**Businesses:** Invest in infrastructure and social support programs, including through public–private partnerships, to uplift the mental health of their surrounding communities as part of their corporate social responsibility initiatives. **Technology and digital health companies:** Support integrated care models, providing the technology needed for cross-sector collaboration and seamless integration across providers for a smoother patient and provider experience.	**Housing providers:** Offer stable, safe housing to support individuals with MHCs. **Social service departments:** Help people with MHCs, including by providing assistance with basic needs and connecting people to employment, counseling, and other community resources that promote independence. **CHWs:** Serve as a trusted bridge between communities and the health-care system by navigating complex systems, addressing social needs, educating individuals, coordinating care, and improving mental health outcomes. **Parks and recreation services:** Offer inclusive opportunities for physical activity to create a positive environment for physical and mental well-being.	**Policymakers:** Create incentives for the adoption of integrated care models. Allocate funding for social support programs, as outlined in Core Element #3.
	Funding	**Businesses and nonprofit organizations:** Provide flexible research financing opportunities to close the funding gap. Provide scholarships and financial support to students seeking to join the mental health profession.	**Nonprofit organizations:** Collaborate with governments and other agencies to unlock additional funding for mental health services.	**Policymakers:** Designate sufficient funds for mental health, including preventive services, community-based initiatives, crisis intervention protocols, and school-based programs. Strategically deploy funds to reduce fragmentation and mitigate barriers to accessing mental health care.
	Data and Measurement	**Businesses:** Partner with governments for third-party data collection and measurement to evaluate and improve the efficacy of their mental health strategies. **Technology companies:** Provide the digital infrastructure needed for data collection and analysis.	**Academia:** Partner with government agencies to provide third-party data and research/assessment support that offers a deeper understanding of the state of mental health and the efficacy of a country's existing mental health strategy.	**Policymakers:** Coordinate nationwide data collection and analysis by outlining which mental health measures are to be captured and assessed. Use the data to inform future policy and funding decisions. Regularly reevaluate existing mental health strategies and policies and update them as needed to address the evolving mental health needs of the population.

Source: Milken Institute (2026)

Ensuring Implementation and Accountability for Impact

Outlining mental health strategies is a practical first step toward improving mental health. Thoughtful implementation and widespread accountability are critical to the sustainability and success of mental health plans and practices. Throughout our research, thought leaders described how barriers to implementation stifle innovative solutions and hinder meaningful progress toward mentally healthier nations. Barriers include the following:

- Delays and extended periods of time between strategy development and implementation
- Lack of political will
- Leadership turnover and inconsistencies between administrative terms
- Insufficient post-implementation monitoring, data collection, and measurement
- Siloes and a lack of coordination among key stakeholders
- Budget, financing, and funding constraints
- Lack of infrastructure for strategy implementation and management
- Discrepancies between the national strategy and local implementation
- Failure to include lived experience perspectives, inadvertently creating services that do not meet the needs of the intended recipients
- Ineffective communication between accountable parties, including governments, private-sector actors, philanthropic organizations, people with lived experience and their loved ones, and other partners
- Failure to include and/or to implement accountability metrics

> **As one of our thought leaders noted about implementation, "(It) only means something if you ensure that it actually gets implemented and that you can then track the outcomes and prove to other people that it was worth the investment."**

A country's mental health strategies must be robust and include clear plans for sustained implementation and accountability, accounting for the unique social, political, and economic factors that collectively impact mental health, without being so prescriptive that they impede innovation. Built-in flexibility is necessary to meet people where they are and to tailor the approach to each community's needs and resources. Given the number and diversity of stakeholders involved, strong accountability metrics are critical to ensuring coordination and follow-through. Establishing an oversight board, composed of representatives from all affiliated stakeholder groups, can foster buy-in and continued engagement. By convening regularly to assess the efficacy of mental health strategies, oversight boards can refine strategies as needed, ensuring continued success and improved mental health outcomes.

Conclusion

The mental health crisis has reached a defining moment. Without comprehensive and cohesive strategies, executed thoughtfully, the human and economic costs will continue to rise. Transforming mental health into a national priority requires collective action, and no action is too small. From policymakers to the private sector, from community-based partners to individuals themselves, every stakeholder and community has a role in improving outcomes and quality of life for people living with MHCs. The future of mental health must be not only inclusive but also sustainable.

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Madelyn McLaughlin, senior associate, Public Health at the Milken Institute, has contributed to more than a dozen reports and articles focused on mental health and the role of employers as key public health partners. She also coordinates public health programming at the Global Conference and the Future of Health Summit. Before joining the Milken Institute, she conducted research with the Georgetown University Lombardi Comprehensive Cancer Center's Cancer Prevention and Control program on HPV vaccine hesitancy. McLaughlin holds a degree in human science from Georgetown University.

Jason Richie, former director, Public Health at the Milken Institute, focused on mental health. He most recently served as the associate director for state government affairs at the American Nurses Association (ANA), where his responsibilities included collaborating with state nursing associations and regulatory boards across the country, leading ANA's Advocacy Institute, and advancing mental health, nursing shortage, safe staffing, and workplace violence issues. Richie also served as a cochair of the National Forum of State Nursing Workforce Centers' Advocacy Committee. Prior to ANA, Richie addressed integrative health legislation and regulations for the American Massage Therapy Association, colorectal cancer screening as well as endoscopic research at the American Society for Gastrointestinal Endoscopy, and labor policy for the Service Employees International Union. Richie earned his bachelor's degree from Willamette University and then a Master of Science in health policy from the University of California, San Francisco, where he focused on the opioid epidemic. Richie currently volunteers with the National Institute of Health's (NIH) Office of NIH History and Stetten Museum.

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