A Plan for Mental Health, Seen from September 2026

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> This plan is an initial draft prepared with AI models. It is open for review by subject-matter experts and will be revised as they join the work and as world and national events change.

Introduction

More than a billion people live with a mental health condition, and in low-income countries fewer than one in ten of them receive any care (WHO). Anxiety and depression are the most common of these conditions, and together they cost the world economy an estimated US$1 trillion a year. Mental health conditions are the second largest cause of long-term disability, and suicide killed an estimated 727,000 people in 2021 (WHO).

Mental illness belongs among species-level problems because of its scale, its neglect and the existence of cheap treatments that work. Governments spend a median of about 2 percent of their health budgets on mental health, the same share as in 2017. Several brief psychological treatments have been shown in randomised trials to work when delivered by people with a few weeks of training, at a cost of tens of dollars per patient. War and displacement produce trauma on a large scale (see Ending War and Displacement), and poverty raises the risk of depression, which in turn makes it harder to escape poverty (see Ending Poverty).

This essay sets out a seven-part plan and tests it against events in 2025 and 2026, a period in which the evidence for low-cost care kept growing while the money to deliver it fell.

Where things stand

The main figures come from WHO's *World Mental Health Today* and *Mental Health Atlas 2024*, published on 2 September 2025, and its fact sheets updated in August and September 2026.

Measure	Figure	Source
People living with a mental health condition	more than 1 billion	WHO

Measure	Figure	Source
People with depression	about 322 million (5.2% of adults)	WHO
People with an anxiety disorder, 2023	about 470 million	WHO
Share of people with anxiety disorders who receive treatment	about 27.6%	WHO
Suicide deaths, 2021	727,000	WHO
Share of suicides in low- and middle-income countries	73%	WHO
Median government mental health spending	about 2% of health budgets	WHO
Mental health spending per person	US$65 in high-income countries; US$0.04 in low-income countries	WHO
Specialised mental health workers per 100,000 people (median)	13.5 globally; 1.1 to 2.4 in low- and lower-middle-income countries; 67.2 in high-income countries	WHO Mental Health Atlas 2024
Psychiatrists per 100,000 people (median)	0.1 in low-income countries; 7 in high-income countries	WHO Mental Health Atlas 2024

Suicide is the third leading cause of death among people aged 15 to 29 (WHO). Even in high-income countries only about a third of people with depression receive mental health treatment (WHO). From the 22 countries with complete data, the Atlas puts treatment coverage for psychosis at about 40 percent, and below 10 percent in low-income countries (WHO Mental Health Atlas 2024).

Most spending still goes to large institutions. Psychiatric hospitals take 47 percent of government mental health spending worldwide and 69 percent in the WHO African Region, while community mental health services receive 11 percent. In the 45 countries that reported the figure, 49 percent of admissions to psychiatric hospitals and psychiatric units were involuntary, and more than one admission in five to a psychiatric hospital lasted over a year (WHO Mental Health Atlas 2024). Fewer than 10 percent of countries have fully moved to community-based models of care (WHO).

The burden is growing faster than the population. The Global Burden of Disease 2023 study, published in *The Lancet* in October 2025, found that among non-communicable diseases the largest increases in age-standardised disability-adjusted life years between

2010 and 2023 were for anxiety disorders, up 62.8 percent, and depressive disorders, up 26.3 percent (GBD 2023, The Lancet).

In the Atlas survey, 81 percent of responding countries said mental health and psychosocial support was part of their emergency response, and 74 percent met at least three of five WHO criteria for integrating mental health into primary care (WHO Mental Health Atlas 2024). On current trends, however, suicide rates will fall by only 12 percent by 2030, against a Sustainable Development Goal target of one third (WHO).

Part I: The plan

The plan starts from the workforce figures above. A low-income country with one psychiatrist per million people cannot close its treatment gap by training specialists alone, so most care has to be delivered by trained non-specialists, backed by a small specialist workforce and paid for from ordinary health budgets.

1. Train lay counsellors to deliver talk therapy at scale

Ministries of health, with NGOs and donors, should train community health workers, nurses and lay counsellors to deliver brief structured therapies such as problem-solving therapy and behavioural activation, and should pay and supervise them as part of primary care. WHO's mhGAP guideline, updated in 2023, is written for health workers in non-specialist settings and is used in more than 100 countries (WHO).

Three randomised trials show what lay workers can achieve. In the Friendship Bench trial in Harare, published in *JAMA* in December 2016, 24 clinics and 573 adults took part. Supervised lay health workers, many of them older women known locally as "grandmothers" (Friendship Bench Zimbabwe), delivered six sessions of problem-solving therapy. After six months, 13.7 percent of the intervention group had symptoms of depression, compared with 49.9 percent of the control group (JAMA). In Goa, India, 495 patients with moderately severe to severe depression were randomised to the Healthy Activity Programme, a behavioural activation treatment delivered by lay counsellors, or to enhanced usual care. At twelve months 63 percent of the programme group were in remission against 48 percent of controls, and at US$65.66 per patient the treatment cost less overall than usual care because it reduced other health spending (PLOS Medicine). In Peshawar, Pakistan, lay health workers delivered WHO's five-session Problem Management Plus to 346 adults in a conflict-affected area; after three months the treated group had markedly lower anxiety and depression scores than the control group (JAMA).

Programmes built on these models report low costs. The King Baudouin Foundation puts the Friendship Bench's cost at US$13 to US$16.50 per client (King Baudouin Foundation). StrongMinds, which trains lay facilitators to run group interpersonal therapy for depression in several African countries, reports a cost of US$10.55 per person

(StrongMinds). Both figures are the organisations' own or their funders' and have not been independently audited.

2. Move care into primary health care and the community

Governments should shift spending from long-stay psychiatric hospitals to mental health care in general hospitals, primary clinics and community teams, and should keep a short list of essential psychiatric medicines reliably stocked at primary level. WHO lists psychological treatments as the first-line treatment for depression, with antidepressants such as the generic selective serotonin reuptake inhibitor fluoxetine added for moderate and severe cases (WHO).

Care near home reaches more people for the same money, and the hospitals that absorb most budgets are where involuntary admissions and year-long stays are concentrated. High-income countries show the direction of travel: they spend 25 percent of their mental health budgets on psychiatric hospitals, 28.4 percent on care in general hospitals, 26 percent on community mental health services and 14 percent on primary care (WHO Mental Health Atlas 2024).

3. Prevent suicide by restricting the means

WHO's LIVE LIFE approach to suicide prevention names four interventions: limiting access to the means of suicide, responsible media reporting, social and emotional skills for adolescents, and early identification and follow-up of people at risk (WHO). In low- and middle-income countries the first usually means highly hazardous pesticides.

Pesticide self-poisoning caused an estimated 110,000 deaths a year in 2010 to 2014, 13.7 percent of global suicides, or 19.7 percent once under-reporting in India is allowed for (Journal of Affective Disorders). A systematic review of 27 studies found that national bans on commonly ingested pesticides were followed by falls in pesticide suicides in five of the six countries studied, including Sri Lanka and Bangladesh, and by falls in total suicides in three of them (Lancet Global Health). A WHO-funded modelling study of 14 countries estimated that banning highly hazardous pesticides would prevent about 28,000 suicides a year at an annual cost of I$0.007 per person, or I$94 per healthy life-year gained in low- and lower-middle-income countries (Lancet Global Health). The ministries that must act are agriculture ministries and pesticide regulators, which health planners do not control.

4. Protect young people early

The *Lancet Psychiatry* Commission on youth mental health, published in 2024 and led by Patrick McGorry of Orygen in Melbourne (The Lancet Psychiatry), reported a peak age of onset of about 15, found that mental ill health accounts for 45 percent of the burden of disease among people aged 10 to 24, and criticised health systems that split services at age 18 in the middle of that risk period (MQ Mental Health Research). The plan therefore

calls on education and health ministries to fund school programmes that teach social and emotional skills, youth services for ages 12 to 25 that young people can enter without a formal diagnosis, and clear duties on digital platforms to reduce harm to children.

Distress among young people in rich countries is high. In the 2023 US Youth Risk Behavior Survey, 39.7 percent of high school students reported persistent sadness or hopelessness, including 52.6 percent of girls, and 20.4 percent had seriously considered suicide in the previous year (CDC). In Europe, Central Asia and Canada, the share of 11- to 15-year-olds with problematic social media use rose from 7 percent in 2018 to 11 percent in 2022 (WHO Europe).

5. Build mental health care into every humanitarian response

WHO estimates that 22 percent of people who have lived through war or other conflict in the previous ten years have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia (WHO). Humanitarian agencies and host governments should fund mental health support from the first week of an emergency: psychological first aid, care in general health facilities using the mhGAP Humanitarian Intervention Guide, and brief psychological treatment for people whose distress persists (WHO).

WHO's non-specialist programmes have been tested in these settings. In a cluster-randomised trial among 694 South Sudanese refugee women in northern Uganda, Self-Help Plus, five audio-guided group workshops led by briefly trained facilitators, reduced psychological distress at three months (Lancet Global Health). A 2026 systematic review of Problem Management Plus covering 23 studies and 5,377 participants in humanitarian settings found consistently good feasibility and acceptability when non-specialists delivered it under supervision (Epidemiology and Psychiatric Sciences).

6. Pay for it

Governments should raise mental health spending from a median of about 2 percent of health budgets toward a share closer to the burden, and should include mental health care in national insurance and benefit packages so that patients do not pay out of pocket. Donors should fund training and supervision systems with a written plan for handing them to governments.

The economic case has been made several times. A WHO-led study in *The Lancet Psychiatry* estimated that scaling up treatment for depression and anxiety in 36 countries from 2016 to 2030 would cost US$147 billion and return US$4 in better health and ability to work for every US$1 spent (WHO). The 2018 Lancet Commission on global mental health and sustainable development projected that mental disorders would cost the world economy US$16 trillion by 2030, mainly through lost productivity (The Carter Center; The Lancet).

7. Measure results and regulate new treatments and tools

Most countries cannot say how many people with depression or psychosis they treat; the Atlas could estimate psychosis coverage for only 22 countries (WHO Mental Health Atlas 2024). Health ministries should report treatment coverage for a few tracer conditions each year. Regulators should also set rules for digital and AI-based mental health tools and for new drug treatments, so that tested products can extend care and untested ones cannot be sold as treatment.

Sequencing

In the first two years the fastest gains come from banning the most hazardous pesticides, stocking generic medicines in primary care, keeping existing humanitarian mental health programmes running, and training the first cohorts of lay counsellors with paid supervisors. Over three to ten years the aim is to put lay counsellors on government payrolls, shift budgets from long-stay hospitals to community care, and build youth services for ages 12 to 25. Over a generation the goal is treatment coverage for common conditions in poor countries comparable to what rich countries achieve now.

What makes it stick politically

Mental health programmes last when they sit inside systems that already have constituencies, which is why StrongMinds' 2026 expansion into Rwanda and Tanzania through government partnerships matters (StrongMinds). Lay counsellors on a public payroll are harder to cut than a donor project with a fixed end date. Finance ministers respond to the productivity figures above, and children's mental health gives legislators of different parties a shared cause, as the cross-party pressure to restore the US 988 youth line described in Part II shows.

Where reasonable people disagree

Researchers disagree about how much of the rise in adolescent distress since about 2012 is caused by smartphones and social media. Jonathan Haidt argues that the timing of the rise, its simultaneous appearance in several English-speaking and Nordic countries, its concentration among girls and experiments in which cutting social media use improved mood point to social media as a cause (After Babel). Candice Odgers, reviewing his book *The Anxious Generation* in *Nature* in March 2024, wrote that research has produced "a mix of no, small and mixed associations", that most data are correlational and suggest young people with existing problems use social media more, and that blaming social media could distract from the real causes, while agreeing that the platforms need considerable reform (Nature).

Some clinicians worry that the one-billion figure includes mild and transient distress and invites overtreatment, especially with medication; others reply that the gap in care for

severe conditions such as psychosis makes overdiagnosis a concern mainly in rich countries. Disability rights advocates want involuntary treatment ended, while many psychiatrists and families of people with severe illness regard it as sometimes necessary. Opinion is also divided on AI chatbots, which supporters see as a way to reach people no counsellor will reach and critics see as untested products that can harm vulnerable users, and on how fast regulators should approve psychedelic drugs.

Part II: The plan in the world of September 2026

Element 6, globally: commitments grew while money fell

The political declaration of the UN high-level meeting on non-communicable diseases and mental health set a target of 150 million more people with access to mental health care by 2030. The United States blocked adoption by consensus on 25 September 2025, objecting to recommended taxes on unhealthy products and to what Health Secretary Robert F. Kennedy Jr. called “gender ideology”, and the General Assembly adopted it by vote on 15 December 2025, 175 to 2, with the United States and Argentina opposed and Paraguay abstaining (Health Policy Watch; WHO).

The institutions expected to help are weaker. WHO’s Director-General told staff on 28 March 2025 that the 2026–27 budget would be cut by 21 percent, from US$5.3 billion to US$4.2 billion (Health Policy Watch). The World Health Assembly approved a US$4.2 billion base budget in May 2025 (WHO), and by July the number of programme departments at Geneva headquarters had been cut by nearly half (Health Policy Watch). Public sources do not show how far WHO’s mental health staff were reduced, and meeting the 150 million target will depend mainly on national budgets.

Element 1: the evidence for lay counsellors grew as their funding was cut

The 2025 US foreign aid cuts described in the starvation and war essays also reached mental health. A survey by the Global Mental Health Action Network and the Mental Health Innovation Network, published on 9 June 2025, covered 131 US-funded mental health programmes in 32 countries. These programmes served 981,850 people in 2024 and expected to serve 207,030 in 2025, a drop of about 775,000. Of 348,450 people in psychological treatment, 79 percent lost services; of 190,601 receiving medication, 75 percent lost access. Some 6,835 of 9,343 mental health staff positions were eliminated and 13 suicide hotlines closed entirely. Those who lost care included more than 310,000 torture survivors and 255,000 children (GMHAN).

Programmes outside government budgets can disappear within weeks. Ukraine’s national programme “Ty yak?” (“How are you?”), launched in 2022 at the initiative of Olena Zelenska and coordinated by the Mental Health Coordination Center of the Cabinet of Ministers, credits USAID support on its website (Ty yak?); Peace Insight reported in

February 2026 that it had trained more than 400,000 professionals (Peace Insight). How the programme has been funded since the US cuts could not be confirmed from public sources.

The models themselves kept growing where they had other funders. In May 2026 the Friendship Bench won the King Baudouin Foundation's 2025–2026 Africa Prize, worth €250,000; the foundation reported that the programme had supported more than a million people, trained more than 3,000 community health workers and operated in 12 countries (King Baudouin Foundation). Friendship Bench Zimbabwe reports 1,093,104 clients seen (Friendship Bench Zimbabwe). StrongMinds reports more than two million people treated since 2013, including 426,642 in 2024, and says 74 percent of participants are free of depression at the end of treatment (StrongMinds). These figures are self-reported and not independently verified.

The 2026 review of Problem Management Plus identified the gap that the aid cuts exposed. Only 9 percent of the studies reported on sustainability and 17 percent on costs, and the authors concluded that too little is known about embedding the programme in health systems (Epidemiology and Psychiatric Sciences).

Elements 2 and 3: hospitals and suicide prevention

Psychiatric hospitals' share of government mental health spending, 47 percent in the 2024 Atlas, is well below the roughly two thirds reported in 2020, though WHO cautions that the change may partly reflect a different set of responding countries and revised questions (WHO Mental Health Atlas 2024). With fewer than 10 percent of countries fully moved to community care, the second element remains largely unmet.

Only 47 percent of 138 responding countries reported a national suicide prevention strategy or programme in the Atlas survey (WHO Mental Health Atlas 2024). A ban on highly hazardous pesticides costs less than a cent per person a year and needs no new workforce or donor money, which makes it the part of the plan that governments can adopt in 2026 regardless of aid budgets.

Element 4: young people, where policy moved ahead of the evidence

Australia has tested the platform part of the youth element most directly. From 10 December 2025, platforms including Facebook, Instagram, Snapchat, TikTok, YouTube and X have had to take reasonable steps to stop people under 16 from holding accounts, with fines of up to A$49.5 million for companies that fail to do so (ABC News). The government said more than 4.7 million accounts were deactivated, removed or restricted within days (Prime Minister of Australia). An eSafety survey of 898 parents in late January 2026 found that about a third of children still had accounts, and on 31 March 2026 the regulator opened investigations into five platforms for possible non-compliance (ABC News).

The first results of eSafety's two-year evaluation, which follows more than 4,000 children and families, were released on 31 July 2026. In the three months after the ban took effect, the share of under-16s with an account fell from 52.4 percent to 42.1 percent, and the share using social media at all fell only from 85.9 percent to 81.5 percent. Reported fear of missing out fell from 43.3 percent to 36.3 percent (eSafety Commissioner via Medianet). No results on depression, anxiety or self-harm have yet been published, and further reports are due through 2028. Other governments have acted without waiting for them: France passed a law in July 2026 barring social media for under-15s, Denmark's parliament approved an under-15 ban, Malaysia and Indonesia announced under-16 bans, and the United Kingdom plans a ban from spring 2027 (Al Jazeera; TechCrunch).

The bans are best treated as natural experiments, with Australia's evaluation, funded from the start, as the model to copy; no ban substitutes for the school programmes and youth services that the evidence more clearly supports.

In the United States, the specialised option for LGBTQ+ young people on the 988 Suicide and Crisis Lifeline, launched in 2022, ended on 17 July 2025; the Trevor Project, one of its providers, says it had served about 1.5 million young people (The Trevor Project). In the 2023 Youth Risk Behavior Survey, 65.7 percent of LGBQ+ high school students reported persistent sadness or hopelessness, against 31.4 percent of heterosexual students (CDC). Congress directed that the service be restored in the fiscal year 2026 appropriations law, and in July 2026 the Department of Health and Human Services said it aimed to resume it by the end of the year, a timetable criticised by legislators of both parties (Spectrum News).

Element 5: war and displacement enlarged the need

At the end of 2025, at least 117.8 million people were forcibly displaced, about one in 70 people on Earth. The total fell by roughly 4 percent in 2025, the first fall in a decade, but the war with Iran that began on 28 February 2026 reversed the trend: Israeli attacks have displaced more than a million people in Lebanon since late March, and 3.2 million people are internally displaced in Iran (Al Jazeera). UNICEF reported on 31 July 2026 that 386 children had been killed and 2,117 injured in Iran alone (UNICEF). No estimate of mental health need has been published for either population.

In Gaza, UNICEF's 2026 appeal, issued in December 2025, states that more than a million children require psychosocial support; it aims to reach 384,767 children and caregivers with community-based mental health and psychosocial support within a total request of US$673.8 million (UNICEF). In Ukraine, WHO estimated in December 2022 that about 9.6 million people might have a mental health condition (WHO); no more recent estimate was found, and none for Sudan.

Most countries now list psychosocial support in their emergency plans, but the money to deliver it is the money the aid cuts removed, in the same crises where food rations are also

being cut.

Element 6, in the United States: cuts to coverage, level funding for services

In the United States the largest change came through health insurance. The One Big Beautiful Bill Act was signed on 4 July 2025 (FactCheck.org). According to Georgetown University's Center for Children and Families, it contains about US$990 billion in gross cuts to Medicaid and CHIP over ten years, and the Congressional Budget Office estimated in August 2025 that the enacted law would increase the number of uninsured people by 10 million by 2034, 7.5 million of them because of the Medicaid and CHIP provisions (Georgetown Center for Children and Families). Medicaid is the single largest payer for mental health services in the United States (Medicaid.gov).

Congress rejected the administration's proposal to fold the Substance Abuse and Mental Health Services Administration into a new agency. The fiscal year 2026 Labor-HHS package, which the House passed 217 to 214 and the President signed on 3 February 2026, ending a partial government shutdown that had begun on 31 January (ASAHP), provides about US$7.4 billion for the agency, roughly level with fiscal year 2025 (Alliance for Rights and Recovery). Federal grant programmes for mental health held steady, while coverage under the largest payer for treatment is set to shrink.

Element 7: chatbots and psychedelics arrived before the rules

General-purpose chatbots are now widely used for emotional support. In August 2025 the parents of Adam Raine, a 16-year-old who died on 11 April 2025, sued OpenAI in San Francisco Superior Court, alleging that ChatGPT contributed to their son's suicide. In November 2025 OpenAI denied liability, argued that he had misused the product and said ChatGPT had directed him to crisis resources more than 100 times (NBC News). On 1 August 2025 Illinois enacted the Wellness and Oversight for Psychological Resources Act, which bars the use of AI to provide therapy or make therapeutic decisions while allowing licensed professionals to use it for administrative support (Illinois IDFPR). California's SB 243, signed on 13 October 2025 and in force since 1 January 2026, requires operators of companion chatbots to maintain protocols for responding to suicidal ideation, refer users to crisis services, remind minors that they are talking to a machine and report annually to the state Office of Suicide Prevention (California State Senate). The FDA's Digital Health Advisory Committee met on 6 November 2025 to consider generative AI mental health devices (FDA).

New drug treatments are moving through regulators faster than before. On 18 April 2026 the President signed an executive order directing the FDA to expedite review of psychedelic treatments for serious mental illness and committing US$50 million from the Department of Health and Human Services to match state investment in psychedelic

research; no psychedelic was rescheduled by the order (TIME; ABC News). Compass Pathways, which has reported two Phase 3 trials of its psilocybin treatment COMP360 in treatment-resistant depression, holds a National Priority Voucher, expects to complete its new drug application in the fourth quarter of 2026 and plans a launch in the first half of 2027, subject to FDA approval and rescheduling by the Drug Enforcement Administration (Compass Pathways, SEC filing). The legal scholar Mason Marks has warned that pressure for speed could set the field back if safety review is cut short (TIME).

Regulators should therefore distinguish general chatbots, which should be required to respond safely to users in crisis as California now requires, from products marketed as treatment, which should meet the evidence standards of any other therapy. Where there is one psychiatrist per million people, a tested digital tool supervised by lay counsellors may be the only care available, so outright bans of the Illinois kind carry their own cost in poor countries. Psychedelic treatments, if approved, will reach specialist clinics in rich countries first and will do little for the treatment gap in poor countries for years.

Part III: Revised priorities for the next 6 to 12 months

1. **Keep existing lay-counsellor and humanitarian programmes running.** European governments, philanthropies and development banks should fill the worst gaps left by the 2025 US cuts, starting with services for torture survivors, children and refugees, and should route the money through government health systems.
2. **Ban highly hazardous pesticides** in the countries with the highest rates of pesticide suicide. Agriculture ministries can do this within a year at almost no cost to the public budget.
3. **Turn the 150 million target into national plans.** Each government that voted for the December 2025 declaration should publish a costed plan with a baseline for treatment coverage of depression and psychosis and a date for putting lay counsellors on the public payroll.
4. **Fund mental health care in the Iran, Lebanon, Gaza, Sudan and Ukraine responses** as part of health and food assistance, using WHO’s non-specialist programmes, and publish estimates of need for Lebanon, Iran and Sudan.
5. **Evaluate the social media bans before copying them.** Every country adopting a ban should fund an independent evaluation that measures mental health outcomes, and should expand school and youth services at the same time.
6. **Set basic safety rules for AI chatbots and new drugs.** Crisis detection and referral should be a legal duty for chatbots used by the public, products sold as therapy should face ordinary evidence standards, and accelerated review of psychedelics should keep full safety review.
7. **Protect mental health coverage in rich-country insurance programmes,** including US Medicaid as its eligibility changes take effect, and restore the 988

LGBTQ+ youth service as Congress has directed.

Conclusion

The central claim of the plan has held up: depression and anxiety can be treated cheaply by trained lay workers, pesticide regulation prevents suicides, and treatment returns several times its cost. The events of 2025 and 2026 show that the binding constraints are money and political attention. In December 2025 governments committed to reach 150 million more people with mental health care, in the same year that aid cuts removed care from about 775,000 people in 32 countries and WHO's budget fell by a fifth.

The next year will show whether lay-counsellor programmes can move into public health budgets, whether the youth social media laws improve mental health, and whether the responses to the wars in Iran, Lebanon and Sudan include mental health care at the scale WHO's estimates imply.

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