Mental Health and Work

Fitter Minds, Fitter Jobs

From Awareness to Change in Integrated Mental Health, Skills and Work Policies

Foreword

COVID-19 brought an unprecedented health crisis which quickly turned into a broader economic, labour market and social crisis. These uncertain circumstances led to a surge in the prevalence of mental distress, anxiety, and depression across OECD countries, and especially for young people and for adults facing job and income losses. The sizeable impact of the crisis on population mental health has placed a spotlight on a long neglected issue, and triggered a belated yet much-needed discussion both among the public and policy makers on how to protect and promote mental health.

Mental health issues can be debilitating for those who have to live with them but also have significant social and economic implications for society. Individuals experiencing mental distress are less likely to complete education or to find employment and have a good job. They are also more likely to struggle with work performance and to earn less, and at increased risk of job loss and labour market exit, all of which can have consequences on income and well-being. The COVID-19 crisis further deepened the challenges facing individuals with mental health conditions, while the changes in how we learn and work prompted by the pandemic could have potential long-term implications for mental health policy.

In 2016, Ministers of Health and of Employment from all OECD countries welcomed the *Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*. This was a milestone. It marked the recognition by OECD countries that the obstacles to ensuring good mental health for all individuals cannot be overcome within the health system alone, and that it requires a "mental-health-in-all-policies" approach that addresses the interactions between mental health conditions and social and labour market outcomes, especially in youth, workplace and welfare policies. Such an approach also requires a three-way change in how policies are delivered, characterised by: (1) intervention and *support by the right persons*, especially front-line actors; (2) *early intervention*, following a timely identification of mental health issues; and (3) the provision of *integrated services* and interventions from different providers and authorities.

This publication summarises steps taken by OECD countries in the past five years towards implementing timely and integrated provision of services in health, youth, workplace and welfare policies. It builds on the Report on the Implementation of the Recommendation on Integrated Mental Health, Skills and Work Policy five years after its adoption. This 2021 Report was approved by the Employment, Labour and Social Affairs Committee and the Health Committee of the OECD in April 2021, and welcomed by OECD Ministers at the Ministerial Council Meeting in October 2021. This publication therefore draws on information provided by member countries, including through:

- A Policy Questionnaire on Recent Country Experience in the four areas covered in the Recommendation (health, youth, workplace, and welfare) in the period 2015-20;
- A Follow-Up Questionnaire on Dissemination and Usefulness of the Recommendation, which also included questions on countries' early mental health responses to the pandemic;
- Evidence collected as part of the Mental Health Benchmarking Project and published in mid-2021 in the OECD publication *A New Benchmark for Mental Health Systems*;
- A supplementary Questionnaire for Non-Government Stakeholders in mental health policy;

- A set of survey-based comparative indicators on the labour market, skills and health outcomes of individuals experiencing mental health conditions.

This publication was prepared by the Directorate for Employment, Labour and Social Affairs, led by Stefano Scarpetta. Shunta Takino was the main author of the publication. Christopher Prinz managed the project and the team working on the publication. Duncan MacDonald prepared the section on mental health indicators and Daniel Camacho contributed to the data work in Chapter 2. Dana Blumin provided statistical support throughout the publication. Lucy Hulett and Liv Gudmundson prepared the document for publication. Francesca Colombo, Emily Hewlett, Mark Keese, Helen Lockett, Mark Pearson and Stefano Scarpetta provided comments and suggestions at various stages of the project. Claire Marguerettaz and Céline Folsché provided essential assistance on the legal process of assessing the implementation of the Recommendation.

Chapter 1 of this publication provides the rationale of a whole-of-government and cross-sectoral approach to mental health policy as set out in the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, and Chapter 2 presents a series of indicators across 32 of 38 OECD countries on the mental health, skills and work outcomes for individuals experiencing mental health issues. Chapter 3 presents the key findings of the 2021 Report on the Implementation of the OECD Recommendation on Integrated Mental Health, Skills, and Work Policy.

Chapter 4 draws on insights from across the OECD on the impacts of the COVID-19 crisis on mental health. The analysis and data presented in this chapter benefitted heavily from the expertise and insights of Emily Hewlett, Yuka Nishina and José Bijlholt, including through their work on the OECD Mental Health Benchmarking Project. The analysis also draws on discussions with and comments from Lara Fleischer and Jessica Mahoney of the OECD Centre on Well-being, Inclusion, Sustainability and Equal Opportunity. Tracey Burns and Francesca Gottschalk of the Directorate for Education and Skills also provided in-depth comments on the impact of COVID-19 and school disruptions on young people's mental health. It also identifies emerging priorities in mental health policy and discusses how these priorities could affect integrated mental health, skills, and work policies going forward.

The authors would also like to extend their thanks to delegates of the OECD Employment, Labour and Social Affairs Committee and the OECD Health Committee for their valuable comments on the 2021 Report on the Implementation of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy. The authors are especially grateful for countries' responses to the Policy Questionnaire on Recent Country Experience, which informed the developments assessed in Chapter 3, and the Follow-Up Questionnaire on Dissemination and Usefulness of the Recommendation, which informed the discussion of immediate policy responses to the COVID-19 crisis included in Chapter 4.

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Executive summary

Tackling mental health consequences needs a whole-of-government approach

The OECD publication *Fit Mind, Fit Job*, published in 2015, concluded that an integrated whole-of-government approach was needed to tackle the poor social, education and employment outcomes of individuals with mental health conditions. Living with such conditions makes it harder to stay and do well in school, to transition to higher education or work, to work effectively and productively, and to stay employed. Changing this is not a task for the health system alone but one that must involve all policy fields. Particularly large improvements can come from measures in four policy areas, namely youth, workplace, welfare and health policy. The importance of policy interventions in these four policy areas was already recognised across OECD countries, all of whom have adhered to the *OECD Recommendation on Integrated Mental Health, Skills and Work Policy*. This Recommendation sets out principles on how countries can strengthen mental health policies through coherent action across three dimensions, including: i) the involvement of front-line stakeholders not normally seen as mental-health actors (the "*who*" of a good policy approach), ii) a focus on early identification and early intervention in all policy areas (the "*when*"), and iii) the provision of integrated health, education and employment services (the "*what"*).

Countries are in different stages in their development of integrated policies

This new publication, *Fitter Minds, Fitter Jobs*, looks at improvements in policies in the five years since the adoption of the Recommendation. An assessment of the implementation of the Recommendation makes clear that OECD countries are in different stages in their development towards integrated mental health, skills and work policy. The four stages of development typically include: i) developing the right rhetoric; ii) building the foundations for a more integrated approach; iii) shifting from trials to a scaled-up integrated approach; and iv) providing integrated mental health, skills and work plans in practice. It is not necessary but quite common for countries to go through all steps to reach the final stage. To date, few countries have reached the final stage in any of the four policy areas, and progress is also uneven across the three dimensions of an integrated policy approach (the *"who, when and what"*).

Progress towards integrated approaches is uneven across the four policy areas

Progress in policies to improve the mental health of young people has been considerable in many countries, with increasing attention to more integrated services. This change is reflected in widespread efforts to increase the understanding of mental health among teachers and educators, and in dedicated funding to strengthen mental health supports available to young people. On the contrary, welfare systems have shown the least progress across OECD countries. The potential role of the social protection system and employment services in fostering an integrated approach remains unfulfilled. Programmes for individuals with mild-to-moderate mental health conditions, who would typically be in the unemployment system, are especially rare. Mental health care is recently expanding in some countries following years of chronic underinvestment in mental health services. However, initiatives to involve work and employment considerations when designing health systems remain limited. Finally, workplace policies show advances

in many countries through a mix of regulations relating to psychosocial risk assessment and prevention but tend to be disconnected from the mental health care and the social protection system. In particular, policies to support the mental health and return to work of employees on sick leave are lacking.

Progress is uneven across the three dimensions of an integrated policy approach

OECD countries have made substantial progress in equipping front-line stakeholders such as teachers, managers, caseworkers or general practitioners (the "*who*") with an understanding of mental health and increasingly also with knowledge on the critical links between mental health, education and employment. Yet, structural barriers to implementing a whole-of-government approach and the continued shortage of finances dedicated to mental health in all policy areas continue to hamper efforts to develop more integrated interventions for people experiencing mental health issues (the "*what*"). Countries are also shifting to prevention, promotion, and early identification of mental health issues, but timely intervention is often still confined to silos (the "*when*"). Such uneven progress across the "*who*", the "*when*" and the "*what*" can be problematic as effective and timely support is reliant on success in each of the three dimensions.

Policy changes have so far not translated into better labour market outcomes

Policy changes in the past five years have not been enough to improve the labour market and income position of persons with mental health conditions. Data for a five-year period prior to the COVID-19 pandemic for 25 European OECD countries suggest that individuals with mental health conditions have benefitted from the strong economic and labour market conditions during this period, but not as much as their peers without mental health conditions in most countries. There remains a 20% employment gap and a 17% wage gap (on top of the employment gap) between individuals with and without mental health conditions across those countries. However, the unemployment gap has increased in almost all of these countries, suggesting that jobseekers without mental health conditions have been able to find work more easily; persons with mental health conditions are now almost three times as likely to be unemployed. The strong labour market has also not helped inactive persons with mental health conditions into work; the share receiving out-of-work benefits is now 45% higher among individuals with mental health conditions than among individuals without mental health conditions.

The COVID-19 crisis made integrated whole-of-government approaches more urgent

The sudden change in the way we live, learn and work due to COVID-19 is creating new mental health challenges, which again require a response that goes beyond the health system. While it is too early to assess the long-term impact of the COVID-19 experiences, and the possibility of mental health impacts turning into higher long-term prevalence of mental health conditions, specific groups – including young people and workers who lost their jobs – are reporting disproportionate declines in mental health status, and need to be supported through the crisis and beyond. A silver lining of the mental health impacts of the COVID-19 crisis has been a breakdown of the stigma associated with poor mental health, which has triggered discussions on the impact of good mental health for life, education and employment. This sudden awareness of the importance of good mental health for all life domains presents a window of opportunity for policy makers to implement a policy transformation. The next policy reassessment five years from now will show how countries have reacted and how far they have come in developing an integrated approach to mental health policy.

1 What does a mental health-in-all-policies approach look like?

This chapter provides the rationale of a whole-of-government approach, set out in the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, and explains the importance of an integrated, cross-sectoral approach to mental health policy. It introduces the "*who*, *when* and *what*" (or the three Ws) of effective integrated mental health policy as outlined in the implementation report on the Recommendation, which argues that countries need to take into account "who" is carrying out an intervention, "when" intervention is taking place, and "what" such interventions look like.

Mental health conditions are widespread and costly for individuals, employers and society. At any point in time, about 20% of the population experiences a mental health condition. People with mental health conditions have much lower rates of employment, higher rates of unemployment, lower wages and incomes, and higher rates of dependence on all types of working-age benefits. The total cost of mental health is estimated to be at least 4% of GDP, including through labour market costs such as reduced productivity and increased absence, social spending costs and direct costs for health care systems (OECD, 2021[1]). The characteristics and impacts of mental health conditions imply that the health system alone cannot solve the problems, which instead require a whole-of-government response.

Mental health is critical throughout one's lifetime from childhood to old age. For young people, whose mental health status also depends on their parents' mental health and any genetic predisposition, mental health issues can affect education and labour market outcomes. For adults of working age, mental health issues can affect performance at work and result in prolonged sick leave, unemployment and labour market exit. For the elderly, poor mental health affects participation in society and is associated with loneliness. Across the OECD, students indicating mental distress are 35% more likely to have repeated a grade at school, and adults with mental health issues are 20% less likely to have a job.

Despite the strong links between mental health and labour market outcomes, widespread stigma surrounding mental health persists. Individuals experiencing mental health issues are often considered unable to work, to learn or to live together with other members of society, even when they can in most instances. Promoting mental health in all areas of societies thus remains crucial to cultivating a culture of acceptance of mental health issues. This could help to address myths that still surround mental health, and create an accepting environment for individuals to seek support.

A comprehensive policy response to the challenges posed by mental health conditions not only requires cross-sectoral action, but also changes in delivery of policies and services. A three-way change is required, characterised by (1) intervention and support by the right persons and especially front-line actors (the "who"), (2) early intervention, including the timely identification of mental health issues (the "when"), and (3) the provision of integrated services and interventions (the "what").

The key foundations of an integrated approach to mental health policy form the body of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, which was adopted by the OECD Council in 2015. This Recommendation sets out how governments can promote the provision of early and fully integrated services to improve social and labour market outcomes for people with mental health problems.

Box 1.1. Note on language

Using appropriate language in the field of mental health is important for at least two reasons: to align with rapid ongoing shifts in the use of language that go hand-in-hand with continuing efforts to raise awareness and address stigma; and to ensure clear communication of the population groups in focus. As much as possible, language should be person-centred, strengths-based, and recovery-focused. This publication therefore uses language that is inclusive and covers mental health conditions at all levels of severity, from those that have a significant and long-term impact on a person's life and day-to-day functioning, through to those that are highly prevalent in the population but do not necessarily need specialist mental health care. In line with these considerations and to not use language that describes people as their label or diagnosis, this publication predominantly uses the terms "mental health conditions" and "mental health issues", whereas the terms "mental illness" and "mental disorder" are avoided. Occasionally, the publication uses the broader term "mental distress" to refer to an individual experiencing poor mental health, but not necessarily a clinically significant mental health condition.

The OECD Recommendation on Integrated Mental Health, Skills and Work Policy

The *OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy* (hereafter "the Recommendation") is a legal instrument that sets out policy guidelines and principles for an integrated whole-of-government approach to promote the social, educational and labour market inclusion of individuals experiencing mental health conditions. It was adopted by the OECD Council in 2015 on the proposal of the OECD's Employment, Labour and Social Affairs Committee and the Health Committee, in consultation with the Education Policy Committee.

Box 1.2. What is an OECD Recommendation?

OECD Recommendations are non-binding OECD legal instruments adopted by the OECD governing body – the Council. They represent a political commitment to the principles they contain and entail an expectation that OECD Members and non-OECD Members that have adhered to them (the Adherents) will do their utmost to implement them.

The OECD has developed more than 300 Recommendations since its creation, with around 170 of them still in force today. OECD Recommendations can fulfil different objectives: levelling the playing field by ensuring fair competition between actors on the international arena, whether countries or companies; supporting international exchange by facilitating the transfer of goods, capital, services and information across borders; improving domestic outcomes and well-being through internationally agreed policies for implementation at domestic level to benefit individuals and societies.

Further information on OECD Recommendations is available on the online Compendium of OECD Legal Instruments (http://legalinstruments.oecd.org).

At the time of release of this publication, all 38 OECD countries had adhered to the Recommendation, thus expressing their political will and commitment to fulfilling the principles set out in the Recommendation, and no non-OECD countries had adhered. This publication therefore looks at policy developments and indicators in all and only OECD countries. The term "OECD countries" is therefore used in the place of the term "Adherents" throughout this publication.

The Recommendation draws heavily on *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work* (OECD, 2015[2]), a landmark publication published in 2015 that synthesised and summarised findings from nine country-specific reports on the link between mental health and work (Australia, Austria, Belgium, Denmark, the Netherlands, Norway, Sweden, Switzerland and the United Kingdom). *Fit Mind, Fit Job* found that the impact of mental health for education, labour market and social policies had long been neglected, resulting in insufficient attention and policies to improve the education, employment and social outcomes of individuals experiencing mental health conditions, with mental health policies delivered in silos.

At the High Level Policy Forum on Mental Health and Work hosted by the Netherlands in 2015, ministers and high-level government officials welcomed *Fit Mind, Fit Job*, and called on the OECD to develop policy principles on integrated mental health, skills and work policies. In December 2015, the Recommendation was finalised and adopted, and in early 2016, Ministers of Health and Employment from all OECD countries welcomed the Recommendation at the OECD Employment and Labour Ministerial and High-Level Policy Forum held in Paris. Since then, the Recommendation has been used by OECD countries to shape reform and inform progress towards integrated mental health, skills and work policy.

The Recommendation sets out principles on how countries that have adhered to the Recommendation can strengthen mental health policies through coherent action across three dimensions. These are the involvement of front-line stakeholders not normally seen as mental-health actors (the "**who**" of a good policy approach), a focus on early identification and early intervention in all policy areas (the "**when**"), and

the provision of integrated health, education and employment services (the "**what**"). The Recommendation covers policy principles in the following four thematic areas:

- **Mental health care systems** should provide more timely and appropriate access to services that take into account the role that meaningful education and work can play in promoting good mental health. The Recommendation thus outlines the need to ensure primary care workers are trained in mental health, and the value of strengthening the education and employment focus of the mental health care system.
- **Youth and education systems** should support young people throughout all stages of education and in the transition from school to work. The Recommendation thus calls for co-ordinated and timely access to support for children and young people delivered through schools, investments in preventing early school leaving, and continuous support for young people experiencing mental health issues in the transition from school to higher education and/or work.
- **Workplaces** should promote good mental health at work and support employees experiencing mental health issues in their return to work. The Recommendation thus calls for policies to promote psychosocial risk assessment, to increase awareness and competence of line managers in mental health, and to support return-to-work for workers experiencing mental health issues on sick leave.
- **Social protection systems and employment services** should be equipped with the knowledge and resources to respond to the needs of people experiencing mental health issues. The Recommendation thus calls for ensuring caseworkers receive training to understand mental health issues, and for integration of mental health treatments into the delivery of employment services to support jobseekers experiencing mental health issues into work.

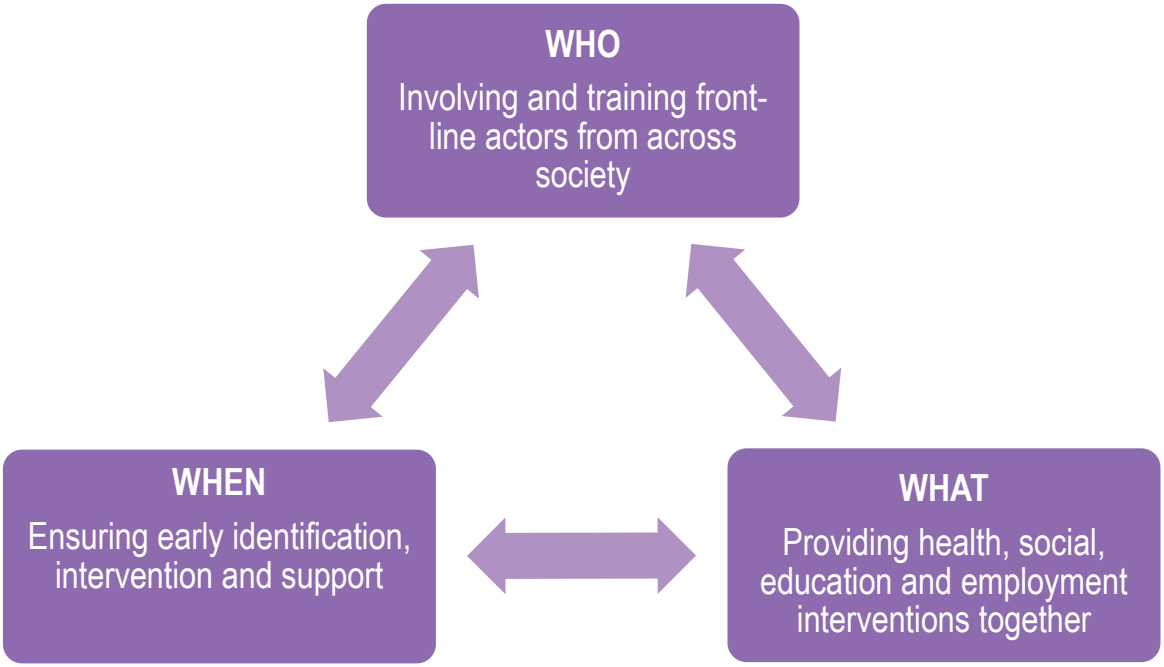
The three Ws: Dimensions of an integrated mental health, skills and work policy

To develop an integrated mental health, skills and work policy, countries need to take into account **who** is carrying out an intervention or providing support**, when** intervention or support is taking place, and **what** intervention or support is provided. It is only when each of these three dimensions are addressed, that intervention can be effective. Interventions to support and promote mental health often leave out key stakeholders, come too late, and are provided in an isolated manner that fails to reflect the integrated nature of the challenges of mental health issues.

As shown in Figure 1.1, these three dimensions are interlinked and reinforcing each other. For instance, the impact of policies to reduce waiting times e.g. for psychotherapy (seeking to address the "when") can be amplified by ensuring that mental health supports are integrated into and available in all areas of society including in schools and workplaces where symptoms of mental health issues can first become apparent (the "what"). In turn, to ensure that mental health, skills and work supports are effective in schools and workplaces, front-line actors such as teachers and line managers need to be trained and have competence in mental health such that they can identify potential mental health issues and initiate support (the "who").

To realise integrated mental health, skills and work policies in full, countries need to combine integrated services and supports at the working level with a cross-sectoral and strategic prioritisation of mental health, as reflected in integrated mental health plans and strategies. In the absence of such plans, while there may be some good practices of integrated services that support mental health, these are likely to be isolated cases that do not reflect a general approach.

Figure 1.1. Who, when and what: the three Ws of integrated mental health policies



Who: The role of front-line actors in identifying mental health conditions and ensuring access to support

It is not possible to achieve progress towards integrated mental health, skills and work policy if the task of supporting individuals with mental health problems is left to specialist mental health care workers and institutions alone. Effective policy harnesses the key role that front-line actors across all of society – especially but not only teachers, line managers, general practitioners and employment counsellors – have in identifying mental health conditions and addressing its impact on students, workers, patients and jobseekers. This relates to both training offered to them and ensuring there are individuals with experience and understanding of mental health issues in schools, universities, workplaces and employment services. The importance of competence-building (see Box 1.3 for a definition of mental health competence) also closely relates to timelier intervention (the "when"), as in the absence of adequately trained front-line actors, possible signs of mental health issues are likely to go unnoticed resulting in late intervention and support.

In the health system, a key priority for the "who" dimension is the expansion of mental health competence among workers in the primary care sector such as general practitioners, nurses and occupational health specialists. These health care workers often act as gatekeepers within the health system to specialist health services such as treatment from a psychiatrist or psychotherapist, and thus are well-placed to refer individuals experiencing mental health conditions, where deemed appropriate. In education and youth support systems, policies should increase awareness and understanding of mental health issues among education professionals and families of students, and provide actors in the education system with an understanding of psychological and behavioural adaptations that are crucial to the learning process. In workplaces, raising competence is an important part of broader anti-stigma policies at work, including the development of guidelines for line managers, human resource professionals and worker representatives such that employees experiencing mental health issues can get appropriate support. It is also vital to invest in mental health competence and training for caseworkers, social workers and vocational counsellors who are responsible for administering employment services and social benefits, not least as poor mental health can be a key barrier to finding employment.

Box 1.3. What is "mental health competence"?

The term "mental health competence" throughout this publication refers to the need to train front-line actors in the health system, at the workplace, in education institutions, in public employment services, and beyond. The broad term "competence" reflects the need for front-line actors to not only understand mental health as a subject, but also to know what next steps may be appropriate to take.

Mental health competence should thus be broadly understood as consisting of three elements:

- **Understanding and awareness of the subject of mental health** – front-line actors need an understanding of what mental health is, how to communicate or talk about mental health in a non-stigmatising manner, and learn about behavioural changes that could indicate potential mental health conditions. Front-line actors may be able to acquire this aspect of mental health competence (partially) through public awareness campaigns.
- **Understanding of the interlinked nature of mental health** – front-line actors need to be trained in and develop an understanding of how broader factors such as workplace and school environments, as well as personal and family circumstances, can influence mental health, and thus how their actions as front-line actors are vital in supporting the mental health of the general population.
- **Capacity to take appropriate and timely course of action** – front-line actors need to be aware of the options available to them to support an individual exhibiting mental distress or symptoms of potential mental health conditions, and then have the capacity and skills to take an appropriate and timely course of action. Front-line actors can only acquire this aspect of mental health competence through training.

The exact nature and level of competence in mental health required will differ from position to position, as will the options available in terms of courses of action and interventions. General practitioners may be able to distinguish between episodes of mental distress and above-threshold mental health conditions, and thus use their competence to decide whether an individual may benefit from a referral to a specialist. By comparison, managers in the workplace may use their competence to identify potential symptoms of mental distress or mental health issues, which may be noticeable through behavioural changes at work such as sudden low productivity, unexplained absences from work, or repeated lateness. While managers are unlikely to be able to refer an employee directly to a mental health specialist, they could take steps such as checking-in more regularly, adapting working arrangements or asking executives in the firm of the possible options available to support the employee.

When: The importance of early identification, intervention and support

Early identification and intervention is the most effective way to support people experiencing mental health issues. Youth and workplace policies are crucial as workplaces, schools and universities are often the first places where symptoms of potential mental health issues arise before individuals turn to or are recommended to seek support through the health system. Evidence suggests that measures to address mental health issues are far more effective if put in place when students are in schools rather than after they have stopped attending. Similarly, supporting people to stay in work is far more effective than helping them return to a job after unemployment or sickness absence, including for individuals with mental health conditions (OECD, 2015[2]).

For young people, a key pillar of the "when" dimension is the provision of timely access to co-ordinated and non-stigmatising support and treatment for this group. More broadly, investment in prevention of early

school leaving including through ensuring access to mental health care can be beneficial, as keeping young people in school can protect against poor mental health, and strengthens future labour market outcomes.

In workplaces, the promotion and rigorous enforcement of workplace psychosocial risk assessments and workplace strategies to enhance mental health and well-being can play an important role in minimising the risk factors of poor mental health. For workers absent from work or on sick leave due to mental health issues, early support and intervention is necessary to prevent long-term sick leave and facilitate a lasting return-to-work. As outlined in Chapter 2, among workers who take sick leave, individuals with mental health conditions take more than 50% more days off sick than their counterparts who are not experiencing mental health conditions across OECD countries. Early action is particularly important for this group, as returning to work becomes more difficult as absences are prolonged, and as many individuals may have undiagnosed mental health conditions that prevent timely return-to-work. In Sweden, for example, prior OECD analysis has shown that return to work becomes difficult after three months of sick leave for people experiencing mental health issues (OECD, 2015[2]).

After an individual with mental health conditions drops out of the labour market and services and social benefits kick in, intervention once again comes too late, resulting in further detachment from the labour market and the risk of deterioration of mental health. Yet few initiatives have sought to address the mental health issues experienced by unemployed jobseekers (McDaid, Hewlett and Park, 2017[3]), and mental health treatments thus need to be integrated in public and private employment services. Effective early treatment can also help to reduce preventable disability benefits.

Another challenge is the lack of early action in the health system itself to help people reconnect with school or work. Even after an individual has first seen a mental health specialist, or has discussed mental health problems with a general practitioner, they then often face long waiting times to receive the care, treatment and support they require, and when they receive support, it may not have an education or employment focus. As outlined in Chapter 2, on average across European OECD countries, in the mid-2010s, more than two-thirds (67%) of individuals with mental health conditions reported difficulty accessing medical care due to financial, waiting time or transportation constraints. The promotion of timely access to effective treatment of mental health conditions in both community and primary care settings is therefore critical.

What: Providing health, social, education and employment interventions together

The core premise of an integrated mental health, skills and work policy is that action is required in a range of policy fields – including health, youth, labour, and welfare policy – to address various needs concurrently. For such an approach to be planned and delivered, decision-makers in different thematic areas need to prioritise the integration of services and interventions.

This requires a greater focus in the mental health care system on the employment dimension, including the introduction of education and employment outcomes as a measure to evaluate performance. Medical professionals should address issues at work and school – such as sickness absence and truancy – that are often closely associated with mental health. Similarly, appropriate support structures need to be put in place that link youth and community centres and educational institutions at all ages – from pre-school, school and higher education institutions – to assistance through treatment and counselling that may primarily be offered in the health system.

Integrated interventions are equally important in the workplace and in social protection systems. Work has a profound impact on mental health and meaningful work is often an important contributing factor to recover from mental health conditions. Enforcement and promotion of psychosocial risk assessment in the workplace is only possible with the support and involvement of occupational health services. Promoting timely return-to-work, which is also a key element of the “when” and “who” dimensions, requires the involvement of physicians and mental health practitioners in addition to dialogue between employers, employees and their representatives. In welfare systems, employment services should integrate mental

health treatment into their services, including through the delivery of evidence-based psychological counselling combined with employment support for individuals with mild-to-moderate mental health conditions. Such policies are key to facilitating a return to work and preventing labour market exit for individuals with mental health conditions, as evidence suggests that standalone treatments (without employment support) has only a limited impact in supporting individuals experiencing mental health conditions in finding work (OECD, 2015[2]).

Raising awareness and tackling stigma: A requirement of integrated mental health policy

Raising awareness of mental health and normalising discussions around mental health is a key component of mental health plans and strategies. Discrimination against individuals living with mental health conditions remains widespread, and discussions around mental health remain a taboo subject in many contexts across OECD countries.

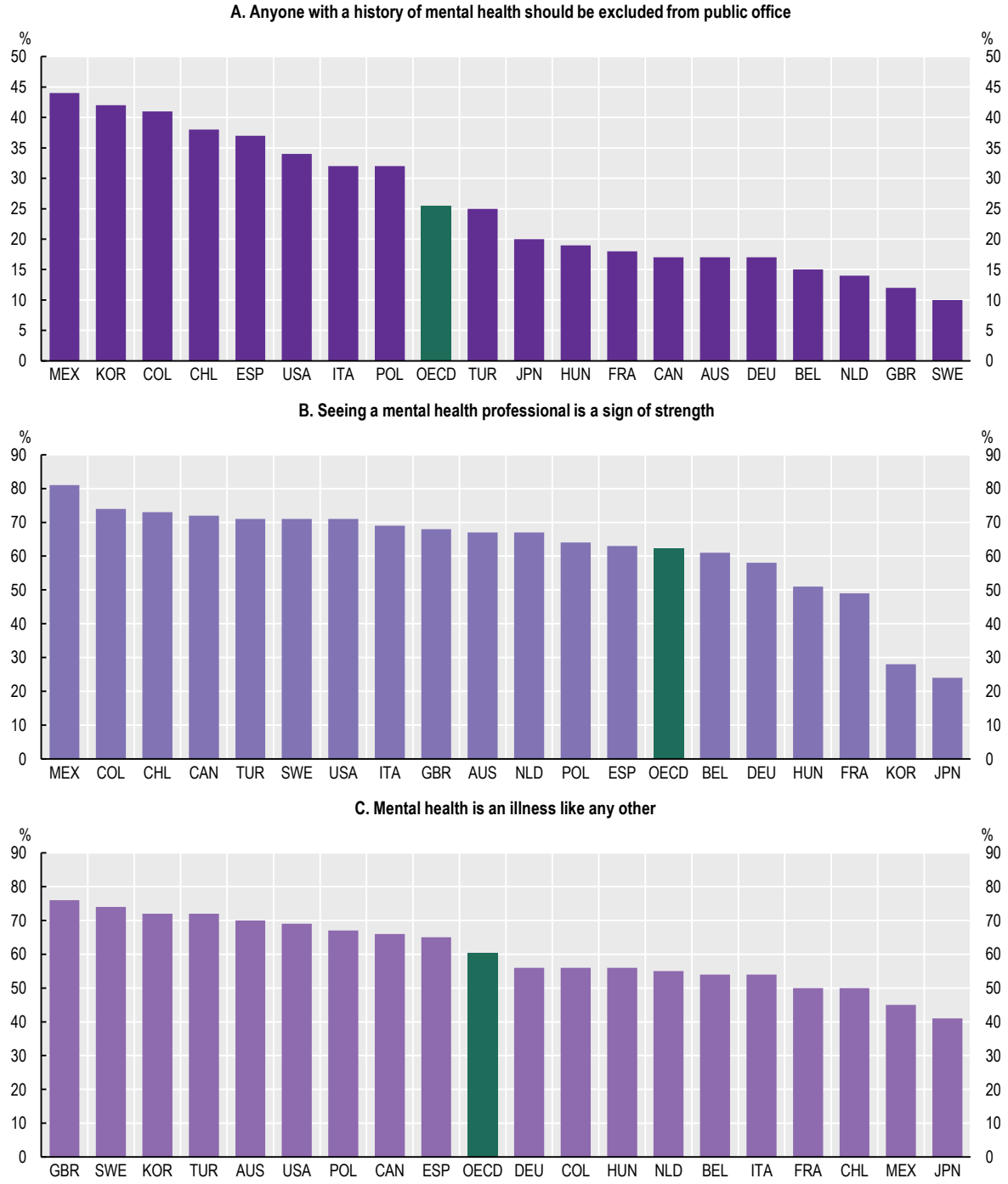
In 2019, Ipsos conducted a global survey on attitudes on mental health in 29 countries, including 19 OECD countries, which found that stigma surrounding mental health remains prevalent, although with significant variation across countries (Figure 1.2). On average, across the OECD countries, 60% of respondents agreed that mental illness was an illness like any other [illness], while 25% agreed that anyone with a history of mental illness should be excluded from public office (The Policy Institute | King's College London and Ipsos, 2019[4]). A lack of public awareness weakens all initiatives and interventions to support individuals with mental health conditions.

Moreover, in the absence of self-awareness and presence of stigma at the individual level, individuals are less likely to seek mental health support when they need it. In 2019, on average across the OECD countries, less than two-thirds of respondents stated that they considered seeing a mental health professional as a sign of a strength (Figure 1.2). In the presence of such stigma, even if an individual is aware of the need to seek help, they are unlikely to do so if they sense that their co-workers will ostracise them, or that any colleague or manager they seek help from would be dismissive of their need for treatment or support. In an environment with widespread stigma, workplace programmes that offer support for individuals with symptoms of mental distress alone may be insufficient, as workers experiencing mental health conditions may be reluctant or afraid to seek support. The same analogy applies to schools and higher education institutions, as well as welfare systems.

Raising awareness and addressing stigma is also a foundation to increase the mental health competence of front-line actors as outlined in Box 1.3. For example, public awareness-raising campaigns can help front-line actors to understand what mental health is and how to communicate and talk about mental health in a non-stigmatising manner. Awareness is particularly important for those who come into regular contact with individuals with mental health conditions, whether teachers, caseworkers or line managers, as without awareness, there is no foundation on which to build competence.

Figure 1.2. Discrimination against individuals experiencing mental health issues persists and stigmatisation of mental health issues remains high, but with variation across OECD countries

Proportion of respondents stating that they agree with statements on mental health



Note: OECD is the unweighted average of the 19 countries shown. In Panel A, higher values indicate higher levels of discrimination and stigma, whereas in Panels B and C, lower values indicate higher levels of (self-)stigma. Results for the United Kingdom refer to Great Britain (excluding Northern Ireland).

Source: Ipsos MORI / King's College London (2019), World Mental Health Day 2019, https://www.ipsos.com/sites/default/files/ct/news/documents/2019-10/world-mental-health-day-2019_0.pdf.

StatLink https://stat.link/e4ab56

Integrated mental health policies: The role of health systems, youth policies, workplace policies and welfare systems

This publication covers four thematic policy areas that play a key role in integrated mental health, skills and work policies – namely health systems, youth support systems, workplaces, and welfare systems. As outlined below, action across each of these policy areas is vital to improving the health, educational and labour market opportunities and outcomes of people experiencing mental health issues.

Health systems must recognise the importance of work and education for mental health

Health care systems often face a dual challenge of under-investment in mental health care and structural barriers to integrating such care with social and employment support. Ensuring timely access to effective treatment for individuals experiencing mental health issues must remain a priority, including for mild to moderate mental health conditions, and not only in specialist care, but also through primary health care and community mental health services. Expanding the mental health competence of front-line actors in primary health care is vital as most individuals experiencing mental health issues receive treatment from non-specialists, and individuals are likely to first approach general practitioners, family doctors and occupational health specialists when experiencing mental health issues.

Health systems and care providers must also recognise the beneficial role that meaningful work and education can play in promoting mental health, and thus ensure integration of considerations into the delivery of interventions and services. This includes strengthening the employment focus of the mental health care system, including by introducing employment outcomes in quality and outcomes frameworks within health systems and strengthening co-ordination with employment services. Policies should also ensure health professionals have the resources needed to support people who are absent from school or work due to issues related to mental health through evidence-based treatment and integrated support. The key role that health systems play in promoting good mental health and ensuring timely, accessible and high-quality mental health services is expanded upon in more detail in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* (OECD, 2021[1]). This publication offers insights into how well countries are delivering the mental health policies and services that matter for good mental health outcomes.

Box 1.4. OECD Mental Health System Performance Benchmark

In 2017, OECD Health Ministers asked the OECD to help them better understand mental health system performance across countries. As a result, the OECD developed a Mental Health System Performance Benchmark, which offers a framework covering six dimensions and 23 indicators of performance: from accessibly of care, to high-quality and person-centred services, good prevention and promotion, an integrated and multi-sectoral approach, strong governance and leadership, and a focus on innovation. *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, developed in consultation with OECD countries and mental health experts and released in June 2021, provides a framework that is complementary to the Recommendation with an emphasis on integrated approaches to mental health. Thus, the Benchmark indicators include the educational and labour market outcomes of individuals experiencing mental distress or mental health conditions.

Source: OECD (2021[1]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, https://dx.doi.org/10.1787/4ed890f6-en.

Youth policies can ensure timelier identification and intervention

A recent meta-analysis on age of onset found that around half of all mental health conditions are established by age 18, and two in three by age 25 (Solmi et al., 2021[5]), consistent with prior findings which have shown that mental health conditions predominantly emerge from childhood to young adulthood (Kessler et al., 2005[6]). This means that in many cases, symptoms and signs of mental health issues are apparent from a young age, making mental health interventions and support in childhood, adolescence and youth particularly important. If mental health issues remain unaddressed during this period, symptoms and conditions may deteriorate and prevent individuals from living fulfilling and productive working lives.

Schools and educational institutions play a particularly important role in promoting the mental health of children, adolescents and young people. Monitoring and improving the overall school and preschool climate to promote socio-emotional learning and mental health through whole-of-school interventions is therefore critical. Irregular attendance at school can often be one of the first signs of mental health issues and eventually result in early school leaving.

Childhood, adolescence and youth are stages of life that are also characterised by important life transitions that can place significant pressures on mental health. Over the period of around 20 to 30 years, individuals have to adapt from being fully dependent on a caregiver to being self-sufficient contributors to society. This publication looks specifically at policies to support young people navigate the transition from secondary education into post-secondary education and into the labour market, and the need to ensure access to treatment for individuals with mental health conditions through each of these transitions.

Workplaces can support workers experiencing mental health issues

Employers play an important role in helping their employees to manage and deal with mental health issues. Workplaces are environments where most individuals spend a significant proportion of their lives, yet there remains both a lack of awareness and understanding of the impact mental health can have on the work of individuals and the labour productivity losses that can result from poor mental health among employees. The implementation of strategies to raise awareness of mental health in the workplace can help to address stigma and discrimination, and guidelines on mental health – often developed by governments – can help line managers, co-workers and human resource professionals, as well as work representatives, support individuals experiencing mental health issues.

Policies must also recognise the many layers of workplace policies required to both prevent the exacerbation of mental health issues and promote good mental health among all workers. As a foundation, psychosocial risks should be a core component of occupational health and safety policies, but this should be supplemented by policies to promote good mental health in the workplace so that all employees and workers can experience better mental health. These policies are of particular importance as poor-quality jobs, bad leadership and high job-strain can contribute to stress in the workplace and the worsening of mental health among employees. Such policies include measures to require and encourage employers to support individuals with mental health conditions on sick leave in returning to work.

Employment services can offer integrated mental health support

Mental health conditions also place significant pressure on social benefits and employment services of OECD countries. Mental health conditions are prevalent not only among disability benefit recipients, but also among recipients of unemployment benefits and social assistance. As shown in Chapter 2 of this publication, across the OECD, between one-third and one-half of all benefit recipients experience mental health conditions, and the longer people receive social benefits, the higher the prevalence of mental ill-health, reflecting, at least in part, the negative effects that joblessness can have on mental health.

These pressures on social benefits and employment services are rising further as awareness of mental health conditions continues to grow. A dual challenge therefore exists to better support individuals with mental health conditions in the social protection system, and also to alleviate the increasing pressure placed on the system, and in particular on disability benefits. Improving the responsiveness of social benefits and employment services to the needs of individuals experiencing mental health conditions addresses both of these challenges. This not only reduces pressure on the disability system but can also bring benefits for individuals experiencing mental health conditions, as meaningful employment can be beneficial for their mental health.

This requires a mix of legislation and policies to strengthen services in welfare systems and employment services. The recognition of possible work capacity – even if this is partial – of individuals claiming benefits for reasons related to mental health, for example, is one form of legislation that can facilitate individuals to return to work after periods of prolonged absence. Policies can also strengthen the mental health component of social benefits and employment services, including through providing access to employment and mental health support together to help jobseekers into work.

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The Policy Institute | King's College London and Ipsos (2019), *World Mental Health Day 2019*, https://www.ipsos.com/sites/default/files/ct/news/documents/2019-10/world-mental-health-day-2019_0.pdf (accessed on 11 March 2021). [4]

2 What are current social and labour market outcomes for persons with mental health conditions?

This chapter presents a series of indicators across 32 of 38 OECD countries on the mental health, skills and work outcomes for individuals experiencing mental health issues. The indicators are based on a large number of national and European population surveys, necessitating an approach that facilitates cross-country and cross-survey comparisons. The indicators show a considerable and systematic disadvantage of persons with mental health issues across many domains of life and limited progress, if any, over the past five years. Differences between countries can be large but the disadvantage is universal. The findings suggest there is a long way to go to eliminate the stigma underlying this deep-rooted disadvantage.

This chapter presents a series of indicators across 32 of 38 OECD countries on the mental health, skills and work outcomes for individuals experiencing mental health issues. These indicators aim to convey the differences in labour market and well-being outcomes between these groups. The choice of indicators and time span partly reflects data constraints. However, each section aims to present some of the most recent data and highlight topics that may be of practical use to policy makers.

Throughout this chapter, an indicator of mental distress serves as a proxy for those with a mental health condition. In theory, when measuring the presence of a mental health condition, an interviewer could simply ask if a person is experiencing a given condition. However, in practice, this determination is difficult to achieve using a standardised questionnaire. Respondents may be hesitant to share information that they consider stigmatising (Clement et al., 2015[1]; Corrigan, Druss and Perlick, 2014[2]), or may not be aware of their mental health condition. An alternative approach would focus on those diagnosed with a mental health condition. This approach is problematic for the same reasons but also because not all people experiencing mental health conditions seek help, or even a diagnosis. Many people with common mental health conditions attempt to address their issues themselves (Mojtabai et al., 2011[3]). Therefore, restricting the scope to those with a diagnosed mental health condition will not be adequate.

In lieu of a direct measure of the presence of a mental health condition, this section uses indirect measures of mental health status (known as “mental health instruments”) commonly utilised in population surveys. It thereby follows previous OECD analysis (OECD, 2012[4]) and assumes that in each country examined, irrespective of the year, a constant 20% of the working-age population has some form of mental health condition, whether they have been diagnosed with that condition or not. This assumption is in broad agreement with epidemiological evidence, which suggests that up to 30% of the adult population have had a mental health condition over any 12-month period and around 20%, or around one in five, at any point in time (Kessler et al., 2005[5]; Alonso et al., 2004[6]; Steel et al., 2014[7]). This methodology also reflects the notion of mental health being a continuum, with poor mental health at one end and flourishing mental health on the other, rather than the absence or presence of a mental health condition.

As discussed in Chapter 4, studies point to population-wide increases in mental distress during the COVID-19 crisis. Although the indicators in this present chapter look at the mental health, skills and work outcomes of individuals experiencing mental health issues prior to the onset of the pandemic, and thus do not need to take this into account, trends in prevalence will need to be watched carefully going forward, as it is unclear whether or not prevalence of mental health conditions will return to the previous ‘norm’.

The methodology used in this chapter has strengths and drawbacks. Core to the current analysis, it permits cross-country and cross-survey comparisons. By taking the respondents with the bottom quintile of scores over a battery of questions on their mental health status, this approach abstracts away from the specification of the mental health instrument included in any given survey. For example, many European OECD countries have contributed to the European Health Interview Survey (EHIS), which employs an 8-question version of the Patient Health Questionnaire (PHQ-8) and is specific to measuring risk for depression, while non-European countries (and some European ones) include a series of mental health questions that are survey specific. Results from these various surveys are better comparable using this relative mental health indicator.

A downside of this proxy approach is that there is no certainty that a person classed as having a mental health condition actually has one. To some extent, this is an intended feature, as the mental health indicator aims to capture also those who have a mental health condition, but have not sought professional help (including those who are unaware of their mental health condition). However, it is possible that there are some differences in mental health prevalence across countries, which the indicator assumes away. The same limitation applies for comparisons over time within countries. In considering this limitation, the set of indicators below does not focus on differences in prevalence across countries or over time, and instead presents outcomes that could be useful to policy makers. It thus also avoids discussing potentially large cross-country cultural differences in the levels of awareness, stigma and discrimination.

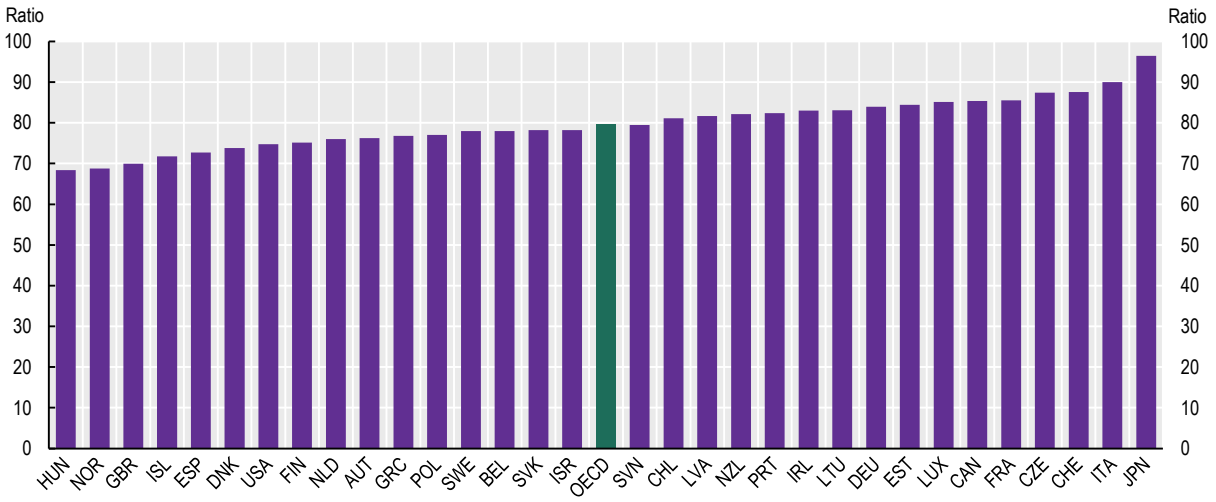
Employment outcomes

In every OECD country examined, people with some form of mental health issue (that is, those scoring in the lowest 20% in a battery of questions about respondents' mental health status) had lower and sometimes much lower employment rates than those not reporting signs of a mental health issue. Figure 2.1 depicts the ratio of the employment rates for these two groups. Values below 100 indicate lower employment rates for people with mental health conditions than those without.

On average, the employment rate for persons with a mental health condition was 20% less than for those without. The mental health employment gap ranges from over 30% for Hungary, Norway and the United Kingdom, to 10% in Italy and only 3.6% in Japan. For those with more severe mental health issues – that is, those with a mental health score in the lowest 5% of respondents – the gap is even larger, averaging almost 38% and ranging from 55% in the United States to 9% in Japan (not shown in the figure).

Figure 2.1. The employment gap between persons with and without mental health condition is large

Employment rate ratio between persons with and without a mental health condition, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. A value of 100 indicates that people with mental health conditions are equally likely to be working as persons without mental health conditions. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See Annex Table 2.A.1 for details.

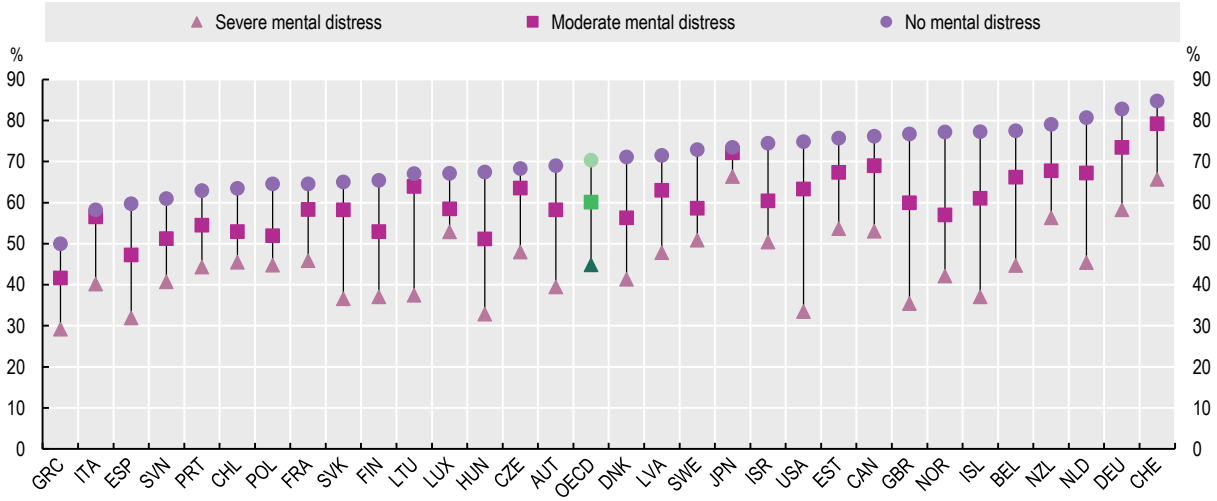
StatLink https://stat.link/bhozky

This indicator provides a simple indication of the relative employment outcomes of these groups. As transitions to unemployment negatively affect mental health (Paul and Moser, 2009[8]; Murphy and Athanasou, 1999[9]), it is unlikely that any country will ever achieve a value of 100 (indicating equal employment outcomes). However, countries can close the employment gap through various measures, by engaging unemployed workers to address their mental health condition, improving the job prospects of people with a mental health condition, adapting the workplace to encourage workers to stay in employment where appropriate, and enhancing the early identification and treatment of mental health conditions (OECD, 2015[10]). Successful policy measures in each of these domains would improve the indicator shown in Figure 2.1, pushing it toward 100.

Presenting employment rates as a ratio controls for overall labour market context and the business cycle. Figure 2.2 presents the underlying raw employment rates by severity of the mental health condition, which shows that the ratio is only part of the story. For example, both Italy and Switzerland score highly in Figure 2.1, demonstrating that those with a mental health condition in those countries have more similar employment outcomes as those without. However, Figure 2.2 shows that these high ratios stem from two different realities. Switzerland has high overall employment rates, while employment rates in Italy are relatively low, regardless of the mental health status. More generally, across the OECD, there is a strong correlation (0.89) between the employment rates of those with and without a mental health condition. That these two different scenarios for Switzerland and Italy result in similar ratios suggest similar outcomes, but different potential policy solutions. Italy could likely yield greater gains by improving the overall labour market situation than focusing on those facing a mental health condition, as broad labour market measures will likely benefit both groups. Conversely, Switzerland may find greater improvements in the well-being of people with a mental health condition by implementing targeted interventions for people in need.

Figure 2.2. Across the OECD, one in two persons with a mental health condition are in work

Employed people aged 15-64 over total population aged 15-64, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Ireland data excluded due to data quality concerns.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See Annex Table 2.A.1 for details.

StatLink https://stat.link/7rzubc

Definition and measurement

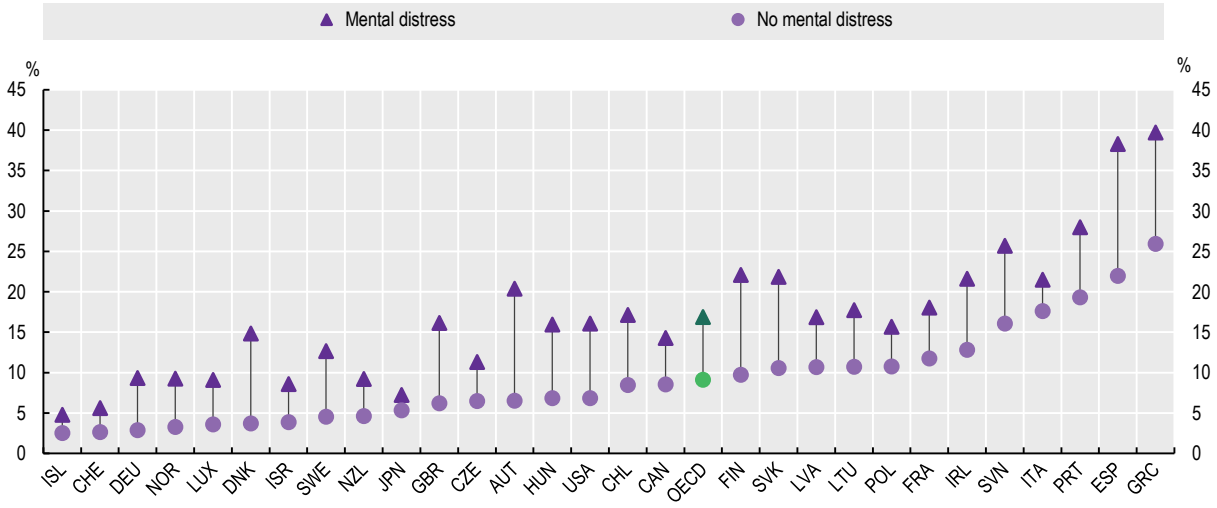
Figure 2.1 presents a ratio of employment rates. The employment rate is itself a ratio of the working-age population as a whole and the working-age population in employment. The ratio in Figure 2.1 compares those with and without a mental health condition. Values below 100 indicate that the employment rate for those with a mental health condition is lower than for those without. Figure 2.2 presents the underlying employment ratios that constitute Figure 2.1. The underlying employment rates are derived from health surveys, and may differ from official employment rates as computed from labour force surveys.

Labour force outcomes

Many people reporting a mental health condition want jobs, but cannot find them. This is evident in Figure 2.3, which shows that unemployment is much more prevalent amongst those who have a mental health condition. Across OECD countries, the unemployment rate was, on average, 85% (7.7 percentage points) higher for people reporting a mental health condition than for those not reporting such condition. While the mere act of being unemployed can be very distressing, this difference in unemployment rates also suggests either that people with poorer mental health are looking for jobs without success, or that they are transitioning more frequently into and out of work, or both.

Figure 2.3. Persons reporting mental health conditions are much more likely to be unemployed

Unemployed working-age individuals as a share of the labour force, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Data for Estonia is excluded due to data quality issues.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, INHIS-3, GSS, NHIS (2013), CSLC, ENCAVI. See Annex Table 2.A.1 for details.

StatLink https://stat.link/i9d087

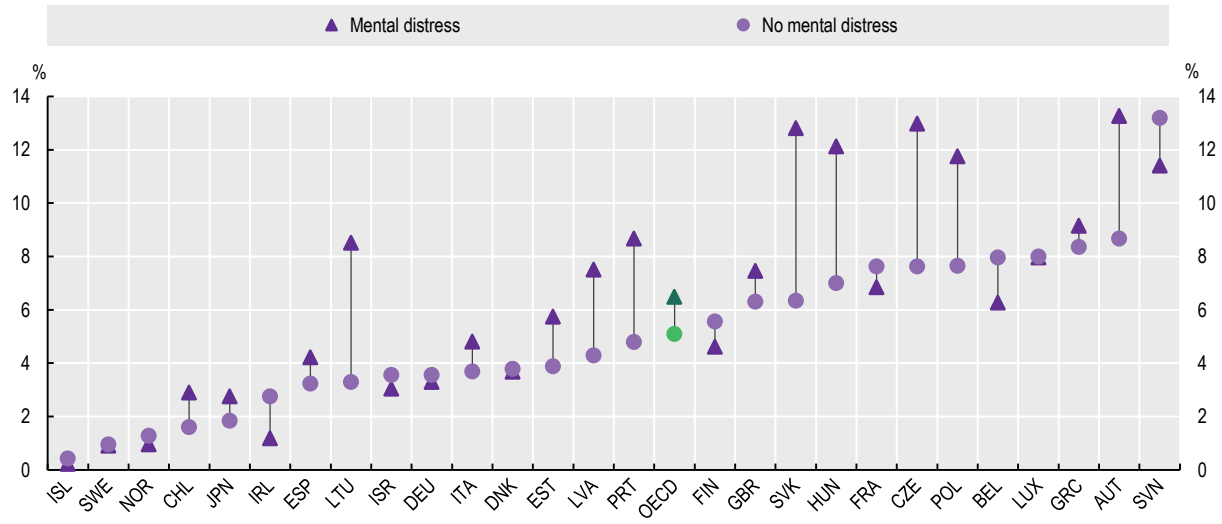
The consistency of this pattern across countries highlights the link between a higher incidence of mental health conditions and reduced well-being within the unemployed found in many studies (Clark, 2003[11]; Strandh et al., 2014[12]; Brand, 2015[13]). Moving from employment to unemployment can be a stressful experience for many individuals, and can lead to lower life satisfaction, doubt, and loss of self-esteem, and longer durations of unemployment are associated with a higher burden of disease and mental distress (Herbig, Dragano and Angerer, 2013[14]). Indeed, unemployment can leave lasting negative mental health effects, many of which may even outlast the unemployment spell itself (Knabe and Ratzel, 2011[15]).

Despite the scarring effects that periods of unemployment have on mental health, the variation apparent in Figure 2.3 suggests that policy can play a role in lessening the impact. For example, Germany and Switzerland have similar levels of unemployment among persons without mental health conditions, while the unemployment rate for those with a mental health condition is higher in Germany than in Switzerland. Similar comparisons are possible with Israel and Denmark, New Zealand and Sweden, the Czech Republic and the United Kingdom, to name a few. Further in-depth comparisons of the demographic and policy landscapes between these pairs of countries could uncover insights into effective policies to limit the mental distress that stems from unemployment.

In some cases, working age individuals opt to take early retirement rather than remain in work or search for a job in unemployment. The share of those taking early retirement varies considerably across OECD countries but, for most countries, does not differ greatly empirically by the presence of a mental health condition (Figure 2.4). On average, 5.1% of those not reporting a mental health condition have taken early retirement, compared with 6.6% of those reporting such conditions. However, some countries show much greater differences between those with and without mental health conditions, particularly those from central Europe and the Baltics. Within these countries, people with mental health conditions are more than 80% more likely to take early retirement than those not reporting mental health conditions. Research confirms that premature exits from the labour market via early retirement can often be driven by poor (mental) health (Biffl and Leoni, 2009[16]; Olesen, Butterworth and Rodgers, 2012[17]; OECD, 2015[10]). Other evidence suggests that voluntary early retirement can be associated with improved mental health (Melzer, Buxton and Villamil, 2004[18]), implying that much of the incidence of early retirement in those with mental health conditions was likely motivated by involuntary exits from work.

Figure 2.4. In some countries, persons reporting mental health conditions tend to retire earlier

Share of the working-age population (aged 15-64) in retirement, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, GEDA, INHIS-3, CSLC, ENCAVI. See Annex Table 2.A.1 for details.

StatLink https://stat.link/cisvln

Definition and measurement

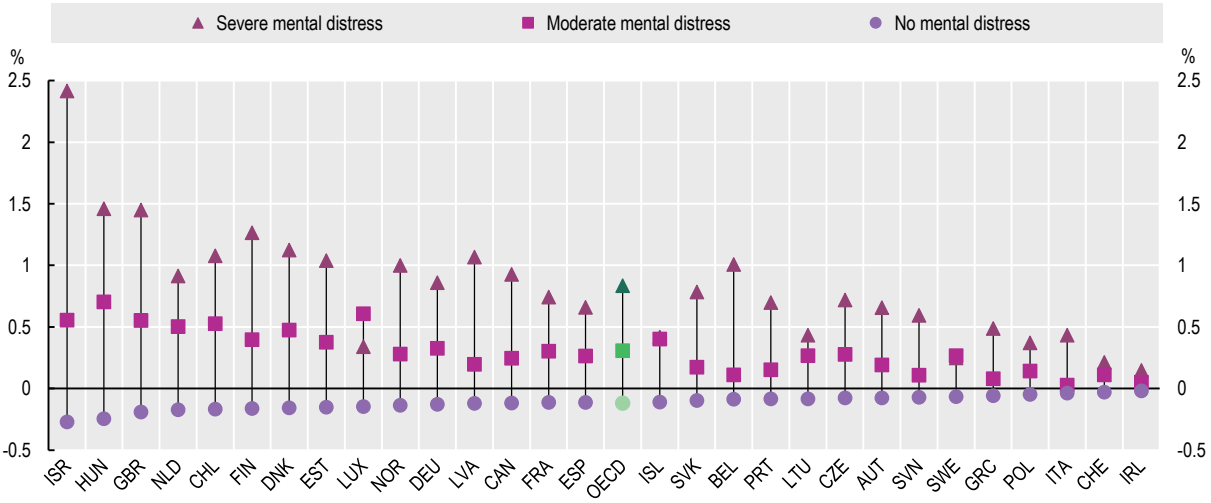
To facilitate the comparison of labour market outcomes by mental health status, unemployment rates shown in Figure 2.3 have been calculated from health surveys. These unemployment rates may not match those commonly reported in labour force surveys. In Figure 2.4, respondents who have taken "early retirement" are those who have retired before age 65. In practice, the normal retirement age varies across countries, and occasionally by gender. For example, retirement in France is possible for some workers aged 55, while the normal retirement age is 63.3. Likewise, the retirement age is 62.2 years in the Slovak Republic, and 62 years for men and 61.7 years for women in Slovenia.

Income and earnings

Individuals with mental health conditions are more likely to live in lower-income households than those without such conditions. On average across OECD countries, those with moderate mental health conditions were 31% more likely to live in households in the lowest income quintile than expected if evenly distributed amongst the income distribution (Figure 2.5). Comparatively, those with no mental health conditions were 12% less likely to live in low-income households. People reporting severe mental health conditions fare far worst: on average, they are 83% more likely than expected to live in low-income households. They are almost 2.5 times more likely than expected to be in low-income households in Israel and more than twice as likely in Chile, Denmark, Finland, Hungary, Latvia and the United Kingdom.

Figure 2.5. Persons with mental health conditions more likely live in lower income households

Share with equivalised income falling in the lowest household income quintile, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Income data available in Israel does not provide quintiles, but rather broad groups of earnings. Income deciles for Canada are not equivalised. Values above zero indicate an over-representation of a group within the lowest earnings quintile.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3. See Annex Table 2.A.1 for details.

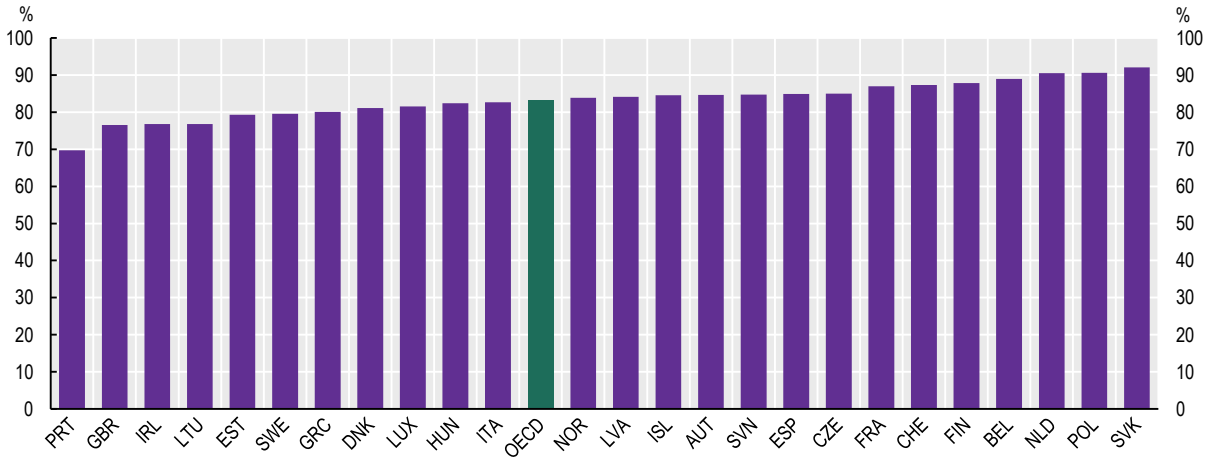
StatLink https://stat.link/78qbhi

Examining individual wages directly, the same pattern is evident: people with mental health conditions receive lower wages than those without. Figure 2.6 presents a comparison of full-time wages between those with and without mental health conditions for a subset of European OECD countries, for which such data is available. Values below 100 indicate that workers with mental health conditions earn less than those without, which was the case in all countries examined. On average across all countries, workers with mental health conditions were earning 83% of workers without mental health conditions. For example, in Portugal, workers reporting a mental health condition earned about 70% of the wage of their peers without mental health conditions, while the difference between the two groups was smaller in the Netherlands, Poland and the Slovak Republic (with a wage gap around 90%). A more detailed analysis of the worker characteristics could shed more light on the nature of these differences, and explore how outcomes differ within further refined groups, such as by age, gender, education and occupation.

While it is likely that simply having a low income, or being a member of a low-income household, is mentally distressing, these variations in the income and earnings distribution of individuals by mental health status suggest that countries have policy tools at their disposal that can help alleviate the distress associated with low incomes. One policy tool is the encouragement of employment amongst those with mental health conditions. There is a moderate correlation (0.5) between the employment gap between people with and without mental health conditions and their concentration within the lowest income quintile. This suggests that efforts to improve employment can also help lift those people out of poverty.

Figure 2.6. Persons with mental health conditions have lower wages than those without

Average gross wage for full-time workers with over those without a mental health condition, 2013



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Due to differences in the reference period for reporting income and mental health, observations were limited to those full-time workers who have not changed jobs during the past year. Data for Denmark, Finland, Iceland, Lithuania, Norway and Sweden include all full-time workers, as discriminating variables are not available.
Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013.

StatLink https://stat.link/65y2gf

Definition and measurement

Figure 2.5 presents the ratio of the total share of survey respondents in the lowest income quintile to the share of the groups by mental health status in the lowest quintile (minus 1). Values above zero indicate an over-representation of a particular sub-group compared to an even distribution of people across the income quintiles. Figure 2.5 uses equivalised household disposable income: total household earnings plus investment income and social benefits, less income taxes and social contributions, divided by a factor to equate different-sized households. Many surveys, including the EHIS, adjust household disposable income using the so-called *OECD-modified equivalence scale*, which divides total household income by the sum of the weights assigned to each household member (weight 1 for the household head, 0.5 for their spouse, and 0.3 for each dependent child). Other data, including the data for Chile, divide household income by the square root of the household size (this is also the method used in all recent OECD publications on income distribution and poverty). The income measure used in Figure 2.6 is the gross employee income (that is, before taxes and transfers) for those workers who have not changed jobs in the past year and who currently work full-time hours.

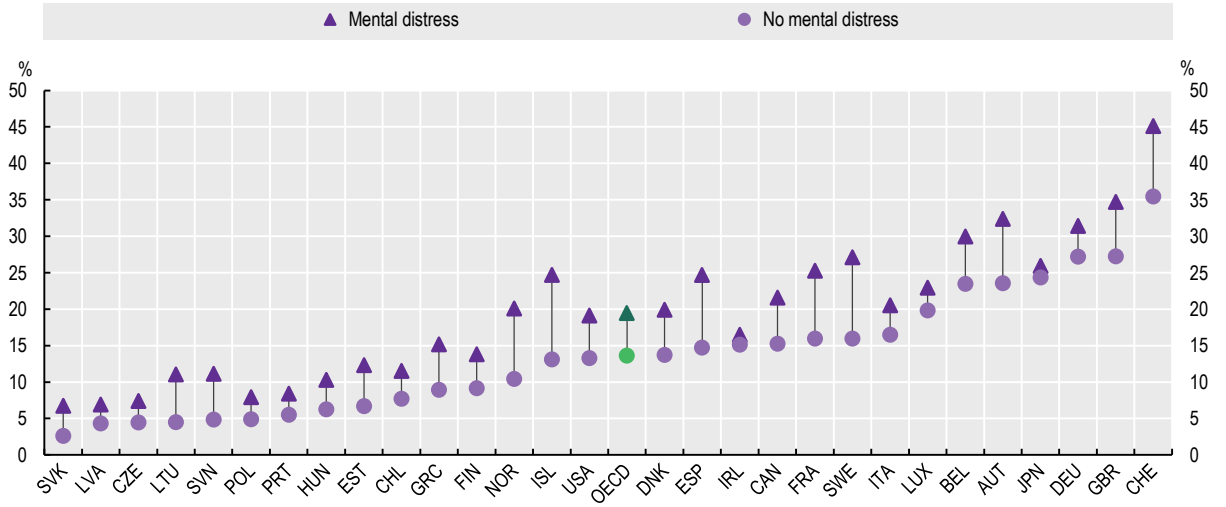
Work arrangements

There are some, but rather minor, differences in the work arrangements between people with and without mental health conditions. Figure 2.7 presents the share of dependent employment (that is, employees) that works part-time. In each country, those with mental health conditions were more likely to work part-time, though this difference was minimal in some countries, notably in Ireland, Latvia, the Czech Republic, Poland, Hungary and Luxembourg. On average 19.5% of workers with mental health conditions worked part-time hours, compared with 13.6% of those without such conditions. Within workers with mental health conditions, the share working part-time ranged from 6.7% in the Slovak Republic to 45.1% in Switzerland.

A high share of workers with mental health conditions working part-time is not necessarily an undesirable outcome. While many of these workers could possibly be involuntary part-time workers, who cannot find full-time jobs, another subset of part-time workers may be using reduced hours to balance the demands of a mental health condition. For those for whom this is the case, access to flexible hours or work schemes could be an essential means of managing their condition while remaining attached to the labour market. Some research suggests that part-time sick leave schemes in Sweden and Norway lead to positive outcomes for workers with mental health conditions (Andrén, 2011[19]; Markussen, Mykletun and Roed, 2010[20]), though other work examining a similar scheme in Denmark suggests these positive effects disappear after controlling for unobserved factors (Høgelund and Holm, 2011[21]). More research could clarify the value of part-time work as a management strategy for those with mental health conditions.

Figure 2.7. Persons with mental health conditions are more likely to work part-time hours

Share of dependent employment that works part-time hours, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Part-time work classifications follow national definitions.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/gyd8vt

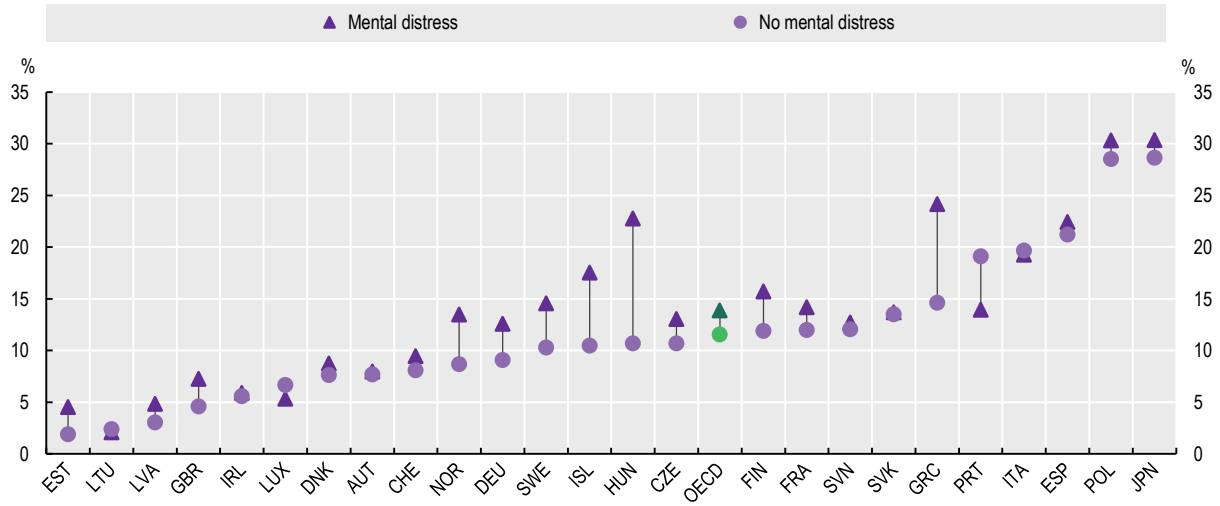
Separately, and maybe counterintuitively, there is a less clear relationship between temporary contracts and mental health status. Figure 2.8 presents the share of workers that report mental health issues who are on temporary contracts compared with those without mental health issues. For most countries, there is a negligible difference between these two groups. While on average, those with mental health issues are slightly more likely to work on temporary contracts – 13.9%, versus 11.5% for those without mental

health issues – much of this difference stems from differences in a few countries, notably Greece, Hungary and Iceland, and to a lesser extent Germany, Norway and Sweden.

In Hungary, more than a fifth (22.8%) of people with mental health issues are temporary contract workers, versus only 10.7% of those without such issues. Likewise, in Greece, one-quarter (24.1%) of workers with mental health conditions hold temporary contracts, while 14.6% of workers without conditions do. The differences in these countries, in light of the lack of difference in most other OECD countries, suggests that cultural work practices or policy regimes in these countries may favour temporary contracts for those with mental health conditions over other workers. For instance, in employment protection legislation regulating the eligible use of temporary contracts, the maximum successive duration and allowable number of successive renewals varies across OECD countries. In Greece and Hungary, there are no restrictions on the usage of fixed-term contracts, while in countries such as Italy, Lithuania and Luxembourg fixed-term contracts are primarily only allowed when replacing temporarily absent workers or when there is a clear time-limited need (OECD, 2020[22]).

Figure 2.8. In most countries, temporary contracts do not appear linked to mental health status

Share of dependent employment that holds temporary employment contracts, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, SHS (2012), GEDA, CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/q5cks4

Definition and measurement

Figure 2.7 presents part-time work according to nationally chosen definitions. The OECD often uses an international definition, considering those who work less than 30 hours per week as “part-time” workers. However, the definition of part-time work can vary across countries. For instance, this cut-off is 35 hours per week in Australia, Austria, Iceland, Japan, Sweden and the United States, while it is 36 hours in Hungary and Turkey, and 37 hours in Norway. Workers on temporary contracts shown in Figure 2.8 have self-identified as having employment contracts of limited duration. This may include arrangements such as fixed-term contracts, internships, apprenticeships, or temporary work-agency jobs.

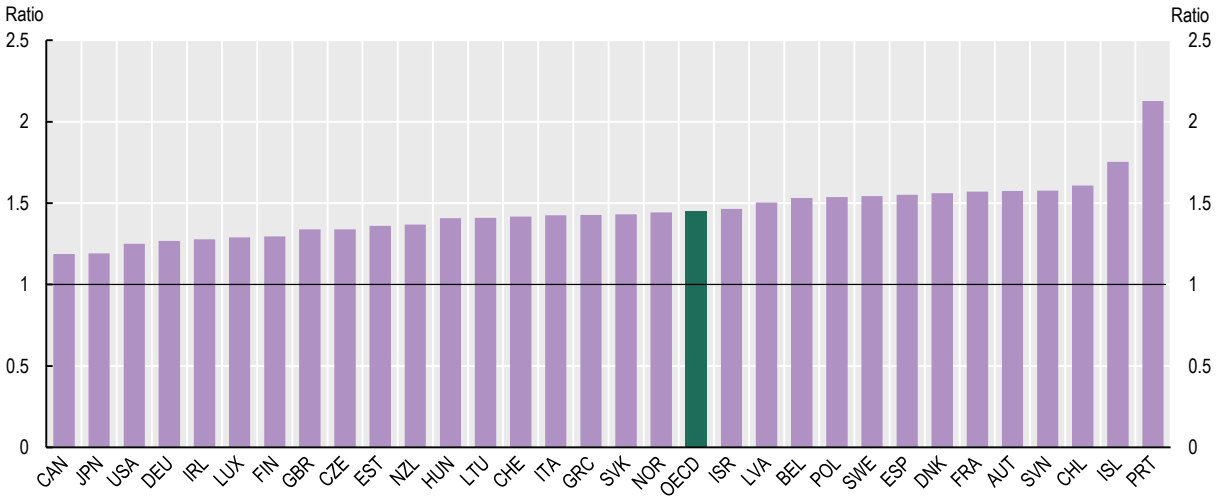
Gender and mental distress

Previous work examining a subset of OECD countries has shown that females have been overrepresented amongst those with mental health conditions (OECD, 2012[4]).This remains true when examining a larger set of OECD countries (Figure 2.9). On average, working-age females were 45% more likely to report mental health conditions than males of that age. This observation was common across all examined countries, although with some variation in magnitude. For instance, females were only 19% more likely to report mental health conditions than their male counterparts in Canada and Japan, but more than twice as likely (113%) in Portugal.

Though many studies have observed that females have a higher lifetime prevalence of many common mental health conditions, including depression and mood disorders, the cause of this difference is not well understood (Riecher-Rössler, 2017[23]; Kuehner, 2017[24]). Certainly, some of this is due to differences in self-reporting, as males have more negative stigmas against mental health care (Ojeda and Bergstresser, 2008[25]; Schnyder et al., 2017[26]; Corrigan, 2004[27]) and perceive themselves as having less of a need for care (Villatoro et al., 2018[28]). External factors also influence mental health status. For example, females are more likely to experience violence, gender discrimination, and gender inequality (Riecher-Rössler, 2017[23]). Rectifying these societal-level gender imbalances is already a priority for many OECD countries, and a by-product of these efforts could be improved mental health outcomes for females.

Figure 2.9. In all countries, a higher share of those reporting mental health conditions are female

Ratio of the share of those with mental health conditions, share female over share male, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Values below one indicate that a higher proportion of males report mental health conditions than females.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, GSS, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/v0a9km

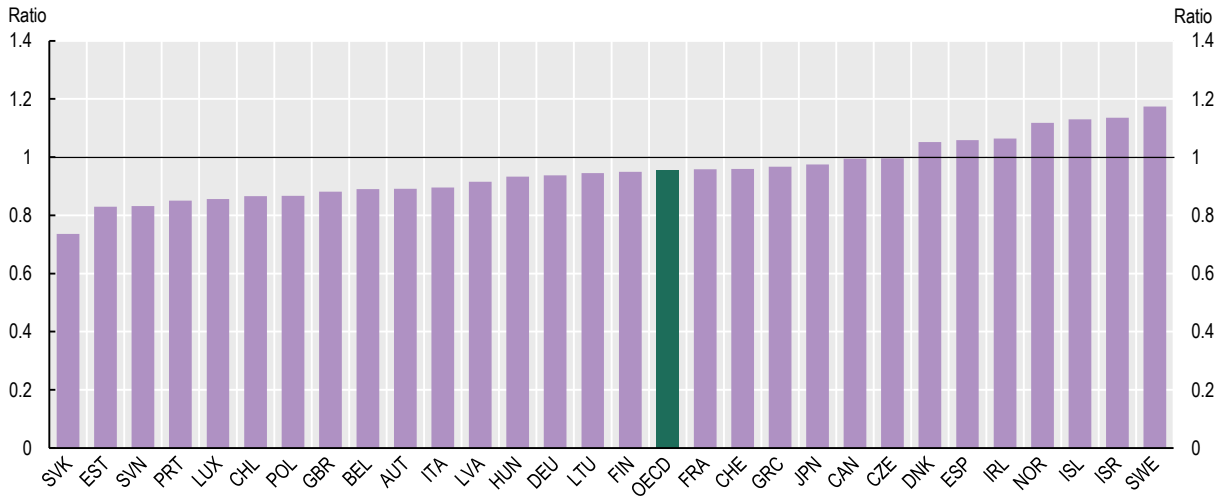
Despite a higher prevalence of mental health conditions for females, this does not necessarily translate into diminished employment outcomes relative to men with mental health conditions. Figure 2.10 presents an indicator comparing the employment gaps by mental health status for males and females. Values above one indicate that females have a larger gap in employment rates than males. On average, males were slightly more likely to have a larger gap in employment rates between those with and without mental health conditions. As an example, in Portugal, the employment rate was 52.5% and 59% for females with and

without mental health conditions, respectively. For men in Portugal, comparable values were 50.1% and 66.2%. These values implied an employment rate ratio for Portuguese females of 0.89, and 0.76 for Portuguese males, indicating a larger gap for men with mental health conditions (value of one=no gap). Of the 29 OECD countries examined, 21 exhibited similar patterns, though Denmark, Spain, Ireland, Norway, Iceland, Israel and Sweden exhibited the opposite.

A number of factors could explain the gender difference in employment gaps. Some evidence suggests that unemployment has a larger effect on the mental health of males than females (Artazcoz et al., 2004[29]) and that having a job is linked with lower anxiety disorder in males, but not in females (Plaisier et al., 2008[30]; Barnay, 2016[31]). Alternatively, the gender differences in perceptions toward mental health can discourage males from reporting a mental health condition unless it severely limits their quality of life (Ojeda and Bergstresser, 2008[25]; Villatoro et al., 2018[28]). Both of these explanations touch on subjective cultural norms and gender perspectives, such as males' self-perceived role as the main income provider, rather than objective differences in the prevalence of mental health conditions.

Figure 2.10. Employment rate gaps tend to be larger for males with mental health conditions

Ratio of share of employment rates of those with and without mental health conditions by gender, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental health conditions have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/tqhd47

Definition and measurement

Figure 2.10 presents a ratio of ratios. The first is the ratio of employment rates between those with and without mental health conditions, similar to the ratio presented in Figure 2.9. The second is the ratio of these first ratios for both males and females. To interpret this indicator, values above one indicate that females have a larger gap in employment rates between those with and without mental health conditions than males. Similar to Figure 2.10, Figure 2.9 also displays a ratio. It compares the share of people who are experiencing mental health conditions, and compares the share of females experiencing conditions (the numerator) to the comparable value for males (the denominator).

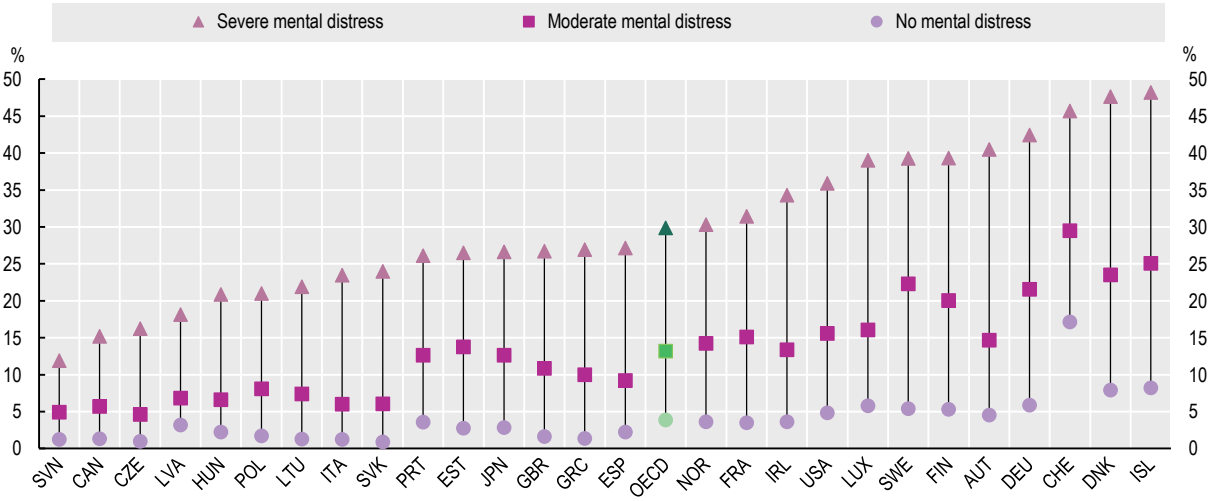
Health care use and needs

Accessible health care for those who need it is essential to providing adequate care. Reflecting an increased need and use for mental health care services, across the OECD, people with mental health conditions are more likely to have visited a mental health professional over the past year (Figure 2.11). In the mid-2010s, on average, more than 13% of those with moderate mental health conditions had visited a mental health care professional, compared with approximately 4% of those with no condition. Among those with more severe mental health conditions, 30% sought the help of a mental health professional. The share of people seeking help varied across OECD countries, ranging from just under 5% in the Czech Republic to almost 30% in Switzerland for those with moderate mental health conditions. For people with severe conditions, the share seeking help ranged from almost 12% in Slovenia to just under 50% in Iceland.

While the share seeking help for those with severe mental health conditions is larger than either of the other two sub-groups, as expected, it also implies that the majority of people with mental health conditions did not visit a specialist in the past year, irrespective of the severity of their condition. There are many reasons why a person with mental health conditions may not seek help. Some people may not perceive a need for care, or would prefer to treat their issues themselves (Codony et al., 2009[32]; Thornicroft et al., 2017[33]; Van Beljouw et al., 2010[34]). Others may see treatment options as ineffective or have had negative experiences in the past with health care providers (Andrade et al., 2014[35]).

Figure 2.11. A minority of people with mental health conditions consult a specialised professional

Share of working-age individuals who consulted a psychologist, psychotherapist, or psychiatrist in the past 12 months, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

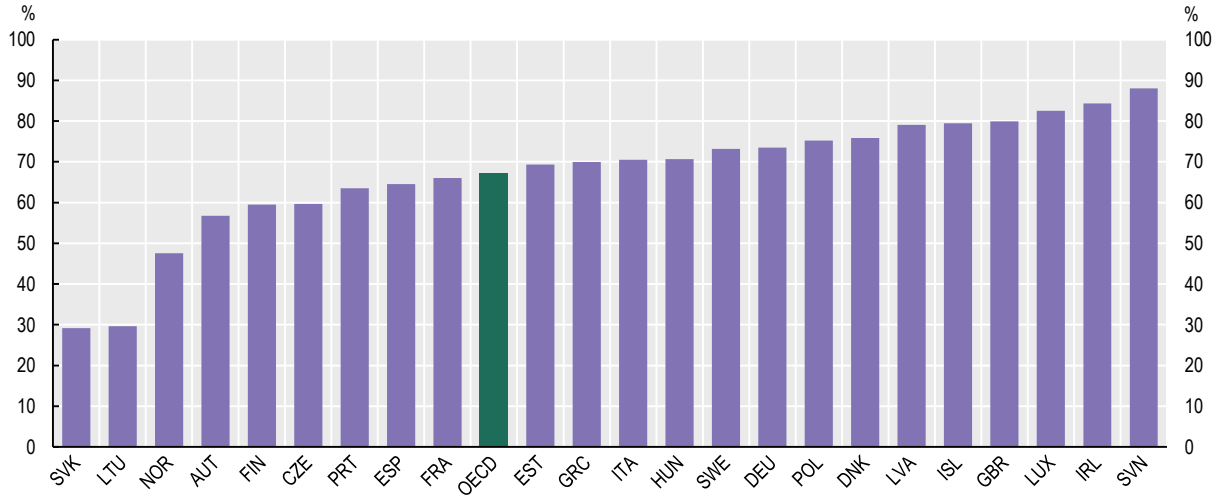
StatLink https://stat.link/ux35g2

However, while many persons with mental health issues do not seek help or do not want help, there are many who want help but may have difficulty accessing it. As shown in Figure 2.12 many people with mental health conditions across Europe needed mental health care, but either could not afford it or experienced a delay in accessing it. On average across Europe, two in three of those with mental health conditions who expressed a need for care, had difficult accessing it. This was the case whether looking at those with only

severe conditions (among them, 68.5% had difficulty accessing care) or when restricting the analysis to those with mild-to-moderate mental health conditions (66.3%). Importantly, Figure 2.12 does not indicate a complete lack of access to health care, but rather that, at least once within the past 12 months, mental health care was difficult to access. Those with mental health conditions are more likely to require medical help, and so difficulties accessing medical care can fall more heavily on them than those without such conditions. A lack of access to medical care can lead to worse outcomes, as common mental health problems can evolve into more serious and debilitating problems if left untreated.

Figure 2.12. At least in Europe, mental health care can be difficult to access

Share of people with mental health conditions that experienced difficulties accessing medical care (due to financial, waiting time or transportation constraints) given they expressed a need for care, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1
Source: EHIS-2, GEDA. See Annex Table 2.A.1 for details.

StatLink https://stat.link/a5q1kc

Many health care authorities have highlighted the role of primary care providers in mental health care (Reiter, Dobmeyer and Hunter, 2018[36]). As expanded on throughout this report, primary care providers serve as gatekeepers to specialised mental health services, and improved training for these gatekeepers can facilitate greater access to mental health professionals for those who need it, and can also facilitate a move away from a binary view of mental health in order to improve prevention efforts (Williams, 2020[37]; OECD, 2015[10]).

Definition and measurement

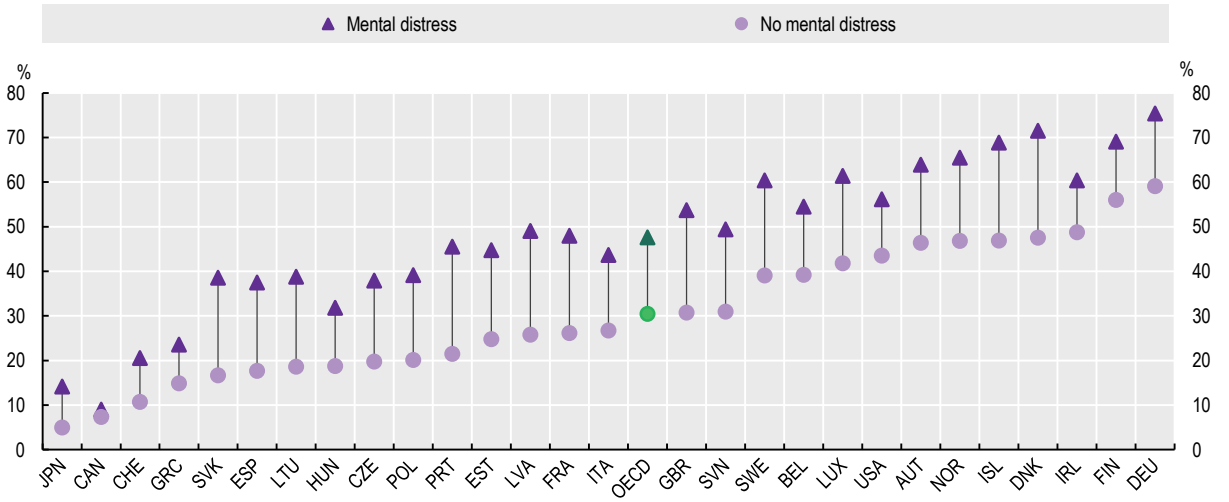
Figure 2.11 presents the share of people who have consulted a mental health professional while Figure 2.12 presents the share who have experienced difficulties accessing mental health care, given a need for care. They responded either that they visited a mental health care professional in the past 12 months or that they had a need for care that was unmet. Values of 100 indicate that all people who wanted care received care. More concretely, respondents expressed a delay in receiving medical care "because the time needed to obtain an appointment was too long" or "due to distance or transport problems?" Respondents also indicated if they needed mental health care over the past 12 months, but could not afford it. Any affirmative indication indicated needed care that was unmet.

Sickness and absence from work

A key component of the societal burden of mental health is reduced productivity in the form of lost working hours (absenteeism) and reduced capacity while working (presenteeism). Mental health conditions drain workers of their motivation and capacity to work effectively. Consequently, workers with mental health conditions are more likely to report having missed work over the past 12 months than those without (Figure 2.13). On average, half (47.6%) of those with mental health conditions had been absent from work during the past year, compared with just under a third (30.4%) of those without such conditions. This is a common problem throughout the OECD, reflecting that many people with mental health conditions need more time away from work, as a means to manage or to address their underlying mental health issues.

Figure 2.13. Persons reporting mental health conditions are more likely to have missed workdays

Share of workers absent from work at least once over the past 12 months, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Data for Japan and Switzerland use a reporting period of four weeks; Canada uses a reporting period of one week.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

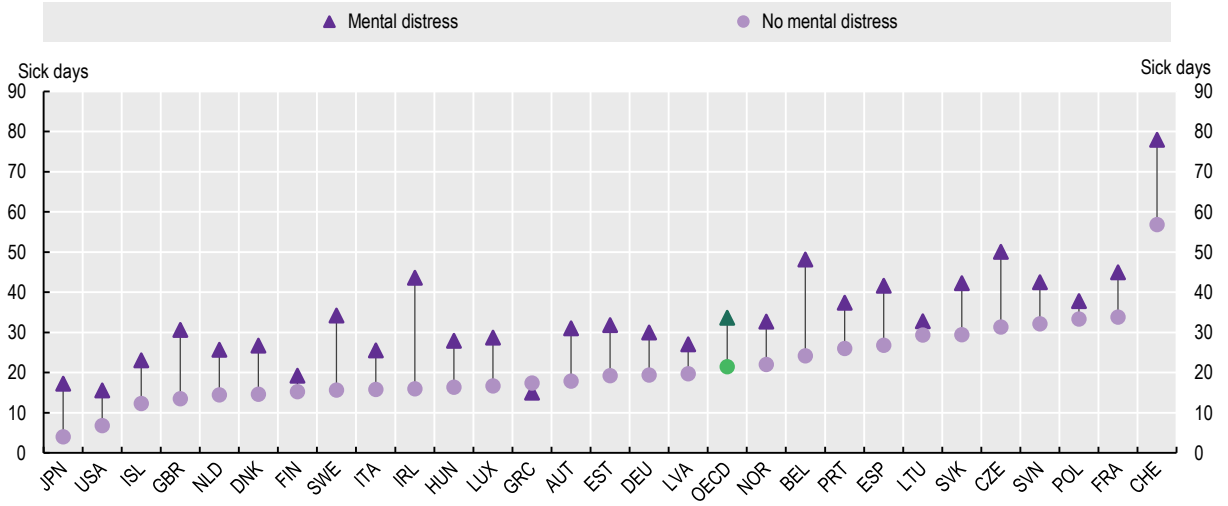
StatLink https://stat.link/03swhe

When workers are absent from work, those with mental health conditions require more time off than those without (Figure 2.14). Given that a worker has been absent from work, those with mental health conditions take on average 33.6 days of leave per year, compared with 21.4 days for those with no mental health conditions. Longer absence durations for those with mental health conditions are observable within every country with the exception of Greece. While these differences are quite small for some countries such as Finland, Lithuania and Poland, the difference is notable for other countries, including Switzerland, Ireland and Belgium. Longer absence durations due to mental health conditions can be costly to workers, as they are associated with more severe depressive symptoms (Shin et al., 2018[38]), which in turn are associated with larger limitations in work functioning when returning to work (Lagerveld et al., 2010[39]).

Working time lost to mental health conditions can be costly to employers as well. US research estimated that absenteeism due to major depressive disorders cost USD 23.3 billion in 2010 (Greenberg et al., 2015[40]). However, the same study estimates that this represented only 12% of the total incremental cost, echoing previous research that more than three-quarters of the workplace-related costs were due to presenteeism or reduced productivity while at work (Stewart et al., 2003[41]; OECD, 2012[4]).

Figure 2.14. Persons with mental health conditions are also taking more days off when sick

Average annual number of sick days taken for those with at least one absence in the past year, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Absence data is reported in aggregated bins. The figure presents the weighted average of the mid-point values of each bin. Data for Switzerland and Japan use reporting period of four weeks and are adjusted to a 12-month period.

1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.

Source: EHIS-2, SHS (2012), GEDA, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/n4zbri

The prevalence of presenteeism highlights that many workers are capable of working with their mental health condition, but that they may require support to maintain their productivity. Research suggests that workers with depression had trouble with interpersonal, time management, and physical tasks, and that these issues can remain even after the symptoms of depression are treated (Adler et al., 2006[42]). This suggests that targeted interventions can help workers with mental health conditions to cope with the demands of work. Other research (Bubonya, Cobb-Clark and Wooden, 2017[43]; D'Souza et al., 2006[44]) has found that increased job security is associated with lower presenteeism, though it has an ambiguous effect on work absences. This research suggests that reducing and managing job stress can be an effective means of improving productivity. Mental health training for managers and developing effective back-to-work management processes can be key routes to achieving this goal (OECD, 2015[10]).

Definition and measurement

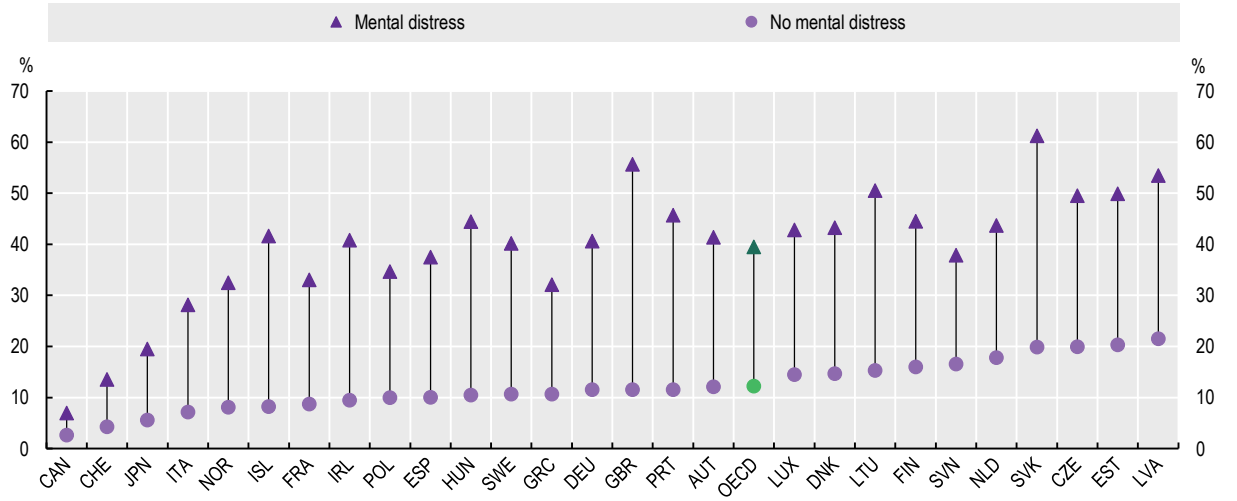
Figure 2.14 shows the resulting average number of sick days in the past year of all those with at least one day of absence, whereas Figure 2.13 shows the share of those with at least one absence in the past year. In many of the surveys used, absence data is reported in aggregated bins, which group together different ranges of sick leave durations. The analysis infers average values by computing the midpoint of each bin and using that midpoint value as the imputed sick leave duration for each worker. If there is an uneven distribution of actual leave days within a particular reported bin (for example, if every worker who took "1 to 9 days" of leave only took one day) then this imputed value approach will provide biased results. Consequentially, the analysis assumes an equal distribution of the number of days of sickness leave taken within aggregated bins.

Mental health and comorbidity

Many people with mental health conditions also report a limiting physical disability. Figure 2.15 presents the co-morbidity of mental and limiting chronic general health problems. On average, 39.5% of individuals with mental health conditions face activity-limiting chronic health problems, compared with 12.2% for those without mental health conditions. While this gap is notable, still a majority of people with mental health conditions do not report such co-morbidity (approximately 60%), suggesting that mental health must be considered both individually and within the context of comorbid physical disabilities and not solely as a subset of a country's disability policy.

Figure 2.15. Mental health conditions are frequently comorbid with other limiting health conditions

Share of the working-age population that report a long-standing health problem that limits their general activity, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, GEDA, CCHS, ENCAVI, CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/953ufq

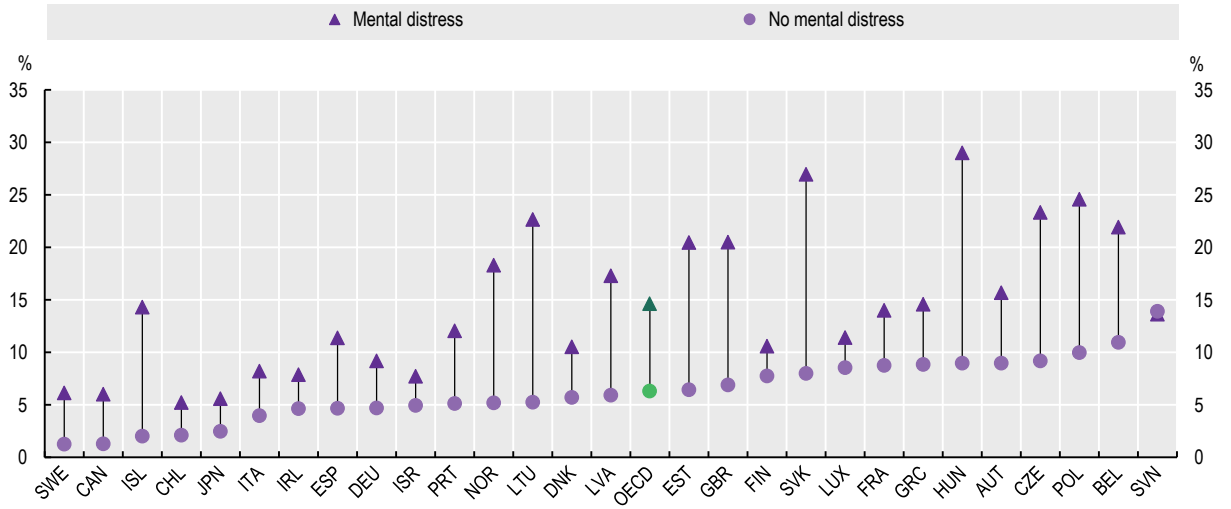
Further, interactions between physical health problems and mental health issues can be diverse and complex. For example, some physical and mental health problems are often found together, such as depression and chronic back pain (Patten, 2001[45]; Lépine and Briley, 2004[46]) or asthma and panic disorders (Carr, 1998[47]; Yellowlees et al., 1987[48]; Vermeulen et al., 2017[49]). In addition, treatment of patients with mental health problems can be complicated by poor adherence to medical treatment plans, possible cognitive impairment, and increased alcohol and substance abuse (Hirschfield, 2001[50]; Sato and Yeh, 2013[51]; Gallo et al., 2013[52]). Likewise, the existence of physical health problems can exacerbate or even generate mental health issues, such as anxiety and depression.

Oftentimes, comorbidity takes individuals out of the labour market. Figure 2.16 presents the share of individuals who report being unable to work due to either a permanent disability or early retirement, by mental health status. As noted in Figure 2.4, the policy environment in some countries encourages early retirement over disability benefits and so, to facilitate cross-country comparisons, Figure 2.16 presents a combined measure of the two reasons for not working. There are notable differences by mental health status. While, on average, 6.3% of people without mental health conditions report being unable to work

due to either a permanent disability or taking early retirement, 14.6% of those with mental health conditions report so. This represents a gap of 8.3 percentage points. This difference can be even greater in some countries, with a gap of almost 20 percentage points in Hungary and at least 14 percentages points in Estonia, the Czech Republic, Poland, Lithuania and the Slovak Republic. However, some countries have smaller gaps, which is often the case when relatively few individuals leave work due to disability. Examples include Chile, Finland, Israel, Ireland, Japan, Luxembourg and Slovenia, which all have gaps of less than 3.5 percentage points. The variety in these gaps suggests that the policy environment could play a role in encouraging workers with interacting health problems to either remain in work or search for employment.

Figure 2.16. Mental health and physical disability often combine to keep people out of work

Share of the working-age population that report being unable to work as a result of a permanent disability or early retirement, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, GEDA, CCHS, ENCAVI, INHIS-2, CSLC. See Annex Table 2.A.1 for details.

StatLink https://stat.link/xfatol

Definition and measurement

Figure 2.15 presents an indicator commonly used to proxy the existence of a physical disability consisting of the combination of two separate questions. The first question asks about the existence of any chronic health problem. The second asks if this problem leads to a limitation of their general daily activity, either moderately or severely. Respondents who answer affirmative to both of those questions are assumed to have a long-term disability. Data for Japan indicates the existence of health problems currently affecting daily activities, and does not reference if the problem is chronic in nature. The indicator in Figure 2.16 presents the share of people who have instead decided not to work due to either disability or early retirement. Early retirement is included as, in some countries people who stop working due to a permanent disability tend to report that their main reason for choosing not to work is due to early retirement rather than due to the presence of a disability. In Japan, this indicator shows those who do not work, but want to, and cannot take up work due to health reasons.

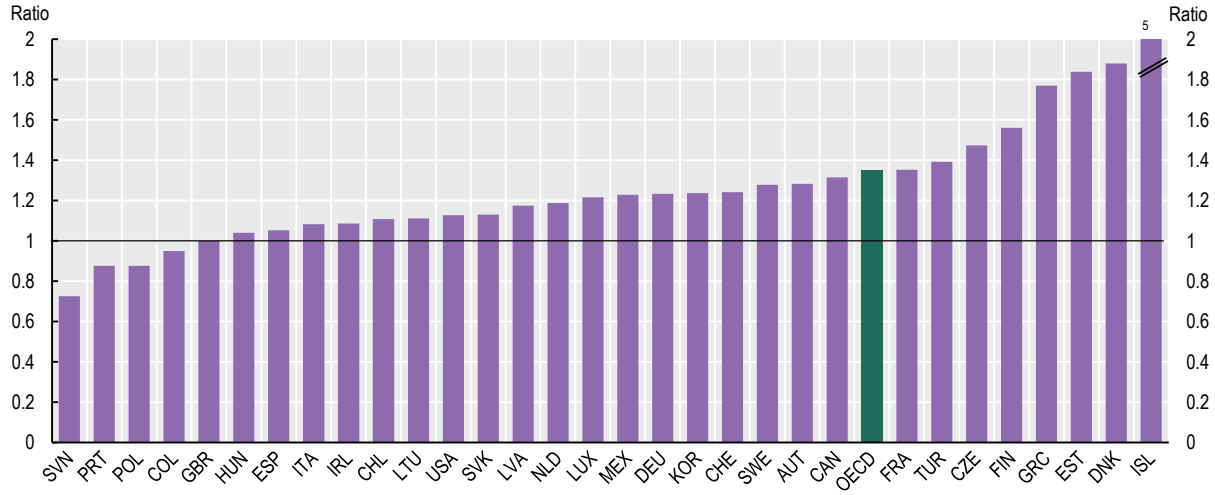
Youth challenges

Mental health issues often manifest themselves at a young age, and can remain an ongoing issue throughout a person's life (Burke et al., 1990[53]; Patton et al., 2014[54]; Rohde et al., 2013[55]; Naicker et al., 2013[56]). The onset of mental health conditions such as depression and anxiety have been linked with decreased school performance (Owens et al., 2012[57]; Fröjd et al., 2008[58]). Childhood is also a critical time for the promotion of well-being and the formation of skills that prepare students for their work life. Thus, it is important to quickly identify and address mental health issues in youth.

Figure 2.17 presents a ratio of the share of students that repeated a grade during their schooling, comparing those indicating mental distress to those not. It shows that, on average across the OECD, students indicating mental distress are 35% more likely to have repeated a grade. This is not the case for all countries. In Slovenia, Portugal, Poland and Colombia, this group of students is slightly less likely to have repeated a grade, while in the United Kingdom there is no difference between the two groups. On the other side of the spectrum, students indicating mental distress in Greece, Estonia, Denmark and Iceland are all at least 75% more likely to have repeated a grade.

Figure 2.17. Students indicating mental distress are more likely to have repeated a grade

Students who have repeated a grade during their schooling, ratio with over without mental distress, 2018



Note: OECD average is the unweighted average of the depicted countries. A value above one indicates that those students indicating mental distress were more likely to have repeated a grade. Students classed as having mental distress scored in the bottom 20% of respondents to the following battery of questions: Thinking about yourself and how you normally feel: how often do you feel as described below? Happy, Scared, Lively, Miserable, Proud, Afraid, Joyful Sad, Cheerful. Components were recoded for comparability. The ratio for Iceland is 4.99.
Source: PISA (2018), https://www.oecd.org/pisa/.

StatLink https://stat.link/8i27ma

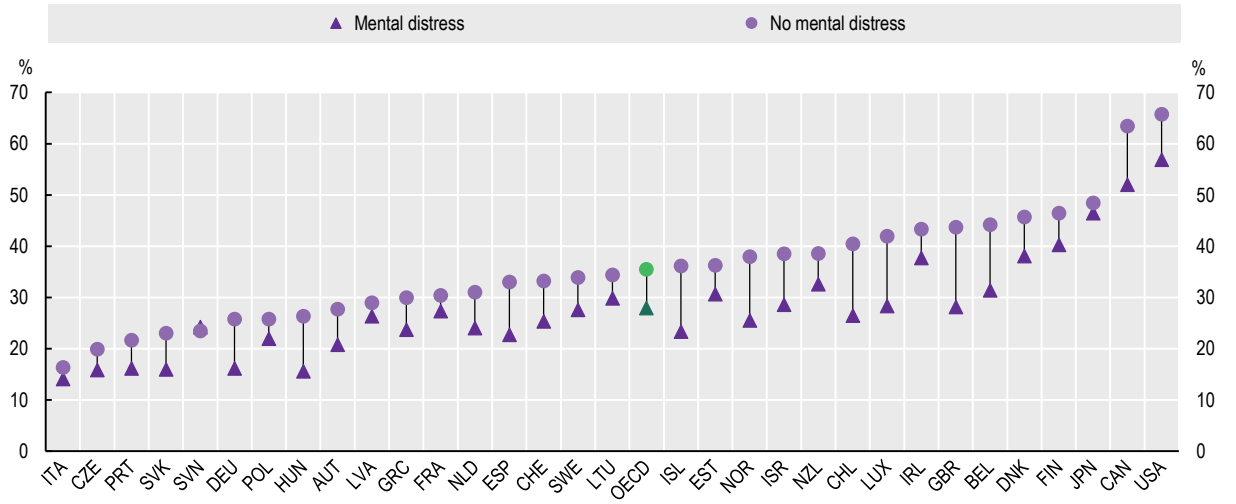
Grade repetition risks disrupting social connections with a student's peer group, removing a potential source of protection against mental health problems (La Greca and Harrison, 2005[59]). Furthermore, grade repetition can reduce the chance of graduating high school, especially if the retention occurs later in their school career (Roderick, 1994[60]; Jacob and Lefgren, 2009[61]). If retained students do manage to graduate high school, they still face a risk of lower overall educational attainment (Manacorda, 2012[62]). Similar outcomes are evident for people with mental health conditions more generally in Figure 2.18, which shows that those with mental health conditions are less likely to reach a high level of education: Only 28% of

those with mental health conditions had achieved a tertiary education, compared with 35% for those not experiencing mental health conditions.

The negative outcomes for students with mental health conditions or experiencing mental distress highlight the need for quickly identifying struggling students and for providing both targeted support and universal prevention measures (OECD, 2015[10]). These can include school-based measures to improve resilience, life skills, and emotional intelligence that can be both effective and cost effective (Weare and Nind, 2011[63]). More targeted interventions, such as cognitive behavioural therapy and interpersonal therapy have a strong evidence base and can reduce the risk of students with depressive symptoms from relapse (Merry et al., 2012[64]). Evidence suggests that the most effective measures to reduce drop-out rates target students on three levels: within school, outside of school, and at a systematic level (Lyche, 2010[65]). Examples include targeted mentoring for at-risk students, and encouraging the involvement of parents in their children's education, and supporting strong positive relationships between students and teachers.

Figure 2.18. Persons with mental health conditions are less likely to complete high-level education

Share of working age individuals with an education at ISCED 5 or higher, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of the depicted countries. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EHIS-2, CCHS, SHS (2012), GEDA, ENCAVI, INHIS-3, GSS, NHIS (2013), CSLC. See Annex Table 2.A.1 for details.

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Definition and measurement

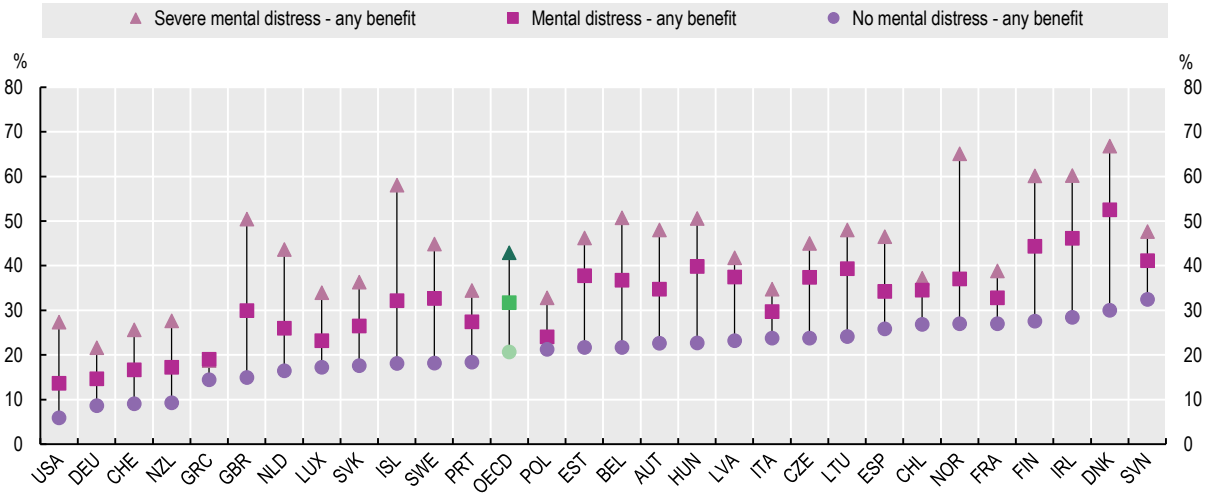
Figure 2.17 indicates the ratio of students who have ever repeated a grade, and compares those indicating mental distress to those not indicating mental distress. This measure of mental health status is taken at the time of the survey, generally when a student is 15 years old. However, students may have repeated a grade at any point over their schooling career. This ambiguity makes it difficult to determine a causality in the relationship between grade repetition and the existence of a mental health condition. The International Standard Classification of Education (ISCED) used in Figure 2.18 categorises educational achievement into nine broad groups. Groups above ISCED-5 indicate various levels of tertiary education, including bachelor, master's, and doctoral degrees or equivalent.

Social protection outcomes

Beyond health services, social benefits are key mechanisms with which governments provide support to people in need. Figure 2.19 presents the share of workers who receive any type of income support by their mental health status. On average within the countries examined, 20.6% of those without mental health conditions received some form of income support compared with 31.7% of those with mild-to-moderate mental health conditions and 42.8% for people with more severe mental health conditions. While many people with mental health conditions receive social protection benefits, it is notable that many do not. For instance, about three in four individuals with mental health conditions in Switzerland, Greece, Germany and New Zealand do not receive any income support.

Figure 2.19. Persons with mental health conditions are more likely to be in need of social benefits

Share of the working-age population receiving main social protection benefits, by mental health status, mid-2010s[1]



Note: OECD average is the unweighted average of depicted countries. Individuals are considered as benefits recipients if the income that they receive from benefits comprises more than 5% of their total gross income (with the exception of Chile, Germany, New Zealand and the United States, where all benefit recipients are included). Data for the United States does not indicate the receipt of unemployment benefits, and so estimates represent a lower-bound estimate of benefit receipts.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EU-SILC (2013), GSOEP, ENCAVI, GSS, NHIS (2013). See Annex Table 2.A.1 for details.

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Those people who are receiving social protection benefits may likely be long-term benefit recipients. Oftentimes, mental health issues are not identified or addressed early within a spell of unemployment or inactivity (OECD, 2012[4]). This represents a missed opportunity as ignoring (mental) health concerns often leads to poor labour market reintegration (OECD, 2015[10]). Early action, when a person is newly out of work, can help to retain their connection to the labour market. Once that connection is lost, either through the passage of time, inadequate work incentives, or excessive barriers to work, it is difficult to re-establish.

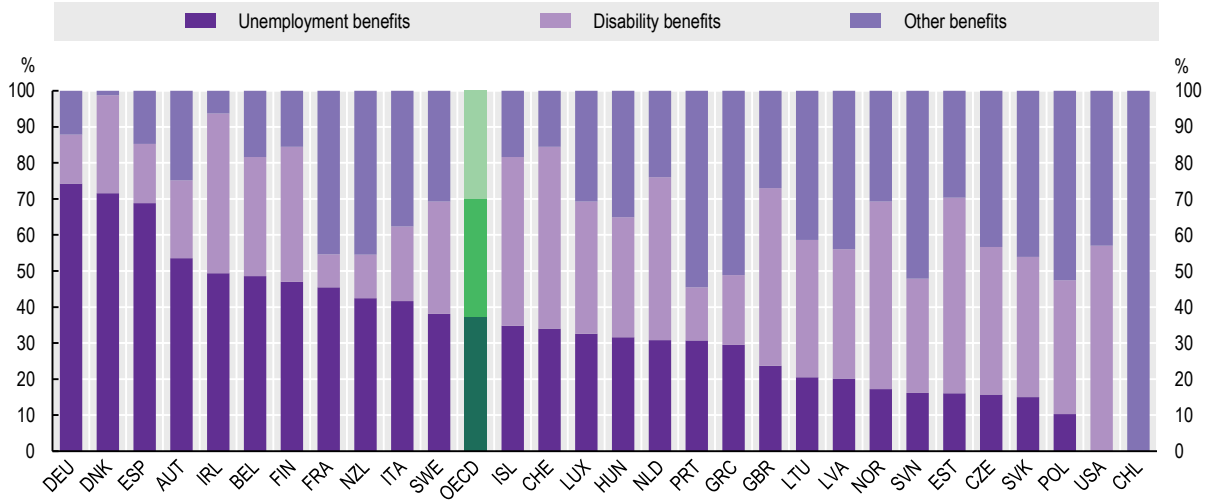
Figure 2.20 presents the distribution of the type of main benefits received by individuals with mental health conditions. The distribution of benefit types varies, both within and between countries. On average, unemployment benefits (37%), disability benefits (33%), and other types of income support (30%) are equally important for the population with mental health conditions. This distribution, however, varies across countries. Persons with mental health conditions in Denmark, Germany, Spain and Austria are more likely to receive unemployment benefits than any other type of benefit, provided they receive a benefit at all. In

Estonia, Switzerland and Norway, on the other hand, they are most likely to receive disability benefits as their primary benefit. In yet other countries such as Slovenia, Portugal, Poland and Greece, persons with mental health conditions are more likely to receive benefits other than unemployment or disability.

People with severe mental health conditions are on average slightly more likely to be receiving disability benefits (39.3% of those receiving benefits) than are those with mild-to-moderate conditions (30%). Previous evidence suggests that people with mental health issues make the bulk of new disability claims, and is more often cited as the reason for work problems when people have multiple health issues (OECD, 2015[10]; OECD, 2012[4]). This highlights the need for an awareness of mental health issues and the work capacity of those with poor mental health within the disability insurance system, and that policy attempts facilitate, where possible, a return to work. Early interventions to curb disability claims, financial incentives for workers and employers to hire and retain workers with mental health issues, and restricting full disability benefits to those who truly cannot work, can all help towards this goal (OECD, 2015[10]).

Figure 2.20. Persons with mental health conditions receive a range of income-support payments

Distribution by type of benefits paid for persons with mental health conditions who receive benefits, mid-2010s[1]



Note: OECD average is the unweighted average of depicted countries, excluding Chile and the United States. In cases where individuals receive multiple benefits, they are assigned to the benefit that provides the most income. Data for the United States does not indicate the receipt of unemployment benefits. Data for Chile does not distinguish by benefit type.
1. The figure presents data between 2012 and 2016. The relevant year for each country is outlined in Annex Table 2.A.1.
Source: EU-SILC (2013), GSOEP, ENCAVI, GSS, NHIS (2013). See Annex Table 2.A.1 for details.

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Definition and measurement

Income support benefits considered in Figure 2.19 include unemployment benefits, social assistance, disability benefits, old age benefits (for working-age workers), sickness benefits, lone-parent benefits, survivor benefits, and other income-replacement benefits. Recipients for whom social protection benefits provide less than 5% of their total income are assumed to receive no benefit. In Figure 2.20, those individuals who receive multiple benefits are attributed to the benefit providing the most income.

Trends over the five years before the COVID-19 pandemic

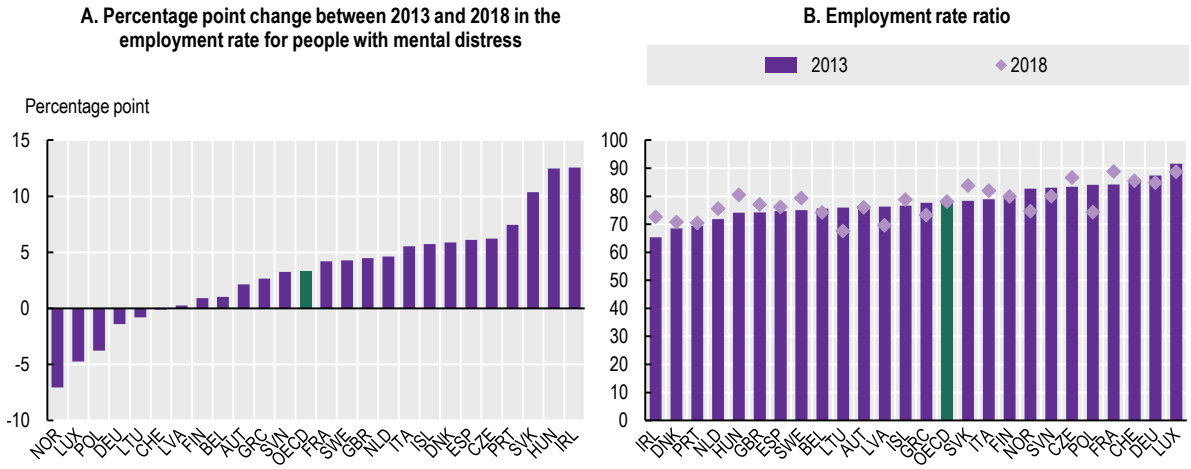
This section presents selected five-year trends for a subset of indicators and a subset of countries for which data is available for two points in time, based on two special modules from the EU-SILC in 2013 and 2018 – thus representing changes pre-COVID-19 (for more on the impact of the COVID-19 crisis, see Chapter 4). Changes are indicative of the labour market trends for persons with mental health conditions but cannot be connected directly with the policy changes over the past five years discussed in more depth in this report, even if the observed period is broadly in line with the period of implementation of the Recommendation. Any policy change will take time to translate into measurable changes in, for instance, employment or unemployment rates, and linking outcomes to reforms requires more in-depth analysis and controlling for factors other than a reform in question.

This section looks at four critical labour market dimensions: employment participation (measured by employment rates), job quality (measured by hourly wages), job security (measured by unemployment rates) and job exits (measured by the share receiving out-of-work income-replacement benefits). The results suggest that, across all countries, persons with mental health conditions generally were able to benefit from the strong labour market conditions in the observed period although less so than persons without mental health conditions. Country-specific findings sometimes tell a slightly different story.

Figure 2.21 presents five-year trends in employment rates and employment ratios. Employment rates have increased in the period 2013-18 in most countries among persons with and without mental health conditions. For those with mental health conditions, rates increased by 3 percentage points on average (Panel A) while the employment gap remained largely unchanged (Panel B). Three countries, Ireland, Hungary and the Slovak Republic, saw a larger increase in employment rates for persons with mental health conditions and a reduction in the employment gap while three other countries, Norway, Luxembourg and Poland, saw the opposite development.

Figure 2.21. In most countries, improved labour market conditions have increased employment rates for persons with and without mental health conditions broadly equally

Percentage point change 2013-18 in the employment rate of people with mental health conditions (Panel A) and ratio of the employment rates (ratio with over without mental health conditions) in 2013 and 2018 (Panel B)



Note: Employment rate is defined as the number of people who declared to be employed out of the total working-age population (people between 15 and 69 years old). OECD average is the unweighted average of the depicted countries. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Panel A: Values presented are the employment rate of people with mental health conditions in 2018 minus the respective value for the year 2013. Panel B: A value of 100 indicates that people with mental health conditions are equally likely to be working as persons without mental health conditions.
Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013 and 2018.

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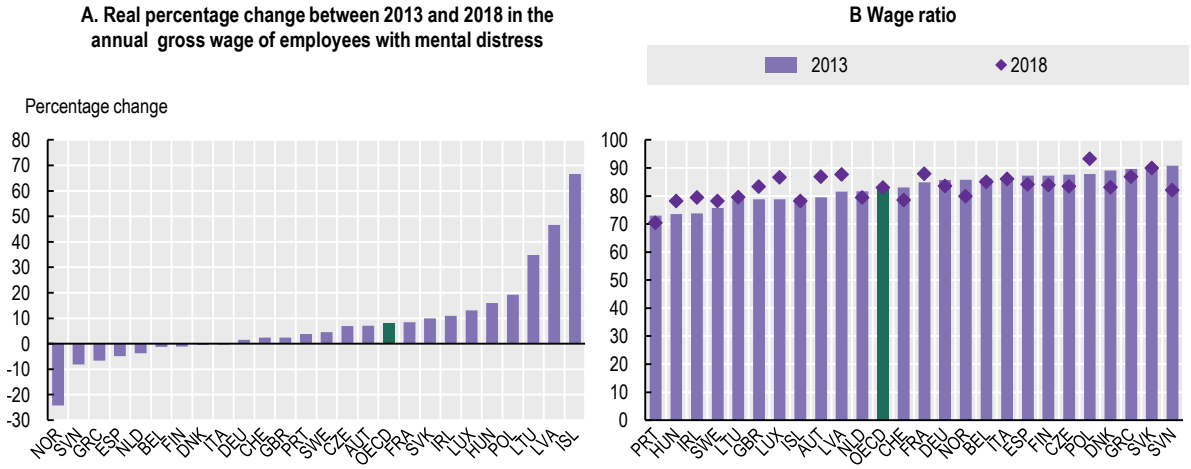
Figure 2.22 presents five-year trends in average hourly wages and wage gaps. Over all countries, the wage gap (Panel B) has changed little: on average across the 25 countries for which comparable data is available, employees with mental health conditions faced a wage gap of about 17% in both 2013 and 2018. This comes on top of the 20% employment gap shown in Figure 2.21. Real wages for employees with mental health conditions have changed little in most countries, with a few exceptions, Norway seeing the largest drop and Lithuania, Latvia and Iceland seeing the largest increase in real wages (Panel A). The impact on the wage gap was small in most cases.

Figure 2.22. Wages have changed little in most countries, irrespective of mental health status

Real percentage change 2013-18 in the average hourly wage of employees with mental health conditions (Panel A) and ratio of the average wage (ratio with over without mental health condition) in 2013 and 2018 (Panel B)



Note: OECD average is the unweighted average of the depicted countries. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Panel A: Values presented are the annual gross wage of people with mental health conditions in 2018 deflated by the CPI minus the respective value for the year 2013. Panel B: A value of 100 indicates that people with mental health conditions earn on average the same gross wage as persons without mental health conditions.
Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013 and 2018.

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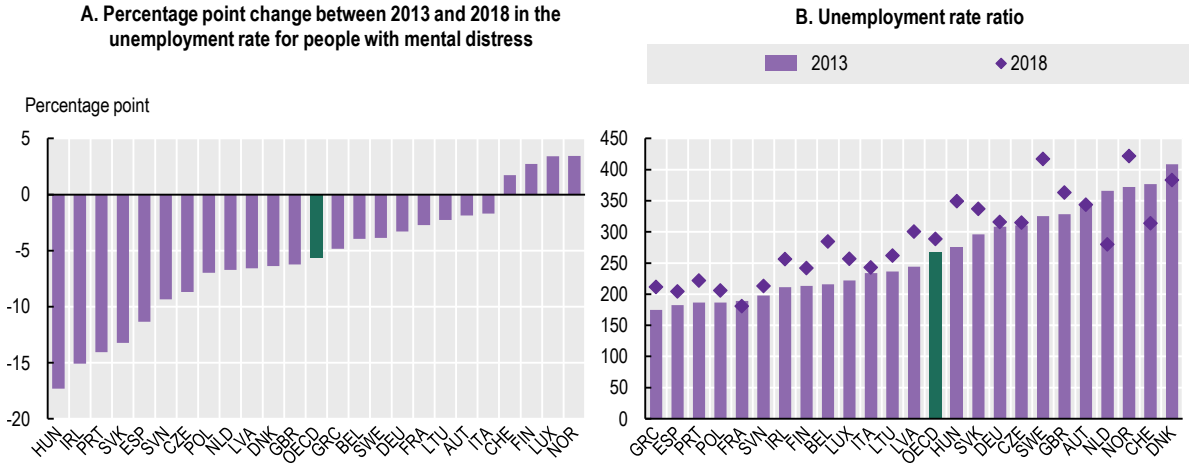
Figure 2.23 presents five-year trends in unemployment rates and unemployment ratios. In the period 2013-18, a period of stable economic growth in most countries, unemployment rates have fallen for persons with mental health conditions in most cases (Panel A). Countries in the south and east of Europe, i.e. countries with relatively high unemployment rates in 2013, saw the fastest decline in unemployment. However, the unemployment gap is very large in most countries and relative to the population without mental health conditions, the unemployment rate has increased in most countries. On average across all 25 countries included, people with mental health conditions are now almost three times more likely to be unemployed which is a notable upward shift from five years earlier (Panel B). The unemployment gap has increased in 21 of the 25 countries, sometimes considerably, and only two countries (Switzerland and the Netherlands) saw a relevant decline in this gap though from a rather high initial level.

Figure 2.23. Unemployment rates have fallen for persons with mental health conditions but less so, in most countries, than for the rest of the workforce

Percentage point change 2013-18 in the unemployment rate of people with mental health conditions (Panel A) and ratio of the unemployment rate (ratio with over without mental health condition) in 2013 and 2018 (Panel B)



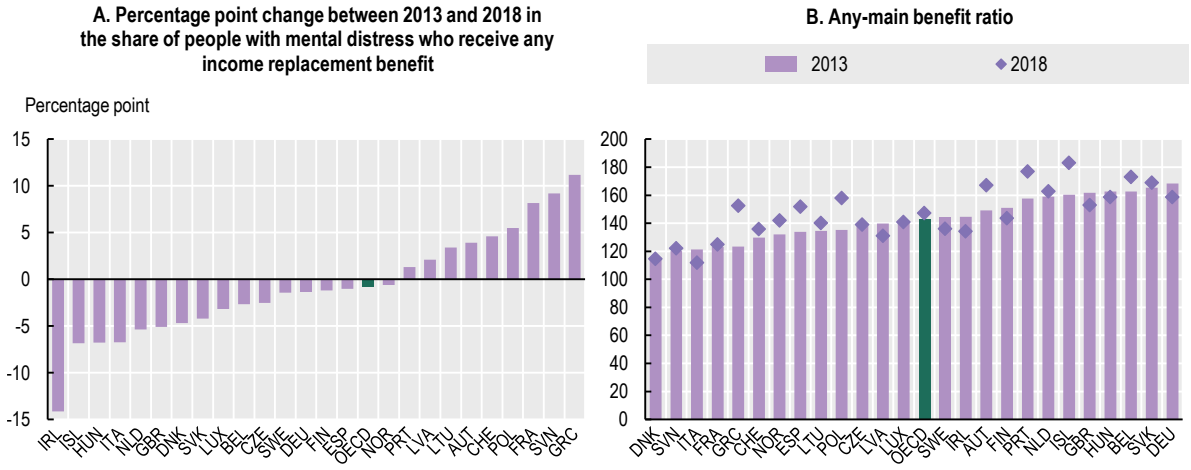
Note: The unemployment rate is defined as the number of people who declared to be unemployed out of the labour force (people who declared to be either employed or unemployed). OECD average is the unweighted average of the depicted countries. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Panel A: Values presented are the unemployment rate of people with mental health conditions in 2018 minus the respective value for 2013. Panel B: A value of 100 indicates that people with mental health conditions are equally likely to find a job as persons without mental health conditions.
Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013 and 2018.

StatLink https://stat.link/el89gk

Figure 2.24 presents five-year trends in rates and ratios of benefit receipt. These estimates include all main income-replacement benefits, irrespective of the reason of benefit receipt: sickness benefit, disability benefit, unemployment benefit, social assistance or welfare benefit, and (early) retirement benefit. While unemployment has fallen in most countries in the period 2013-18, with a 6-percentage-points decline on average as shown in Figure 2.23, inactivity has increased in many countries and the share of people receiving any main benefit has remained largely unchanged over this period on average (Panel A). In nine of the 25 countries, the share of people receiving a social benefit has increased, by up to 10 percentage points, while in the other 16 countries the share has declined by up to 6 percentage points (only Ireland saw a larger decline). Already in 2013, on average across all countries, persons with mental health conditions were about 40% more likely to receive social benefits. By 2018, this gap had increased to about 45% due to significant increases in about one-third of the countries. This suggests that the good economic conditions during the observation period broadly speaking have not helped in bringing inactive persons with mental health conditions into the labour market and/or have not stopped a significant number of those people from exiting the labour market.

Figure 2.24. Labour market exits have developed differently across countries but are generally more common among persons with mental health conditions

Percentage point change 2013-18 in the share of people with mental health conditions receiving a benefit (Panel A) and ratio of the rate of benefit receipt (ratio with over without mental health condition) in 2013 and 2018 (Panel B)



Note: OECD average is the unweighted average of the depicted countries. Individuals with a mental health condition have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Panel A: Values presented are the share of the working-age population (age 15-69) with mental health conditions who received any income-replacement benefit (disability, sickness, unemployment, (early) retirement or social assistance benefits) in 2018 minus the respective value for 2013. Panel B: A value of 100 indicates that people with mental health conditions are equally likely to receive an income replacement benefit as persons without mental health conditions.
Source: European Union Statistics on Income and Living Conditions (EU-SILC), 2013 and 2018.

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The OECD will update the indicators presented in this chapter regularly, for as many countries as possible. Longer time trends in some of the outcome indicators will, sooner or later, allow a deeper examination of the links between policy trends (including trends towards more integrated policies) and trends in social, skills and labour market outcomes for persons with mental health conditions. Poor outcomes remain too costly for the economy and for the people concerned.

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Annex 2.A. Data sources

Annex Table 2.A.1. Data sources and country coverage

Abbreviation	Data Source	Year(s)	Country Coverage
EHIS-2	European Health Interview Survey wave 2	2013	Belgium and the United Kingdom
		2014	Czech Republic, Estonia, Greece, Spain, France, Latvia, Lithuania, Luxembourg, Hungary, the Netherlands, Austria, Poland, Portugal, Slovenia, the Slovak Republic, Finland and Sweden
		2015	Denmark, Ireland, Italy, Iceland and Norway
GEDA	Gesundheit in Deutschland aktuell (Current Health in Germany)	2014-15	Germany
EHIS-3	European Health Interview Survey wave 3	2018	Belgium, the Netherlands
CCHS	Canadian Community Health Survey – Mental Health Questionnaire	2012	Canada
ENCAVI	Encuesta de Calidad de Vida y Salud	2015-16	Chile
INHIS-2	Israeli National Health Interview Survey wave 2	2007-10	Israel
INHIS-3	Israeli National Health Interview Survey wave 3	2013-15	Israel
SHS	Swiss Health Survey	2012	Switzerland
		2017	
GSS	General Social Survey	2014	New Zealand
CSLC	Comprehensive Survey of Living Conditions*	2013	Japan
NHIS	National Health Interview Survey	2013	United States
		2018	
EU-SILC	European Union Statistics on Income and Living Conditions (special ad hoc modules on well-being)	2013 and 2018	Austria, Belgium, the Czech Republic, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom
GSOEP	German Socio-Economic Panel	2014	Germany
PISA	Programme for International Student Assessment	2018	Austria, Canada, Chile, Colombia, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Korea, Latvia, Lithuania, Luxembourg, Mexico, the Netherlands, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States

*Data for Japan is based on OECD analysis of anonymised data obtained through CSLC.

3 How far have we come in implementing integrated mental health, skills and work policies?

This chapter presents the key findings on the implementation of the OECD Recommendation on Integrated Mental Health, Skills, and Work Policy five years after its adoption. While countries are increasingly focusing on integrated policies at the strategy level and awareness-raising efforts are continuing, this is often yet to translate into integrated and well-connected practices at the working level. Progress has also been uneven across the thematic areas, with innovative and integrated practices increasingly seen in youth policies, whereas integrated practices remain rare especially in employment services and the welfare system.

Progress towards integrated mental health, skills and work policies is highly uneven across different policy areas

Five years on from the adoption of the *OECD Recommendation on Integrated Mental Health, Skills and Work Policy*, the importance of a whole-of-government approach to mental health policy is widely accepted across OECD countries. Almost three-quarters of countries responding to the Mental Health Benchmarking Policy Questionnaire (OECD, 2020[1]) in 2020 reported having in place national programmes or strategies for integrated and cross-governmental approaches to mental health governance. OECD countries also fully recognise that tackling stigma on mental health is a requirement of integrated mental health policy.

Box 3.1. Assessing the implementation of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy between 2015 and 2020

The Recommendation instructs the Employment, Labour and Social Affairs Committee and the Health Committee of the OECD to "monitor progress and policy development, including through the use of relevant indicators… no later than five years following its adoption." These two committees include representatives from all OECD countries and oversee OECD work on labour market, social and health policies. To support the two committees on fulfilling this instruction, the OECD Secretariat prepared a draft report to assess progress and policy developments (the "2021 Implementation Report") between 2015 and 2020. The Implementation Report was approved by the two committees in April 2021. It was then noted and declassified by the OECD Council, and made available to the public in October 2021.

This current chapter presents a reader-friendly version of key findings of the implementation report on policy developments between 2015 and 2020. The findings are primarily based on responses from 30 OECD countries to a questionnaire sent by the OECD Secretariat in August 2019 to understand policy developments in each country over this five-year period, supplemented by information provided by countries through their responses to the 2020 Mental Health Benchmarking Policy Questionnaire. Unless otherwise specified, the information in this chapter come from these two sources. The content of this chapter has benefitted from the reviews and written comments from 17 OECD countries at various stages of its development. The main findings have also been discussed in meetings of the Employment, Labour and Social Affairs Committee, the Health Committee, and the Education Policy Committee, which oversees the work of the OECD on education policy.

Note: of the 30 countries providing responses, two countries were accession candidate countries, namely Colombia and Costa Rica. Colombia officially became the 37th member of the OECD in April 2020, and Costa Rica became the 38th member in May 2021. As both countries became Adherents to the Recommendation upon becoming OECD members, they are included in the analysis in this publication.
Source: OECD (2021[2]) Implementation Report of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy; OECD (2020[1]), OECD Mental Health Performance Benchmark Data and Policy Questionnaire.

Yet translating these intentions into integrated practices at the working level remains a major challenge, with significant differences in the extent of progress between countries and in different policy areas. While there is significant recognition in youth policies for an integrated approach that responds to mental health and its impact on education and employment, and new integrated practices have been widespread across OECD countries, there remain few initiatives in welfare systems that systematically link and integrate mental health and employment services.

- **Health care systems** are increasingly prioritising mental health and there is an increased recognition of integrating mental health care treatment with youth, workplace and employment interventions. Such efforts still seem to be often at the strategy level, however, and examples of

working-level implementation of integrated mental health, skills and work policy in the health care system are still relatively limited owing to structural barriers to integration.

- **Youth support and education systems** have implemented many innovative initiatives since the adoption of the Recommendation, and many of these initiatives focus on providing mental health supported that is integrated with education and employment support. The significant progress seen across OECD countries also reflects the prioritisation of strengthening child and adolescent mental health services and policies to promote young people's mental health in recent years.
- **Workplace policies** also reflect the need for a more integrated approach that addresses workers' mental health and employment challenges concurrently. Despite this, workplace policies implemented by OECD countries remain largely focused on psychosocial risk prevention, often overlooking the importance of other aspects of mental health in the workplace. Mental health support for individuals on sick leave remains inadequate – this may be the result of lack of clarity over where responsibility for mental health support switches from the employer to the authorities managing employment services and social protection.
- **Welfare systems** – employment services and social benefits – are lagging significantly behind in most OECD countries in developing and implementing integrated mental health, skills and work policy, especially for individuals with mild-to-moderate mental health conditions. Such conditions are highly prevalent among benefit recipients and employment service users. In isolated cases of integrated services for individuals with mild-to-moderate mental health conditions, the initiative tends to come from the health system. It is unclear what is stopping governments from investments in scaling up integrated health and employment services that have shown good results.

Progress is also uneven across the key dimensions of an integrated approach

Structural barriers to implementing a whole-of-government approach and the continued shortage of finances dedicated to mental health also continue to hamper efforts to develop more integrated support and intervention for people experiencing mental health issues. These are among the major obstacles that continue to prevent OECD countries from ensuring provision of truly integrated health, education and employment interventions (the "what"). By comparison, OECD countries have made substantial progress in equipping front-line stakeholders such as teachers, managers, caseworkers or general practitioners with better mental health competence and increasingly also with knowledge on the links between mental health, education and employment (the "who"). OECD countries are also shifting to prevention, promotion, and early identification of individuals experiencing mental health issues, although timely intervention is often still confined to silos and need to become more integrated (the "when").

Such uneven progress across the "who", the "when" and the "what" can be problematic as effective and timely support for individuals experiencing mental health issues is reliant on success on each of the three dimensions. For instance, some OECD countries have made progress in reducing waiting times for mental health treatment and providing more timely treatment (thus seeking to address "when"). Yet further progress is possible if treatment is provided together with employment support in cases where mental health issues have contributed to job loss (thus addressing the "what"). Insofar, even slow progress in integrated, timely and appropriate polices and services – linking the "who", "when" and "what" – may deliver better outcomes for persons experiencing mental health issues and thus also for the society-at-large than uneven yet fast progress in specific elements of integrated mental health policy.

Countries are in different stages in the development of integrated mental health, skills and work policies

An assessment of the implementation of the Recommendation makes clear that OECD countries are in very different stages in the development towards integrated mental health, skills and work policy, and even within countries, policy development is often uneven, with more progress being seen in some policy areas (e.g. education and youth) than others (e.g. employment services and welfare systems). Countries tend to fall under one of the following four stages.

- **Stage one: Developing the right rhetoric.** Countries in this stage often lack a national mental health plan, and even where they do, show little to no focus on developing integrated mental health, skills and employment services. These countries tend to have only recently started focusing on mental health policy, and stigma against individuals with mental health conditions is highly prevalent. Policy priorities in this stage tend to focus on expanding capacity for community-based mental health services and in some countries, raising public awareness of mental health.
- **Stage two: Building the foundations for integrated mental health, skills and work policy.** Countries in this stage have national mental health plans that emphasise the need for integrated mental health, skills and employment services, but there remain only trials and small-scale policies that provide these integrated services within and outside the health system. Policy priorities in this stage tend to remain focused on the expansion of community-based mental health services and awareness raising, while in parallel, placing emphasis on building the foundations for integrated mental health, skills and work policy.
- **Stage three: Shifting from trials to a scaled-up integrated approach.** Countries in this stage have established mental health plans and strategies for integrated mental health, skills and employment service delivery. In this stage, effective and innovative trials and small-scale policies to provide integrated services are widespread, but such trials are often not scaled-up. Countries in this stage tend to have reached a baseline level of public awareness and primarily rely on community mental health services to support individuals with mental health conditions. Policy priorities in this stage differ somewhat across countries, but those making the most progress place significant emphasis on scaling up integrated policies and service delivery and addressing structural challenges that prevent inter-agency co-ordination.
- **Stage four: Integrated mental health, skills and work plans in practice.** Countries in this stage are executing well-developed integrated mental health, skills and work plans through large-scale evidence-based treatments and interventions – although progress tends to be uneven across the thematic areas. In this stage, mental health performance indicators that go beyond the health care system – such as employment targets – are not only being increasingly developed, but are also included within national mental health plans. Countries in this stage are at the forefront of implementing integrated mental health, skills and work policy among OECD countries. Policy priorities at this stage focus on further extending the availability of integrated mental health, skills and employment services and filling in specific gaps that exist in support for individuals experiencing mental health conditions.

The lack of complete and fully comparable information and data on developments in integrated mental health policy makes it difficult to assign countries to specific stages. It can nonetheless be said that a majority of OECD countries fall around stage two or three, with the remaining countries found in roughly equal shares in either stage one or stage four. The uneven progress across thematic areas also means that while a large number of countries are in stage three or beyond in youth support systems, very few are at a comparable stage for welfare systems.

Strategies reflect the need for a mental-health-in-all-policies approach

Over the past five years, OECD countries have increasingly come to accept the importance of an integrated mental health, skills, and work policy, as shown by the existence of national plans and strategies that emphasise a whole-of-government approach to mental health. In the Mental Health Benchmarking Policy Questionnaire sent to OECD countries in January 2020, almost three-quarters reported having national programmes or strategies for integrated and cross-governmental approaches to mental health governance, and almost all countries reported having mental health strategies or work programmes in ministries other than the Ministry of Health.

Yet much like with the implementation of practices at the working level, the extent to which the thematic areas – health systems, youth policies, workplace policies, and welfare systems – are covered in national mental health plans and strategies varies widely across OECD countries. Most of these plans remain largely centred around the health system, with countries often designing strategies specifically for children and young people. By comparison, considerations for workplace policies and welfare systems are only occasionally integrated, or left at the fringes of national mental health plans. This means that significant areas of government policy, which could make a difference to mental health, are not included in mental health policy, and while there is an emphasis on integration, OECD countries continue to see mental health as first and foremost an issue for the health system.

An increasing emphasis on integration in national mental health plans and strategies

The past five years have seen a significant number of OECD countries adding youth, employment and social protection dimensions of mental health in their national strategies or plans for the first time. While many of these countries have not necessarily set clear youth, employment or social protection targets, their latest plans demonstrate a new commitment to a cross-governmental approach, which represents progress from past plans focusing almost entirely on the health system.

An example of an OECD country that has made significant progress in its latest national mental health plan is Colombia (see Box 3.3). After first recognising the importance of addressing the socio-economic dimensions of mental health in 2013, the country put in place a new National Mental Health Policy in 2018, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The accompanying strategy to promote this plan, published in 2020, sets out clear areas of responsibility for a wide range of government ministries. In Poland, the National Mental Health Protection Programme for 2017 to 2022 calls for implementation of mental health policy by a range of ministries – health, social security, family, education, labour and beyond – and includes a specific qualitative objective of improving employment support provided to jobseekers with mental health conditions. These recent examples show that regardless of where an OECD country is at in its mental health reform process, they can put in place national plans and strategies on mental health that emphasise the importance of an integrated mental health, skills and work policy. For OECD countries that fall in this category, the challenge remains to translate these strategies into action, and furthermore, to develop clear measures and objectives to assess improvements in the integration of the education, employment and welfare outcomes in mental health policy.

A few countries have operationalised education, employment and welfare outcomes within mental health plans. In England (United Kingdom), the government accepted all the recommendations from the 2016 Five Year Forward View for Mental Health by the Independent Mental Health Taskforce to the NHS in England, which explicitly called for better integration of employment and the social protection system in mental health policy. One of the targets is to increase the number of people with mental health conditions supported in finding or staying in work by 29 000 each year through to 2020/2021 by expanding both the Increasing Access to Psychological Therapies initiative (IAPT) and Individual Placement and Support (IPS) programmes (Independent Mental Health Taskforce to the NHS in England, 2016[3]). In the

Czech Republic, the most recent mental health plan from 2020 includes a goal to reduce unemployment among individuals experiencing severe mental health conditions by 5% by 2024.

Young people are often a target group in integrated mental health strategies

The development of new mental health plans specifically for children and youth indicates the importance given to this age group among OECD countries. In the OECD Mental Health Benchmarking Policy Questionnaire, 17 out of 27 responding countries reported having specific national or sub-national mental health strategies for children and/or young people (OECD, 2021[4]). This represents a stark change over the past 20 years, as no country had such a plan at the beginning of this century (Shatkin and Belfer, 2004[5]). While approaches differ across the OECD, many noteworthy strategies and plans on child and youth mental health have been put into place recently that may offer insights for other countries seeking to prioritise this policy area.

In both Ireland and the United Kingdom, for example, taskforces have recently delivered reports on child and youth mental health that have become de facto national mental health plans. In England (United Kingdom), the taskforce prepared the publication, *Future in Mind in 2015*, which set out clear recommendations for the government to pursue to address shortcomings on child and youth mental health. The key themes, which include early intervention, low-threshold services and developing the workforce, are all closely aligned with the Recommendation. Future in Mind has since evolved into a national initiative of the Ministry of Health and NHS England. A taskforce was also recently commissioned in Scotland (United Kingdom), and the recommendations from the taskforce were published in 2019. Similarly, in Ireland, the recommendations from the taskforce report in 2017 recognised the importance of strengthening mental health services in both schools and higher education institutions, including the transition from school to university, which the Recommendation recognises as a key area for improvements in mental health policy.

While France and New Zealand have taken a different approach by placing mental health within the broader framework of well-being, they have also clearly prioritised the mental health of children and young people. In France, the President requested the development of a *Plan d'action en faveur du bien être et de la santé des jeunes* (or Action plan for youth well-being and health). The action plan, launched in 2016, includes concrete actions to promote earlier identification and timelier treatment for individuals with mental health conditions through strengthening psychological support available in higher education institutions, as called for by the Recommendation. New Zealand launched its first-ever child and youth well-being strategy in 2019 led by the Department of the Prime Minister and Cabinet, which identifies improving support for children and young people to promote mental well-being as one of three priority areas. In both countries, the initiative did not come from the health system, but from the President and the Department of the Prime Minister and Cabinet, indicating that the prioritisation of child and youth mental health is increasingly coming from central government figures.

In Canada, where mental health strategy is largely set by provinces and territories, innovative child and youth mental health plans have also recently been developed. The Framework for the Delivery of Integrated Services for Children in New Brunswick 2015, for example, sets out a vision for more integrated mental health services and guiding principles on implementing such practices, which closely resembles the Recommendation. In Australia, the National Mental Health Commission developed the country's first-ever National Children's Mental Health and Wellbeing Strategy for children from birth to 12 years of age (Australian Government, 2021[6]). The government announced the development of the strategy in 2019, which was developed over the course of two years, and then released in October 2021.

Structural challenges remain to translate national mental health plans into practice

Despite the widespread rhetoric and intention for a more integrated mental health, skills and work policy in national mental health plans, successful implementation of such integration remains the exception, not the norm. This partly reflects structural barriers that make working-level collaboration between multiple ministries, agencies and departments within governments costly or difficult to implement. This is a particularly significant obstacle when addressing mental ill-health, as the topic does not easily fall into the existing organisational structure of governments and civil society.

OECD countries are aware of structural challenges and the difficulties they impose on implementing integrated mental health, skills and work policy. For example, Ireland organised three pathfinder projects to experiment and help develop new models for more effective whole-of-government work as part of its Civil Service Renewal Plan. One of the pathfinder projects was specifically on youth mental health policy, the findings of which were released in 2017. Ireland is currently in the process of establishing a Youth Mental Health Pathfinder Team to put these findings into practice.

Similar measures have been taken in Sweden, where in 2015, the government commissioned a national co-ordinator to look into the state of mental health policy and make structural recommendations to allow for better co-ordination of mental health policy at various levels, including for example, between government ministries and agencies, municipalities and the health sector. On the basis of the findings of the inquiry of the national co-ordinator (Swedish Ministry of Health and Social Affairs, 2019[7]), 24 government agencies have been asked to jointly develop a new strategy for mental health and suicide prevention policy, which will be presented in 2023.

In the United Kingdom, a Work and Health Unit (WHU) was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care, with the aim of taking a whole-of-systems approach to health, including specific measures related to mental health. To address the siloes that limit integrated approaches to health and work policies, the WHU prepared a report in 2019 setting out proposals on how the government and employers can better support workers managing health conditions, including mental health issues, at work (HM Government, 2019[8]). The proposals were then made available online in a public consultation, and the findings from this will be released shortly.

There also remains a shortage of investment seen in mental health policies across OECD countries despite the increasing political will to address mental health issues. While methodological challenges make comparison across countries difficult, based on responses to the OECD Mental Health Benchmarking Policy Questionnaire, among countries for which data is available, mental health spending as a proportion of total health spending largely remained unchanged between 2009 and 2019 (OECD, 2021[4]).[1]

Given the continued shortage of investment in mental health and barriers to integrating mental health policies, financial incentives can play a key role in encouraging stakeholders to develop more coherent and integrated mental health services. As a starting point to create such financial incentives, it is essential that budgets are also allocated to mental health in ministries other than the Ministry of Health. Responses to the OECD Mental Health Benchmarking Policy Questionnaire indicate that most countries do not have dedicated mental health budgets for ministries other than the Ministry of Health and many countries had difficulty in identifying whether a dedicated mental health budget existed (OECD, 2021[4]). This is an area where OECD countries can make significant progress over the coming years.

New Zealand has developed a novel approach to creating financial incentives for more integrated mental health services through its Well-being Budget. Instead of basing the budget on initiatives developed by ministries and agencies, it is based on priority areas to promote well-being that are first identified in Cabinet (New Zealand Treasury, 2019[9]). The first budget developed through this method in 2019 resulted in dedicated and record levels of funding being allocated to mental health. While mental health may not have been the top priority for any specific agency or ministry, it was identified as one of five key priority areas where there are the greatest opportunities to improve the well-being and lives of New Zealanders.

Box 3.2. Policy Developments in Mental Health in Colombia, 1998-2020

1998: the first *National Policy of Mental Health* is adopted under the General Health Social Security System. The policy encompasses prevention, screen and mental health services, but there is difficulty executing the plan due to reasons including a lack of funding.

2005 and 2007: the Ministry of Social Protection publishes the *Guidelines of Policy of Mental Health in Colombia* in 2005 and the *National Policy of the Field of Mental Health* in 2007. These look to build upon the 1998 law but are only guidelines on how to develop mental health policy.

2007: the ***2007-2010 National Public Health Plan*** identifies improving mental health as a priority issue, but the focus remains largely on the health system. The most notable target in the plan is to reduce the consumption of psychoactive substances in all territorial entities.

2013: ***Law 1 616 on Mental Health*** modifies and updates the *National Policy of Mental Health* of 1998. The law outlines the rights of people with respect to their mental health, and sets out priorities including prevention of mental illness, promotion of mental health and an integrated approach to mental health. In this law, the term integrated refers largely to integration within the health system. Shades of a more integrated approach to mental health are becoming apparent, with the law including a specific Article on the promotion of mental health in the workplace. The Law also calls for the development of a National Mental Health Council, which meets for the first time in 2016.

2013: Colombia adopts the ***2012-2021 Ten-Year Public Health Plan*** in March. This plan makes mental health a priority area and adopts an approach that recognises that socio-economic inequalities have significant impact on health, including for mental health. This results in an emphasis on what is referred to as "coexistence and mental health".

2018: Colombia releases its new and latest ***National Mental Health Policy*****.** The concept of "coexistence and mental health" is fully embedded in this policy, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The plan includes a multi-level governance strategy with shared responsibilities between different levels of government.

2019: Colombia releases the **Integral Policy for the Prevention and Care of the Consumption of Psychoactive Substances.** This plan recognises the close interlinkages between mental health and the consumption of psychoactive substances, and thus shares five common work lines with the National Mental Health Policy. These are a) promotion of good mental health, b) prevention of mental illness, c) integral treatment, d) integral rehabilitation and social inclusion, and e) sectoral and inter-sectoral management.

2020: the National Council of Economic and Social Policy on Mental Health (CONPES) releases the ***2020-24 Strategy for the Promotion of Mental Health***. The strategy is notable for the wide range of government agencies involved and the specific mandates given to each government agency. The Strategy reflects an integrated approach to mental health that takes into account the social, employment and educational dimensions of mental health policy.

Sources: Plan Nacional de Salud Pública 2007-10 (2007), Ministry of Social Protection, https://www.paho.org/hq/dmdocuments/2010/Politicas_Nacionales_Salud-Colombia_2007-2010.pdf; Ten-Year Public Health Plan 2012-21 (2020), Ministry of Social Protection, https://www.minsalud.gov.co/English/Paginas/Ten-year-public-health-plan.aspx; Ley 1616 de 2013 (2013), Congress of Colombia; Política Nacional de Salud Mental (2018), Ministry of Health and Social Protection, https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf.

Awareness raising efforts are increasingly widespread

Over the past five years, awareness-raising campaigns have been run across many countries at different stages in their mental health policy. This is reflected in the responses to the OECD Mental Health Benchmarking Policy Questionnaire, in which 27 countries stated that they had at least one national or regional anti-stigma or mental health literacy programme (OECD, 2021[4]). In some countries, where there is greater stigma surrounding mental health, awareness raising is emerging as a key priority in the development of an integrated mental health, skills and work policy. In others, awareness-raising campaigns have existed for decades, and in many cases, successfully started a conversation surrounding mental health that continues today. In both of these broad categories, countries are taking innovative steps to raise awareness further among the general public and front-line actors.

Awareness raising is a key priority in countries shifting towards community care

For many OECD countries, awareness raising goes hand-in-hand with a policy focus on shifting away from institutionalised care and towards supporting community care. These countries tend to consider the fear and misconceptions about the "mentally ill" to be a key obstacle to ensuring the acceptance of individuals experiencing mental health issues in the community, and thus see increased awareness as an enabler of the reform of their mental health systems.

One of the clearest examples to address the negative links between stigma and institutionalised care is in Latvia, where the *Cilvēks, nevis diagnose* (Human Not Diagnosis) anti-stigma campaign launched in 2018 aims to make people aware of why deinstitutionalisation is necessary and encourages the public to support a shift towards more community-based social services. The campaign has been run by the Ministry of Welfare, and tells the experiences and stories of individuals experiencing mental health conditions to promote empathy and a better understanding of their capacities, rather than limitations. The awareness campaign was combined with efforts to develop community-based services for individuals with mental health conditions. According to the policy questionnaire response, 20% of Latvia's population had heard about the campaign by the end.

In Estonia, there are two campaigns notable for their emphasis on self-awareness and on encouraging people with mental health conditions to open up. "I'm all right", launched by the Ministry of Social Affairs in 2017, targeted young people aged 13-16 through a video campaign and encouraged them to seek help and talk about their concerns. Meanwhile, in 2018, *Peaasjad* (Head Matters), an Estonian non-governmental organisation ran a campaign to raise self-awareness of depression with support from the Ministry of Social Affairs. The campaign encouraged individuals concerned by their mental health to complete an anonymous online screening test using a ten-item depression scale. As of March 2018, as many as 20 000 individuals had taken the test, with uptake of the online test conducted in over 30 organisations. Other OECD countries including the Czech Republic and Poland have also recently put in place national-level awareness raising campaigns. Examples of mental health awareness campaigns in the Czech Republic are discussed in Box 3.3.

A running theme in these awareness campaigns is the funding from the European Social Fund and the European Economic Area and Norway Grants, which indicates that these countries are closely aligned with the increased focus on mental health seen in Europe as a whole. At the same time, this does not mean that all OECD countries in comparable situations in Europe have national mental health awareness campaigns. Greece, for example, has not had a national awareness campaign since its last initiative ended in 2013. Meanwhile, in Slovenia, while the National Mental Health Plan for 2018-2028 stresses the importance of addressing stigma, the existing campaigns remain locally based, although there are plans to put in a place a national anti-stigma campaign.

Box 3.3. Raising awareness of mental health in the Czech Republic

In 2017 to 2018, the National Institute of Mental Health of the Czech Republic launched *Na Rovinu* as a national campaign to address stigma towards individuals with mental health conditions, which is particularly high in the Czech Republic. For example, only 25% of those surveyed in 2015 said that they would not mind working with someone with a mental illness.

The concept behind *Na Rovinu* is to encourage all actors in society to speak plainly or frankly about mental health – including individuals experiencing mental health conditions – and to deepen public understanding of mental health issues. The key target groups identified in the project are individuals with mental health conditions and their relatives, as well as among paramedics, social workers and the public administration, as these are groups that regularly engage with individuals with mental health conditions.

The *Na Rovinu* website acts as a hub with information on mental health. This includes, for example, tips on how to communicate in a non-stigmatising manner about mental health, the rights of individuals with mental health conditions, and facts and myths surrounding mental health. The personal stories of individuals with lived experiences of mental health conditions are also shared with consent both through the website and social media in an attempt to bring mental health in to day-to-day discussions. *Na Rovinu* also organises events to educate and inform the public on mental health, including on mental health considerations amidst the COVID-19 crisis, as well as aligning campaigns with international movements such as World Mental Health Day.

The *Na Rovinu* project is complemented by mental health awareness initiatives run by non-governmental organisations. This includes *Můj Mindset* (My Mindset), which was started in 2016 and ran a video campaign to tackle prejudice with support from government agencies and Norway Grants, and *Nevypusť duši* (Don't Drain the Soul), a non-profit organisation founded in 2015 which runs workshops for high school students in the Czech Republic, drawing on examples of successful awareness-raising campaigns in the United Kingdom.

Looking ahead, efforts to raise awareness of and address stigma associated with mental health conditions will remain a priority for the Czech Government. In the National Action Plan for Mental Health 2020-30, one of the key objectives for the Ministry of Health is the continued implementation of a nationwide mental health anti-stigma campaign. Non-governmental organisations were consulted in the process of developing this action plan.

Sources: NA ROVINU (2020), NA ROVINU, www.narovinu.net; STOP STIGMATIZACI! KAŽDÝ ČLOVĚK SI ZASLOUŽÍ POROZUMĚNÍ (2020), Můj Mindset [My Mindset], www.mujmindset.cz; Nevypusť duši: Nebojíme se mluvit o duševním zdraví (2020), Nevypusť duši [Don't Drain the Soul], www.nevypustdusi.cz.

Established awareness activities and campaigns are being built upon

In a number of OECD countries, awareness-raising and anti-stigma programmes have existed for decades, and these activities are being continued and strengthened. Although countries take varying approaches, these campaigns tend to be largely delivered by non-governmental organisations, reflecting their particular importance in awareness-raising activities. These programmes often run throughout the year but are scaled-up around relevant awareness days such as World Suicide Prevention Day, Mental Health Awareness Week and World Mental Health Day.

In New Zealand, the main national anti-stigma programme continues to be Like Minds, Like Mine, a programme established in 1997 and funded by the Ministry of Health to reduce discrimination against and

encourage inclusion of those living with mental health conditions. Like Minds, Like Mine launched its most recent campaign, “Just Like, Just Listen”, in 2018, which promotes individuals to ask and listen to the experiences of those with mental health conditions, rather than assuming their needs or capabilities. While the strategic responsibility for the programme lies with the Ministry of Health, the Mental Health Foundation of New Zealand, a prominent non-governmental organisation, leads the communications around the programme. Another example of a well-known government-funded mental health campaign is Opening Minds in Canada, established in 2009 by the Mental Health Commission of Canada, which is funded by Health Canada and operates at an arm’s length from government.

In France, Psycom, financed by Public Health France, the Ministry of Health, and regional health agencies, provides a hub for information on mental health. The public information body provides information to authorities on mental health, as well as tools to fight against stigmatisation and discrimination of individuals experiencing mental health issues, and training. Although Psycom was established as far back as 1992, it was only in 2015 that its mission was expanded from the Paris region to the national level. One notable recent activity by Psycom has been to map the growing number of information sources available on mental health across the country at the request of Public Health France. The exercise culminated in a report published in 2020, which found that while information on mental health may be increasingly available, knowing what information is relevant and of high-quality is becoming increasingly difficult (Psycom, 2020[10]). This shows a key challenge that countries may face as awareness-raising activities proliferate and sources of information become disperse and wide-ranging.

Independent activities by non-governmental organisations are also playing a prominent role and have significant outreach. In the United Kingdom, the Time to Change campaign (2007 to 2021), developed by Rethink Mental Illness in partnership with Mind, contributed to awareness raising for more than a decade, offering a model for other programmes to follow. By its conclusion in March 2021, the campaign had worked with more reached out to more than 1500 employers and 3500 employers (Time to Change, 2021[11]). Meanwhile, the Mental Health Foundation has run a large scale campaign on mental health since it set up the Mental Health Action Week in 2001, which has since become the Mental Health Awareness Week. Other prominent charities such as the Mental Health Foundation and the Royal Foundation of the Duke and Duchess of Cambridge are also running their own campaigns. Other countries such as the United States and Australia also have significant charities and non-governmental organisations that raise awareness of mental health issues and have an international reach.

Among initiatives by non-governmental organisations since the adoption of the Recommendation, Heads Together founded in 2016 by the Royal Foundation of The Duke and Duchess of Cambridge is a notable recent and ongoing initiative. Spearheaded by the Duke and Duchess of Cambridge, the initiative seeks to “change the conversation on mental health” working closely with partner organisations. As part of this initiative, the Heads Up campaign was launched in 2019 together with the Football Association. The campaign was driven by leading football players talking about mental health, and the dedication of the 2020 Football Association Cup to generating conversation on mental health.

Since 2012, there has also been a Global Anti-Stigma Alliance, which brings together well-established campaigns to promote mutual learning. The most recent meeting in 2017 was hosted by the ONE OF US organisation with partial funding from the Danish Health Authority. Representatives from more than 10 national anti-stigma programmes attended the meeting, and shared evidence and lessons learnt from their respective programmes.

Awareness raising increasingly goes beyond the health system

Awareness-raising campaigns across the OECD are also increasingly focusing on young people and the workplace, and stressing that addressing the stigmatisation of mental health requires the involvement of all actors in society. In most national campaigns, children and young people are explicitly stated as a target and there are also networks and non-governmental organisations dedicated to raising awareness of mental

health among younger audiences. These activities combined with the inclusion of mental health in school curricula promote greater awareness and literacy of mental health issues.

While workplaces are not covered as frequently by awareness raising programmes, there are a number of noteworthy recent initiatives that seek to raise understanding of the close interlinkages between the working environment and mental health. This is a promising trend. For example, the Netherlands has made raising awareness of work-related stress a priority of its occupational health and safety policy. As part of this, a "Week for Work-related Stress" has been organised every November since 2014, with activities organised on each day of the week on different themes. In 2019, "Masterplan Monday" was dedicated to both employers and employees developing plans and conversation techniques together to reduce work-related stress and improve well-being at work.

Meanwhile, in the United Kingdom, *See Me*, the Scottish programme to tackle mental health stigma and discrimination, implemented an evidence-based and highly effective anti-stigma campaign aimed at the workplace. *See Me* commissioned a poll and found that for both employers and employees, there was fear surrounding mental health as a topic in the workplace, with 48% of individuals responding that they did not tell their employers about mental health problems for fear of losing their job. Based on these findings, *See Me* launched their The Power of Okay campaign in November 2015, which encouraged individuals to ask the simple question, "Are you okay?" and put the audience in the shoes of the challenges related to mental health that both employers and employees might face in their day-to-day working lives.

Health care systems emphasise mental health, but the shift towards integration with skills and work interventions remains slow

Recognition for the need for greater focus on mental health in the health system

Most countries recognise the need to strengthen mental health services in the health system including for people experiencing mild-to-moderate mental health conditions. This perspective is captured in the *Achieving Better Access to Mental Health Services by 2020* vision for mental health services in England (United Kingdom) released in the autumn of 2014, which states that: "for decades the health and care system in England has been stacked against mental health services and against the people who use them."

Increasing the capacity and scope of mental health services thus appears to be a key priority, and one way to achieve this has been to expand the size of the workforce in the mental health system. New Zealand, for example, is currently implementing its *Mental Health and Addiction Workforce Action Plan for 2017-21*, while the United Kingdom's mental health workforce plan published in 2017 set out a target to employ 19 000 additional members of staff in the mental health workforce by 2020 in the National Health Service.

The questionnaire responses also confirm that a number of countries continue to focus on shifting from hospital- to community-based mental health services. In these countries, the focus of health system reform seems to be on increasing availability and capacity of community-oriented mental health services. For example, in Poland, starting in July 2018, the government has been piloting 27 mental health centres that together can provide support to around 3 million people. Meanwhile, in Hungary, six health promotion centres were launched in May 2016 with the aim of identifying key mental health issues in specific districts, and collecting and evaluating good practice to prevent and treat mental health conditions. Other countries that mentioned measures to strengthen community-based mental health care included, but are not limited to, Greece and the Czech Republic.

Digital technologies are playing an increasingly important role

Since the adoption of the Recommendation, there has been a rapid expansion of a broader range of technology-enabled mental health services, much of which has been driven by increased investment from

the private sector. A recent study has found that over the past six years, global funding into mental health technology has increased almost five-fold from around USD 156 million in 2014 to USD 750 million in 2019 (Octopus Group, 2020[12]).[2]

In particular, app-based tools that provide low-threshold support and offer programmes designed to strengthen self-management, mindfulness and coping skills have boomed. One of the challenges with such apps is to ensure they deliver effective support for individuals experiencing mental distress (Anthes, 2016[13]). A promising initiative to address this potential issue has been the development of a National Health Services Apps Library in England (United Kingdom). Founded in 2017, this library offers a growing list of apps – including many designed to promote better mental health – that have been assessed as being "clinically safe and secure to use" (NHS, 2020[14]).

Investing in a range of digital health technologies including telehealth services, online programmes and app-based support seems especially timely given the ongoing COVID-19 pandemic, which has restricted face-to-face treatment, and resulted in increased reliance on remote treatment and support as examined in further detail in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* (OECD, 2021[4]). OECD countries could, for example, expand use of electronic cognitive-behavioural therapy (eCBT) for individuals with mild-to-moderate mental health conditions, and especially work-focused eCBT, given that it is less costly than face-to-face treatment and has potential for significant outreach, which may allow for more timely intervention and support.

In response to the onset of the pandemic, most countries acted quickly to scale up and introduce telehealth services dedicated to providing mental health support. The challenge is now to transform these emergency measures into well-integrated and established digital mental health services. A notable example of an integrated approach to using digital tools to increase access to mental health support is Finland's Mental Health Hub, which is described in Box 3.4. Building a future-focused and innovative mental health sector as called for by the OECD Mental Health Performance Framework requires countries to take initiative to leverage the possibilities of digital technologies to provide more timely access to mental health support.

Increasing the mental health competence of all health professionals

Closely tied to increasing the capacity of the mental health system is the need to ensure that health professionals – in particular, general practitioners (GPs) – have sufficient knowledge and training to ensure they have the competence and confidence to not only identify mental health conditions, but also to provide treatment and/or refer the individual to a mental health specialist where appropriate. In many cases, front-line actors in the health system already receive initial training in mental health, but may nonetheless benefit from receiving further training. Many countries have implemented policies to strengthen the mental health competence of health professionals over the past five years.

In the Czech Republic, for example, as part of reform to the primary care sector, GPs are currently being trained to increase their competence across all areas including mental health, and to support GPs in speedy and effective diagnosis of mental health conditions, the government has stated its intention to develop best practices and guidelines for diagnosing mental health conditions. Another example is Latvia, where as part of the new Mental Health Plan approved in 2019, GPs and nurses are being trained in mental health through educational programmes.

Going further, training for key health professionals can take an integrated mental health and employment approach. In Australia, there is a promising ongoing project funded by the government and conducted by researchers from Monash University to increase the understanding of the role of GPs in diagnosis and management of work-related mental health conditions. As part of this project, researchers designed clinical guidelines to assist GPs in diagnosing and supporting people in work experiencing mental health conditions. The guidelines were approved by the National Health and Medical Research Council in 2018, released in 2019, and are currently being disseminated (Mazza et al., 2019[15]).

Box 3.4. Finland's Mental Health Hub

In 2009, the Helsinki University Central Hospital developed an eService for individuals with mental health conditions called Mielenterveystalosta [Mental Health Hub] with funding from the government. The motive was to address the fragmented nature of mental health services and to provide better support for individuals in rural areas, which is especially pertinent in a country such as Finland with its low population density and ageing population. Mental Health Hub aims to provide more patients with more timely and better quality access to mental health support. At first, the initiative focused on providing services for the local community, but was expanded into a nationwide online service in 2015.

The Mental Health Hub is a free one-stop hub offering a variety of mental health services. Self-help tools are easily accessible on the hub and help to promote mental health literacy for individuals looking for information, and since 2014, individualised therapy programmes have also been available. For an individual with a referral, free consultations and professional-guided eCBT are also available, as the government covers medical fees. The range of therapies has been expanded significantly in recent years, with online therapy now available for depression, alcohol use, anxiety, panic disorders, bipolar disorder and eating disorders.

One of the innovative features of the *Mental Health Hub* is the symptom navigator, which allows users to be directed to the most appropriate form of support depending on the severity and nature of mental distress. The *Mental Health Hub* even includes a portal dedicated to health and social care professionals so that they can receive training in mental health support and access relevant materials and tools designed by HUS. Materials are designed for not only mental health specialists, but also health care professionals in primary care, nursing and third-sector organisations such as charities. The *Hub* has seen a rapid increase in use among the general population. In the autumn of 2015, there were around 53 000 unique monthly visitors which had risen to in excess of 200 000 unique monthly users by the spring of 2019.

Although the Hub cannot replace all face-to-face services, it holds great potential to transform the traditional doctor-centred health system. According to HUS, virtual visits cost around half that of in-person visits in the case of mental health treatment, and psychotherapists can treat three patients in the time it used to take to see one, which has resulted in the near elimination of waiting lists. It is worth noting that the Hub is only possible because Finland has invested in health data for decades. HUS has used an electronic patient information system for over 25 years, while the My Kanta patient portal allows all individuals with a Finnish personal identity code to access and interact with their health records.

One of the advantages of the Mental Health Hub is its scalability of the technology. This has allowed HUS to expand the Hub into a national virtual hospital called Health Village that goes far beyond mental health services. As of 2020, Health Village has 32 specialist hubs, 115 digital care pathways and 5 virtual knowledge centres with over 540 000 users per month. The expansion of the Health Village was funded by the Finnish Ministry of Social Affairs and Health, and made possible through collaboration with technology key partners such as Innofactor and Microsoft.

Sources: Digital Health Village (2020), Helsinki University Hospital, www.digitalhealthvillage.com/; What can the UK learn from Finland's approach to mental health? (2017), The Guardian, www.theguardian.com/health care-network/2017/apr/05/what-uk-learn-finland-approach-mental-health-nhs; Virtual Hospital improves patients' health care access, dramatically cuts costs (2017), Microsoft, www.customers.microsoft.com/en-us/story/helsinki-university-hospital-health-office-365.

In a number of OECD countries, the World Health Organization's Mental Health Gap Action Programme (mhGAP) has helped to initiate training of primary health care workers in mental health. The programme has played a prominent role in the Latin America and Caribbean region in recent years, with mhGAP implemented in all OECD countries in this region (Chile, Colombia, Costa Rica and Mexico). In Colombia, for example, with support from the Pan American Health Organisation (PAHO), close to 2000 non-specialised professionals in the health sector had already been trained through the mhGAP as of October 2019, while Costa Rica is currently implementing a proposal developed with PAHO to train primary health care workers in mental health.

Measures are being taken to reduce waiting times for mental health care

There is also a growing recognition among countries of the need to provide more timely access to specialist care in the health system. *Fit Mind, Fit Job* noted that individuals often face long waits – even in OECD countries with highly advanced health systems – to receive appropriate mental health care. At least ten OECD countries report having a waiting times target or guarantee in at least one area of mental health care, and a few OECD countries have separate targets specifically for children and adolescents (OECD, 2020[16]; OECD, 2021[4]).[3] In a number of these countries (Denmark, Finland and Norway), a growing proportion of people are being assessed or treated within maximum waiting time targets in recent years.

The United Kingdom recently established its first waiting time standards for mental health care. Since 2016, the National Health Service in England has had a target to ensure treatment within six weeks for 75% of people referred to the Improving Access to Psychological Therapies programme (IAPT), with 95% to be treated within 18 weeks as part of the *Improving access to mental health services by 2020* commitments. A number of other OECD countries are currently developing indicators to assess waiting times. In Canada, for example, since 2018, the Canadian Institute for Health Information has been working with federal, provincial and territorial health ministers to develop indicators to measure access to mental health and addictions services. One of the set of six indicators relates directly to waiting times for mental health care services.

OECD countries primarily consider long waiting times for mental health care to be an issue with the supply of mental health services, and have focused on reducing wait times by increasing service availability and/or resources for services as outlined in *Waiting Times for Health Services: Next in Line* (OECD, 2020[16]). Nonetheless, while less common, there are a few examples of specific waiting time policies that aim to incentivise faster provision of treatment. One example is in Denmark, which expanded its "free choice of hospital" to include treatment for mental ill-health in addition to physical illness. This means that since 2015, Danish citizens can choose to access a limited range of private hospitals in Denmark as well as hospitals abroad to receive mental health care if the hospital to which they are referred is unable to fulfil the waiting time guarantee of 30 days. The performance of regions is monitored and data made publicly available, with the 2018 update on the National Goals suggesting a promising trend of declining waiting times for both adult and child psychiatric care across all regions in Denmark in the period 2012-17. In 2018, 95% of all Danish patients were seen by a psychiatrist or assessed for mental health within the 30-day waiting-time target.

Initiatives from the health system to involve skills and work policy remain limited

Despite the clear emphasis on developing mental health systems integrated with social, educational and employment supports and interventions in many countries, the questionnaire responses suggest that many of the countries still do little in practice to integrate a strong focus on employment and education – as either determinants of mental health status, or as outcomes – within the mental health system itself. There are some examples of progress on this front, but the shift is relatively gradual and the implementation of integrated mental health, skills and work policy remains slow.

One of the most notable initiatives of integrating employment within the mental health systems is the Improving Access to Psychological Therapies (IAPT) programme that has been rolled out across England (United Kingdom) by the National Health Service. First piloted in 2008 and since expanded, the programme originally aimed to expand access to therapies for individuals with mental health conditions such as anxiety and depression. In the early years of the programme, employment advisors (EAs) were also introduced to work alongside therapists to provide practical advice and support to help people to remain in work or enter the workplace (OECD, 2015[17]). While a target of one EA for every eight IAPT therapists was set (1:8 ratio), in reality, in some services there was only one EA for as many as every 50 IAPT therapists.

Starting in 2017, the Work and Health Unit[4] has been investing GBP 39 million on recruiting EAs to provide more integrated mental health and employment support supporting people to remain in, return to or find work and to meet the 1:8 target ratio (Department for Work and Pensions and Department for Health and Social Care, 2017[18]). An evaluation report based on eight case studies from the first wave of the programme found that EAs in IAPT are well-received from relevant stakeholders, namely clients, therapists and employability partners, and early outcomes appear positive with clients citing increased confidence, improvements in mental health, and progress towards return-to-work (Loveless, 2019[19]).

A few other OECD countries have followed the example of IAPT and are implementing programme to increase access to therapies for individuals with mild-to-moderate anxiety and depression. Norway's Prompt Mental Health Care programme was launched in 12 Norwegian municipalities in 2012, but has since been expanded further. Between 2013 and 2019, 600 psychologists were recruited in Norway through a grant scheme to work in the municipalities, and since January 2020, all municipalities have been required by law to offer occupational therapy services. Meanwhile in Sweden, since January 2020, regions have been legally required to put in place rehabilitation co-ordinators within the health system. The core responsibilities of these co-ordinators will be to promote return-to-work through engagement with employers, employment agencies and public employment services, while they will also be required to support patients during their sick leave and rehabilitation process.

Youth support systems and education policies show significant progress

Of the four thematic areas covered by the Recommendation, the most significant progress is taking place in youth support systems. Mental health is understood by OECD countries to be critical for the development of youth, and policies in many cases follow the steps proposed in the Recommendation. This includes policies that target mental health directly, as well as policies supporting youth living with mental health conditions indirectly – such as support for early school leavers. There is also growing recognition of the need for early identification and timely support, as demonstrated by the increased focus on providing low-threshold and non-stigmatising mental health services that are easy to access for young people.

Timely intervention to prevent mental ill-health is a priority in schools

Many countries have attempted to ensure more timely action by putting in place whole-of-school approaches to identify mental health conditions among students, as well as signs of below-threshold mental distress that may be at risk of developing into clinical mental health conditions. Attempts to ensure timely identification and treatment in schools typically include a combination of policies to promote mental well-being and to prevent risky behaviours. These approaches share in common an attempt to address the exacerbation of mental health conditions among individuals by creating environments that are conducive to good mental health and are less likely to result in individuals developing (or aggravating existing) mental health conditions, and are often used to complement one another.

An example of a promotion approach to mental health in schools is Ireland's *Well-being Policy Statement and Framework for Practice* for 2018 to 2023. The framework not only sets out the government's vision for

well-being in schools, but also stipulates that every school in Ireland must implement a school self-evaluation process that follows the framework and looks at well-being in four key areas – culture and environment, curriculum, policy and planning, and relationships and partnerships. Australia also launched its *Australian Student Well-being Framework* in 2018, which provides schools with guidelines on promoting the well-being of students from the first year of school to year 12.

A number of OECD countries have taken more of a prevention approach, focusing on how to limit and prevent high-risk behaviours that are often associated with mental ill-health such as bullying, xenophobia, alcohol and substance use, violence and truancy. For example, in the Czech Republic, there is an ongoing *National Strategy for Primary Prevention of Risky Behaviour* that will run through to 2027, while in Poland, the Ministry of Education commissioned research on effective preventative and prophylactic programmes in schools, the results of which were made available in 2018.

Most OECD countries also report having anti-bullying programmes and strategies at the national level, and many referred to recently implemented measures and strategies to address bullying in schools in their policy questionnaire response. In Denmark, the 2016 *Action Plan for Preventing and Combating Bullying* sets out recommendations for the state, local governments and other organisations to reduce bullying in schools and recognises the importance of anti-bullying measures to promote mental health in schools. Meanwhile, in 2018, Norway established anti-bullying ombudsmen in every county to support and give advice to pupils and parents regarding school safety. A report released in 2020 found that while challenges remain in providing ombudsmen themselves with adequate support in fulfilling their mandate and with ensuring equal access to support across region, the ombudsmen scheme has helped to create a safer environment for children in kindergarten and at school (Seland et al., 2020[20]).

New Zealand is also implementing national-level face-to-face assessments of the mental well-being of secondary students in an attempt to ensure early identification of possible undisclosed or undiagnosed mental health conditions. This involves rolling out the *HEEADSSS Wellness Checks* – an interview-based face-to-face assessment consisting of questions relating to home (H), education and employment, eating and exercise (E), activities (A), drugs and alcohol, depression and suicide (D), and sexual health, safety and personal strengths (S) – to Year 9 students across the country. These assessments were initially implemented as part of the *Youth Mental Health Project*, which was launched in 2012. As of 2019, these wellness checks were performed in 40% of secondary schools, and further extensions are planned.

These in-school early identification measures are also complemented by low-threshold and non-stigmatising mental health support services outside schools for young people in many OECD countries. Examples include *Ohjaamo* one-stop guidance centres in Finland, and headspace services in Australia. By avoiding labelling individuals as sick or problematic, such services can encourage children and young people to seek support when showing first signs of mental ill-health. This can help to ensure treatment and support is made available early before individuals experience more severe mental health conditions and before they have lost connection with schools, apprenticeships or the workplace.

The key to both in-school and out-of-school measures is to ensure they are followed up by timely and appropriate intervention when mental distress or possible mental health conditions are identified, including where appropriate, through referrals to specialists. It is crucial that these measures are complemented by strengthened links and transitions between youth support systems and the mental health system that can help to ensure timely follow-up. In this context, England's Link Programme provides a promising example. As discussed in Box 3.5, the programme brings together education professionals from schools and mental health professionals from the health system to strengthen collaboration, with evidence from the pilot stage suggesting that the programme is strengthening the quality and timeliness of referrals from schools to the health system.

Box 3.5. Mental Health Services and Schools and Colleges Link Programme – England (United Kingdom)

The *Mental Health Services and Schools and Colleges Link Programme* is an initiative launched in 2015 funded by the Department of Education and supported by NHS England, which seeks to promote mutual understanding and strengthen communication between educational institutions and mental health services.

The programme centres around two one-day workshops held around six weeks apart in which education and mental health professionals come together to share "local knowledge and resources" under the leadership of local Clinical Commissioning Groups, which are in charge of planning and commissioning mental health services in their local areas. The workshops use a specially designed framework known as CASCADE, which consists of seven domains, namely:

Clarity on roles, remit and responsibilities of all partners involved in supporting children and young people's mental health.

Agreed point of contact and role in schools/colleges and children and young people's mental health services.

Structures to support shared planning and collaborative working.

Common approach to outcome measures for young people.

Ability to continue to learn and draw on best practice.

Development of integrated working to promote rapid and better access to support.

Evidence-based approach to intervention.

The *Link Programme* began as a pilot initiative in schools between 2015 and 2016 that involved 255 schools. An independent evaluation of the pilot found that it had significantly strengthened communication and joint working between schools and mental health services, improved the quality of referrals from schools to specialist mental health services and even raised the knowledge and awareness of mental health among school staff not directly involved in the initiative.

After the success of the pilot, the Department of Education commissioned the Anna Freud Centre for Children and Families, a non-governmental organisation, to expand and roll out the initiative across the country. Between 2017 and 2019, over 3 000 school, college and mental health professionals took part, and the programme is currently being scaled up to reach every school and college in England.

By strengthening communication and joint work between the health and school systems, the *Link Programme* is playing a dual role of improving timeliness of support for children and adolescents with mental health conditions through more effective referrals (addressing the "when" and "what" dimension) as well as raising awareness of mental health issues among educational professionals (improvement on the "who" dimension).

Source: Link Programme (2020), Anna Freud National Centre for Children and Families, https://www.annafreud.org/schools-and-colleges/research-and-practice/the-link-programme/; Mental Health Services and Schools Link Pilots: Evaluation report (2017), Ecorys UK, https://www.annafreud.org/media/9751/evaluation_of_the_mh_services_and_schools_link_pilots-rr.pdf.

Efforts to increase mental health competence of teachers and educators are widespread

Most OECD countries provide some form of training on mental health to teachers, educators and other front-line education professionals who regularly engage with students, although in some countries, coverage of such training remains limited. The importance attributed to training teachers is reflected in the responses to the OECD Mental Health Benchmarking Policy Questionnaire: 19 out of 27 responding countries said they provided "some" or "a lot" of mental health training to teachers, with only five stating that they provided no training. This is more than the 16 countries reporting they provide training to unemployment service counsellors or staff (OECD, 2021[4]).

Australia continues to take significant steps forward in this field. In November 2018, a government-funded initiative called *BeYou* was launched that provides teachers with the tools to help support the mental health of children. The service is free and available to educators, schools and early learning services in Australia, and integrates past school-based programmes such as *Kids Matter* and *Minds Matter*. As an example, *BeYou* has an Educators Handbook for both early learning services and primary and secondary schools, providing guidelines for educators on how to improve the mental well-being of students.

In Ireland, the National Education Psychological Service (NEPS), which supports teachers in promoting the mental health of students in primary and post-primary schools, has been expanded in recent years. In 2019, 19% of the total education budget was allocated to achieving better education and life outcomes for children with special needs, and as part of this, additional psychologists were recruited to NEPS to support students with complex educational needs (Government of Ireland, 2019[21]). NEPS also provides specific support to school leaders and teachers in establishing student support teams in schools, including through an assigned NEPS psychologist.

In some OECD countries, where training may not provide competence in mental health *per se*, teaching curricula increasingly emphasise the importance of socio-emotional skills that can help build mental resilience and promoting positive mental health. For example, in Mexico, there is an ongoing national programme, with over 2 million participants, that seeks to support socio-emotional learning in secondary public schools. After an evaluation of the programme in 2016 found there were not enough staff qualified or with the skills to teach about socio-emotional skills, directors and teachers from more than 4 200 public high schools were trained through dedicated workshops.

One of the most prominent tools being used to train teachers and educators in mental health is *Mental Health First Aid* (MHFA) and similar programmes that offer courses to provide lay people with evidence-based education on mental health to help them recognise, understand and respond to signs of mental ill-health. Since being first established in Australia, in 2001, there are now licensed providers of mental health first aid in 27 countries that have together trained more than 3 million people worldwide. While MHFA can be taken by anyone and is not limited to schools, many OECD countries have set targets to expand training in schools through these programmes. For example, in the United Kingdom, in 2017, the government announced a plan to make mental health first aid training available in all secondary schools by 2020. As of March 2020, over 2 500 schools had been reached through this plan.

In comparison, the United States has taken a slightly different approach. The Substance Abuse and Mental Health Services Administration has awarded grants to state and local educational agencies as well as non-governmental organisations in recent years to ensure teachers and school leaders have awareness of mental health issues and competence to support students experiencing mental ill-health. This has been done most notably through the "Mental Health Awareness Training Grants" and "Project Advancing Wellness and Resiliency in Education State Education Agency Grants". In 2018, the amount of funding available through these grants totalled almost USD 59 million, while USD 31 million was made available in funding through the latter grant in 2020 (SAMHSA, 2020[22]).

Preventing early school leaving is being prioritised in several OECD countries

When it comes to specific interventions and policies, there is progress in many OECD countries to prevent early school leaving and provide non-stigmatising support. As outlined in *Fit Mind, Fit Job,* investing in the prevention of early school leaving and support for school leavers with mental health conditions is crucial. Early school leaving is more prevalent among young people living with mental health conditions in comparison to those with no mental health conditions, and thus measures to address early school leaving are an important ingredient of an integrated mental health, skills and work policy.

Preventing early school leaving is a priority for the European Commission, with all EU member states having committed in 2010 to reduce the share of early school leavers to under 10% by 2020. While progress has differed from country-to-country, the rate of early school leaving has continued to gradually decrease across the EU-28, and stood at 10.3% as of 2019 (Eurostat, 2021[23]). The priority placed on reducing early school leaving and supporting students to graduation is reflected in Hungary and Latvia where new policies have been implemented since 2015. Hungary is currently in the implementation stage of its "Mid-term Strategy against Leaving School without Qualification (2014-2020)". Early warning and pedagogical support systems to prevent early school leaving were first introduced in November 2016, with the system monitoring risk factors for early school leaving such as absenteeism, difficulties in integration and underachievement. These factors closely align with the risk factors for mental ill-health. Once identified, at the school level, individual plans help students at risk through support that is co-ordinated and integrated with social workers, psychologists and child welfare services. To complement these implementation measures, teachers are trained on how to identify students at risk of early school leaving. In Latvia, the *PuMPuRS* project also provides individualised support to students at risk of early school leaving. By August 2020, the project – launched in 2017 with funding from the European Social Fund – had involved 527 educational institutions and created 43 695 individual aid plans.

Low-threshold and non-stigmatising mental health support for children and young people

The Recommendation calls for non-stigmatising support for children and youth living with mental health conditions. The policy questionnaire responses indicate that there are a number of well-integrated, external – in other words, out-of-school – and low-threshold mental health supports and services that have further developed in recent years. Such services usually take the form of youth centres that go hand-in-hand with in-school measures to support individuals with mental health conditions. These centres can help to avoid labelling young people as sick and problematic, and encourage them to seek support when showing first signs of mental ill-health, long before a mental health condition has been diagnosed.

Australia's headspace centres offers a working example of a low-threshold service that already offered non-stigmatising support to young people aged 12 to 25. In the financial year 2018-19, almost 100 000 young people visited a headspace centre and a further 32 000 accessed online and phone counselling through eheadspace. The number of headspace centres has been increased from 82 in 2015 to 112 in 2019, and additional funding of AUD 263.3 million from 2018-19 to 2024-25 was announced to help meet the high demand for mental health services (Australian Government Department of Health, 2019[24]). Since 2016, headspace is being used as the delivery site for a pilot of integrated and individualised mental health and employment support for young people with mild-to-moderate mental health conditions.

Another example of a low-threshold service targeted at young people is Finland's *Ohjaamo* centres, which are one-stop youth guidance centres that offer integrated agency interventions including psychosocial support. Finland recently concluded a project to implement a national model of psychosocial support for *Ohjaamo* centres to ensure earlier identification of psychosocial issues. The government has since decided to continue to support the project through 2021 and 2022.

Scaling up mental health supports for young people in the school-to-work transition

The policy questionnaire responses also indicate that a number of countries have taken action to support the transition from school to higher education and work, but the emphasis is often not directly placed on mental health. In Denmark, for example, a broad political agreement was reached in 2017 to reform the financing system of universities so that educational institutions are eligible for financial compensation for the extra time that some groups – such as students with disabilities – may need to complete their studies. While there is no explicit focus or mention of mental health in the policy itself, extra time can often enable and support students with mental health conditions to complete their degrees.

In contrast, the United Kingdom is taking measures to specifically support the mental health of youth in the transition from school to higher education. In 2019, the Department for Education set up a taskforce to support students in maintaining good mental health when starting university. The taskforce will focus on four main areas that can affect the mental health of students going into university, namely: independent living, independent learning, healthy relationships and well-being. The taskforce is in its initial phase with the focus currently on spreading existing good practices such as the "Transitions and Know Before You Go" initiative run by *Student Minds*, a mental health charity based in the United Kingdom.

In the United States, an interesting initiative is being run by "The Learning and Working During the Transition to Adulthood Rehabilitation Research & Training Center" at the University of Massachusetts Medical School. While this centre operates mainly in the health system, its focus is on supporting young people with mental health conditions in their transition from learning to working. For example, the centre has produced employment-related tips sheets for young jobseekers with mental health conditions that address practical questions such as "Do I Tell My Boss?", as well as a toolkit for employers of youth and young adult peer recovery workers. The US Government was providing large-scale funding to the centre, through the Department of Health and Human Services, from 2014 to 2019.

Workplaces are addressing psychosocial risk, but return-to-work support remains limited

Most countries reported taking action on workplace policies to reduce psychosocial risks at work and create more mentally healthy and safe working environments. OECD countries have been making progress in this area through a mix of regulations relating to psychosocial risk assessment and prevention, and guidelines for employers and line managers to develop mentally healthy workplace environments as called for by the Recommendation. Yet at the same time, workplace policies are often not integrated with the mental health care system, or with employment services and the social protection system. This is most apparent in policies to address long-term sick leave, which continue to be steered by the social protection system and public employment services, with few obligations or incentives in place for employers to support return-to-work in many OECD countries.

Psychosocial risk is being increasingly integrated in occupational health and safety

Many OECD countries have made significant progress in promoting and regulating psychosocial risk assessment and prevention in the workplace. In *Fit Mind, Fit Job*, a key finding was that implementation of such policies was slow and that traditional issues continue to dominate health and safety policies. The policy questionnaire responses indicate that most countries have moved beyond this stage, with many OECD countries in recent years putting into place strategies and regulations, and offering guidelines to reduce psychosocial risks in the workplace.

Many OECD countries have amended their regulations on occupational health and safety to incorporate psychosocial risks in a better way. In Canada, for example, a 2017 amendment to the Canada Labour

Code makes explicit that occupational health and safety applies not only to physical injury, but also to psychological illnesses and injuries. Following on from this, in 2019, Canada announced it was going to take measures to require federally regulated employers to take preventative steps to address workplace stress. In Spain, Royal Decree-Law 8/2019 introduced mandatory registration of working hours, as a means to hold employers accountable for excessive work hours and unpaid overtime, both of which are risk factors for mental ill-health.

Japan, meanwhile, is a notable example that has placed stronger requirements on employers. Since December 2015, employers with more than 50 employees have been obliged to offer a "stress check" at least once a year. In 2018, 80.3% of employers offered the stress check (MHLW, 2019[25]). Based on the overall findings, employers are obliged to make their best efforts to adjust the work environment to reduce psychosocial stress. Japan has also linked the "stress check" policy to health services. If an employee is recognised as having high stress, they are entitled to request their employer to arrange an interview or consultation with a physician. The employer is then obliged to ensure such an appointment is arranged, and must adjust the individual's working conditions based on the findings of the physician as necessary. The use of questionnaires or tests to assess psychosocial risks in the workplace is also promoted in other OECD countries, although most take a voluntary approach. For example, the National Institute for Safety and Health at Work in Spain, which operates under the Ministry of Labour, has developed a questionnaire and accompanying app known as FPSICO, which can be completed to provide insights into possible psychosocial risks in the workplace.

Many countries have also developed tools to support companies in implementing workplace psychosocial risk assessment and prevention. In Colombia, for example, the Ministry of Labour established not only a set of instruments for the evaluation of psychosocial risk factors in the workplace, but also a guide for the promotion, prevention and intervention on psychosocial risk, both of which were adopted in 2019. In Japan, meanwhile, a web portal called Kokoro no Mimi (Ears of the Mind) provides guidelines and tools for employers and managers to support the mental health of employees, and to implement the stress check. In Spain, as part of the Spanish Strategy for Occupational Health and Safety 2015-2020, the government is developing new guidelines on the management of psychosocial risks. Such guidelines and tools can help businesses and employers implement measures that align with regulation on reducing psychosocial risks at work.

Where OECD countries differ is in how broadly they look at mental health in the workplace. In many countries, these measures are primarily designed to prevent mental health conditions from arising. By defining mental health policy in the workplace narrowly, this preventative approach may only bring benefits for individuals who experience clinically significant symptoms of mental health conditions. In comparison, there are significantly fewer OECD countries seeking to promote better mental health for all employees.

The United Kingdom and Canada stand out as two OECD countries that are taking this broader approach to mental health policy in the workplace. In the United Kingdom, the government is implementing recommendations from *Thriving at Work: the Stevenson/Farmer review of mental health and employees*, commissioned by the Prime Minister and published in 2017 (UK Government, 2017[26]). The review called for emphasis on ensuring mentally healthy workplaces rather than simply dealing with mental health issues when they arise. The recommendations were accepted by the government, and working closely with leading charities, employers and interagency co-operation, a set of six Mental Health and Work standards were developed that any employer can follow to support the mental health of their employees, as well as tips on how to implement these standards. In a similar vein, Canada's National Standard for Psychological Health and Safety, which is discussed in detail in Box 3.6, provides guidelines on how to promote more psychologically healthy and safe work environments for all employees.

Box 3.6. National Standard for Psychological Health and Safety in the Workplace – Canada

Canada's National Standard for Psychological Health and Safety in the Workplace (the Standard), first established in 2013 under the leadership of the Mental Health Commission of Canada (MHCC), is a set of voluntary guidelines that support employers in developing "psychologically healthy and safe work environments for their employees". The Standard aims to contribute to broadening understanding of Occupational Health and Safety by "shifting workplace culture to value mental health and safety as much as physical health and safety".

Compared to other frameworks on mental health in the workplace, the Standard is much broader, and identifies 13 factors for improving psychological health and safety in the workplace. For example, instead of simply focusing on more narrow factors such as workload management and access to counselling, the Standard also stresses the importance of factors such as organisational culture, providing opportunities for employees to grow and develop, and developing workplace environments where employees feel they are connected to their day-to-day work.

Although the Standard predates the Recommendation, in recent years, Canada has developed implementation guidelines and tools to support employers in translating the guidelines into changes in the workplace. In 2017, for example, the MHCC concluded a three-year project to look at how 40 organisations of varying size from different industries and sectors were implementing the Standard. The report from this project identified a number of good practices, as well as factors that may facilitate or act as barriers to implementing the Standard.

The Standard has also been accompanied by a set of animated videos developed in 2016 by the MHCC in partnership with Ottawa Public Health that seek to raise awareness of the 13 factors that can affect mental health in the workplace. Instead of simply raising awareness, the videos provide a thorough and detailed explanation of the interlinkages between workplaces and mental health with individual videos for each of the 13 factors. These videos have been integrated into the broader "have THAT talk" series developed by Ottawa Public Health that aims to raise awareness of the importance of mental health more broadly.

A 2019 poll by Ipsos found that while only a small proportion of employees are aware of the Standard, employees working for organisations that implement the Standard are far less likely to say their workplace is psychologically unhealthy or unsafe (5%) compared to organisations not implementing the Standard (13%). Furthermore, at organisations that implement the Standard, employees who have experienced depression took less days of work (7.4 days per year) than the average employee experiencing depression (12.5 days per year). This indicates that the Standard may already be contributing to an improvement in the mental health of employees.

Sources: National Standard of Canada: Psychological health and safety in the workplace (2013), Mental Health Commission of Canada; Workplaces that are Implementing the National Standard of Canada for Psychological Health and Safety in the Workplace Described by Employees as Psychologically-Safer Environments (2017), Ipsos, https://www.ipsos.com/en-ca/news-polls/workplaces-implementing-national-standard-canada-psychological-health-and-safety-workplace; Case Study Research Project Findings: 2014-17 (2017), Mental Health Commission of Canada, https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_study_research_project_findings_2017_eng.pdf.

One of the main recommendations from the Stevenson/Farmer review was to implement standards on healthy workplace environments within the Civil Service (2017[26]). As a leading employer, it is hoped that the Civil Service can demonstrate good practices for other employers to follow. Since the release of the independent report, the Civil Service has held its own mental health conference that aims to exchange and embed mental health best practices across the Civil Service. One such best practice may be the decision by HM Revenue & Customs to double the number of Mental Health Advocates available to ensure more colleagues can receive individualised face-to-face support.

More can be done to support return to work and reduce preventable sick leave

Increasing evidence from studies in a number of OECD countries shows that combining workplace measures with clinical interventions is more effective than isolated workplace or clinical treatment at supporting employees experiencing mental health issues to remain in and return to work, and thus that integrated support can both prevent and shorten absences due to sickness (Nieuwenhuijsen et al., 2020[27]). This confirms and provides support to the Recommendation's emphasis on promoting timely return-to-work and reducing preventable sick leave of those experiencing mental health conditions. Despite this, there has been limited progress to reduce preventable sick leave, and even in cases where there are promising initiatives, these tend to be focused on adjustments to the social protection system as opposed to strengthening the role of employers for addressing mental health issues of employees on sick leave.[5]

Austria and Denmark have implemented new measures and reforms of the social protection system to prevent long-term sick leave that should be followed closely. In Austria, a new model to promote part-time return to work (WIETZ) was introduced in 2017, in which workers are entitled to shorter working hours and financial protection to support reintegration into the labour market after prolonged sick leave. Since its introduction, more than 7 300 individuals have used the WIETZ model to return to work. Although WIETZ is not exclusively for individuals with mental health conditions, mental ill-health is the most common reason for prolonged absence from work among WIETZ applicants.

Meanwhile, Denmark launched a project in 2015 to trial a model to support return-to-work called IBBIS. The IBBIS model offers integrated support from case managers in the social protection system, employment consultants and health care professionals to support individuals with mild-to-moderate mental health conditions – depression, anxiety and stress orders – return to work after prolonged sick leave (Mental Health Services in the Capital Region of Denmark, 2020[28]). This project has since been further updated to IBBIS II, and will continue through to 2022. This is a rare example of integrated employment and mental health support that is specifically targeted at individuals on sick leave, as opposed to jobseekers who are out of work.

In contrast to reform of social benefits and employment services, policies to incentivise or require employers to prevent long-term sick leave were rarely mentioned in the policy questionnaire responses. This suggests the continuation of a worrying trend mentioned in *Fit Mind, Fit Job*: employers are only held responsible for the mental health of their employees while they are still at work. This may also reflect a lack of clarity on the roles and responsibilities for ensuring support for return-to-work – in many OECD countries, after a period of prolonged sickness absence, there appears to be a gap between the point where employers are responsible and where the support of the employment service and social protection system kicks in.

There are a few examples of stronger requirements and incentives for employers to support return-to-work among employees on sickness absence, but most pre-date the Recommendation. In the Netherlands, employers are obliged by law to provide payment of at least 70% of wages for two years to their employees on sick leave (OECD, 2015[17]). Furthermore, by 2015, in the Netherlands, Norway and Sweden, employers and their corresponding employee both had responsibilities to agree to return-to-work action plans after around eight weeks of sick leave. However, these OECD countries remain exceptions to the norm.

In the questionnaire responses, only Sweden explicitly mentioned measures it had taken to increase the role of employers in supporting return-to-work. Since July 2018, employers in Sweden have been required to draft return-to-work plans for employees within 30 days of onset of sickness absence for employees who are not expected to return to work within 60 days of onset of absence. Employers in Sweden can now also apply for a grant from the Swedish Social Insurance Agency to subsidise costs related to providing workplace-oriented rehabilitation. These combined efforts should provide further encouragement to employers to take greater responsibility in supporting their employees return to work.

Welfare systems show the least progress, with individualised support lacking

Across all OECD countries, recognition of the key role of the social protection system in fostering an integrated policy approach to mental health remains limited. In the few examples where social benefits and employment support have a focus on integrated health and employment support, this is generally targeted at (and limited to) severe mental health conditions – through either a focus on mental health within disability policy, or investments in supported employment (Individual Placement and Support). Although efforts to improve the mental health competence of caseworkers and other actors have been made in recent years, it seems that the high prevalence of mild-to-moderate mental health conditions among people receiving benefits is yet to be fully recognised and reflected in policy in most OECD countries.

Rules and legislations are being reformed to encourage and support return to work

A number of countries have undertaken significant reforms to rules and legislation in social benefits and employment services to incentivise jobseekers experiencing mental health conditions to return-to-work. For example, Canada amended its Employment Insurance (EI) rules effective August 2018 to extend to maternity and sickness benefits. This provision allows EI claimants to work while receiving benefits by providing mothers and those dealing with illness or injury with greater flexibility to gradually return to work. These EI claimants can keep 50% of their benefits for every dollar earned, or up to 90% of previous weekly insurable earnings used to calculate their EI benefit amount. Although not directly targeted at individuals experiencing mental health conditions, this change supports jobseekers financially, including those with mental health conditions, to gradually return to full-time work without risking the loss of benefits.

In Finland, the recently launched work ability programme will adjust rules on benefits to allow individuals with partial working capacity – such as individuals experiencing mental health conditions – to gradually return to work while keeping part of their existing unemployment benefits. Furthermore, in Lithuania, in-work benefits have been extended so those registered as unemployed for at least six months can keep half of their benefits temporarily after finding work. These reforms in Canada, Finland and Lithuania are promising measures that follow in the footsteps of Sweden and Norway, which were identified as countries already supporting gradual return to work in *Fit Mind, Fit Job*.

The policy questionnaire responses also indicate that some countries have recently reformed work capacity assessments by shifting towards identifying capacity – even if partial – and away from disability. For example, in Estonia, the government has recently started to reassess workers on disability benefits to identify individuals with partial work capacity. Initially, in 2016, the measure was implemented on a voluntary basis, but since 2017, individuals with partial work capacity have been required to register as unemployed. Most importantly, the recognition of their work capacities opens up channels to specific and well-targeted employment support. Early signs are promising as many of the initial participants have chosen employment support that is usually targeted at the unemployed, such as training, work trials and work-related rehabilitation (Browne et al., 2018[29]). Estimates from the Ministry of Finance suggested that by 2022, an extra 19 100 people would be in employment and 16 400 more people actively looking for work due to the reform.

Individual Placement and Support programmes need to be scaled up

Fit Mind, Fit Job noted that there were a number of promising examples of employment support being combined with mental health care especially through Individual Placement and Support (IPS), a proven evidence-based practice in which multidisciplinary mental health teams including an employment specialist provide co-ordinated health and employment support for jobseekers in finding and sustaining employment in a competitive setting. The participants are usually individuals who receive mental health treatment through specialist mental health and addiction services.

The policy questionnaire responses indicate that IPS has become more widely implemented across the OECD. This has been mainly throughout trials to test and evaluate IPS programmes for jobseekers with severe mental health conditions. There are ongoing or recent IPS trials in many OECD countries including Denmark, Finland, Ireland, Italy, the Netherlands, Norway and New Zealand. Such trialling and evaluation has proven the effectiveness of the IPS approach across multiple OECD countries. For example, in both Australia and Denmark, recent studies have shown that IPS programmes result in positive employment outcomes for participants, while there are also similar well-established findings in countries such as the United States that predate the Recommendation. Given that IPS has proven to be effective in multiple countries based on decades of research, countries would benefit more from scaling up or rolling out IPS, rather than continuing to pilot the standard IPS approach. Despite this, the policy questionnaire responses suggest that very few OECD countries have scaled up IPS trials and/or included them in national mental health strategies.

The challenge of scaling up IPS may indicate that while beneficial for the jobseeker receiving support, the approach might be considered too resource-intensive or too ambitious to be implemented at the national or regional level, even if it is cost-effective. IPS is rarely mentioned in mental health plans, with a few exceptions such as England (United Kingdom), where the NHS has committed to supporting 55 000 people per year with severe mental health conditions in finding and retaining employment by 2023/24. This may be because some of the principles of IPS which are usually strictly adhered to, such as time-unlimited supports, may not be easily met as IPS is scaled up. This has driven attempts to develop modified versions that may be less costly or easier to implement.

One of the policy questionnaire responses mentioned a modified version of IPS, Italy's "Traineeship as a Springboard out of Unemployment for those Affected by Mental Illness" project. The key premise of this project is to place participants in organised internships and traineeships lasting three to six months where participants can gain real-world experience in competitive employment settings. As the name of the project indicates, the aim was to assess whether such experience in internships and traineeships could then be used to upskill participants such that they can use the experience as a springboard from which to find competitive employment. It will be critical to evaluate the long-run impact of the project, as the effects on labour market outcomes are unlikely to be seen immediately.

Shortage of support for individuals with mild-to-moderate mental health conditions receiving unemployment benefits

A further limitation with IPS is that it usually focuses exclusively on supporting individuals with severe mental health conditions find employment. As a result, such individualised support is provided mainly to individuals who are recipients of disability benefits due to their existing mental health condition. This was also reflected in the policy questionnaire responses, as many of the responses interpreted the section on social protection systems exclusively as referring to disability policy. In comparison, there remains a lack of comparable integrated mental health support for recipients of unemployment benefits, many of whom may have diagnosed or undiagnosed mild-to-moderate mental health conditions.

This approach to mental health support does not reflect the fact that there are likely more individuals with mental health issues receiving unemployment than disability benefits. As shown in Chapter 2, among recipients of benefits who are experiencing mental distress in the OECD countries for which there is data,

37% are on unemployment benefits compared to 33% that are on disability benefits. This distribution varies across OECD countries. In Denmark, Germany, Spain and Austria, individuals experiencing mental distress are more likely to receive unemployment benefits, whereas in Estonia, Switzerland and Norway, individuals experiencing mental distress are more likely to receive disability benefits. Nonetheless, across the OECD, mental health support and services need to be available in all areas of the welfare and social protection system.

There are a few exceptions of integrated support directed at individuals with mild-to-moderate mental health conditions, often modelled on IPS, although these tend to still only be pilots or trials. In Australia, for example, a pilot launched by the Department of Social Services in 2016 aimed to provide IPS for around 2000 young people every year – targeting individuals with mild-to-moderate mental health conditions – through headspace services. An evaluation has found that the programme is effective in improving the education and employment outcomes of these young people (KPMG, 2019[30]), and a literature review has been conducted to assess potential adjustments to further strengthen the effectiveness of IPS programmes for young people. A cost-benefit analysis of the trial in 2020 found that while the implementation of IPS requires additional investment compared to existing employment services under "jobactive", the benefits gained in terms of reduced welfare payments and increased personal income far outweigh the additional costs (KPMG, 2020[31]). Given its success so far, in October 2020, the government announced a further expansion of the trial to a further 26 sites and the continuation of the trial in existing 24 sites through to June 2024. Similarly in both Wales and England (United Kingdom), IPS pilots that target individuals with mild-to-moderate mental health conditions are currently being implemented. The iCAN Work pilot in Wales was launched in 2019 and targeted individuals who have worked for some time within the past 12 months and who are actively seeking work. The pilot was extended amidst the COVID-19 crisis, and the Welsh government has committed to publishing an evaluation of the pilot.

The next step is to scale up the small number of promising examples to provide more widespread and timely access to treatment. While evidence on the effectiveness of IPS remains strongest for participants experiencing severe mental health conditions, these examples show that many OECD countries would also benefit from expanding access to IPS to individuals experiencing mild-to-moderate mental health conditions. The relative lack of promising recent examples of individualised support for this group within the social protection system also indicates a concerning trend – that employment services and social benefits may still approach employment support as only necessary once individuals have been "treated and cured" for their mental health conditions. Such an approach, if still widespread, overlooks that meaningful employment is often a crucial element of treatment and recovery.

Workers in the social protection system are increasingly trained in mental health awareness, but policies need to go beyond disability services

A number of countries – such as Australia, the Czech Republic, Latvia, Lithuania, New Zealand and Switzerland – have put in place measures to provide mental health training to staff in employment services and social benefit offices. However, much like all other mental health policies in the social protection system, initiatives are primarily geared towards individuals on disability benefits. Unlike in schools, workplaces and health systems, the front-line actors in social protection systems tend to be more diverse as individuals with mental health conditions are often connected to different parts of the system. Given that individuals experiencing mental health conditions receive a range of income-support payments and benefits as shown in this report, ensuring mental health literacy and competence across the different parts of the social protection system, including among caseworkers administering unemployment benefits, remains crucial going forward.

For example, in Latvia, a framework is being implemented to train municipal social service workers who work with adults with disabilities related to mental health conditions. By 2023, it is expected that up to 180 social workers will have participated in an intensive six-month training programme focused on providing

support for adults with intellectual disabilities and experiencing mental health conditions. Meanwhile, in Australia, starting in July 2020, the National Disability Insurance Scheme has made support from psychosocial recovery coaches available for participants with psychosocial disabilities. The role of the recovery coach is to support participants in living a fuller and contributing life, including through supporting linkages with broader services including employment and education (NDIS, 2020[32]).

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Notes

[1] Only five OECD countries (Canada, France, Germany, Norway and the United Kingdom) reported spending more than 10% of their health spending on mental health.

[2] GBP 120 million in 2014 to GBP 580 million in 2019.

[3] These OECD countries are Denmark, Finland, Ireland, Lithuania, the Netherlands, New Zealand, Norway, Spain (specific regions), Sweden and the United Kingdom.

[4] WHU was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care.

[5] Although this concerns reform of the social protection system, the policy is about getting individuals who are on sick leave – technically still in employment – back into work and is thus included in the workplace section of the Recommendation. By comparison, reforms targeted at individuals who are already out of work and seeking employment are covered in the social benefits and employment services section of the Recommendation.

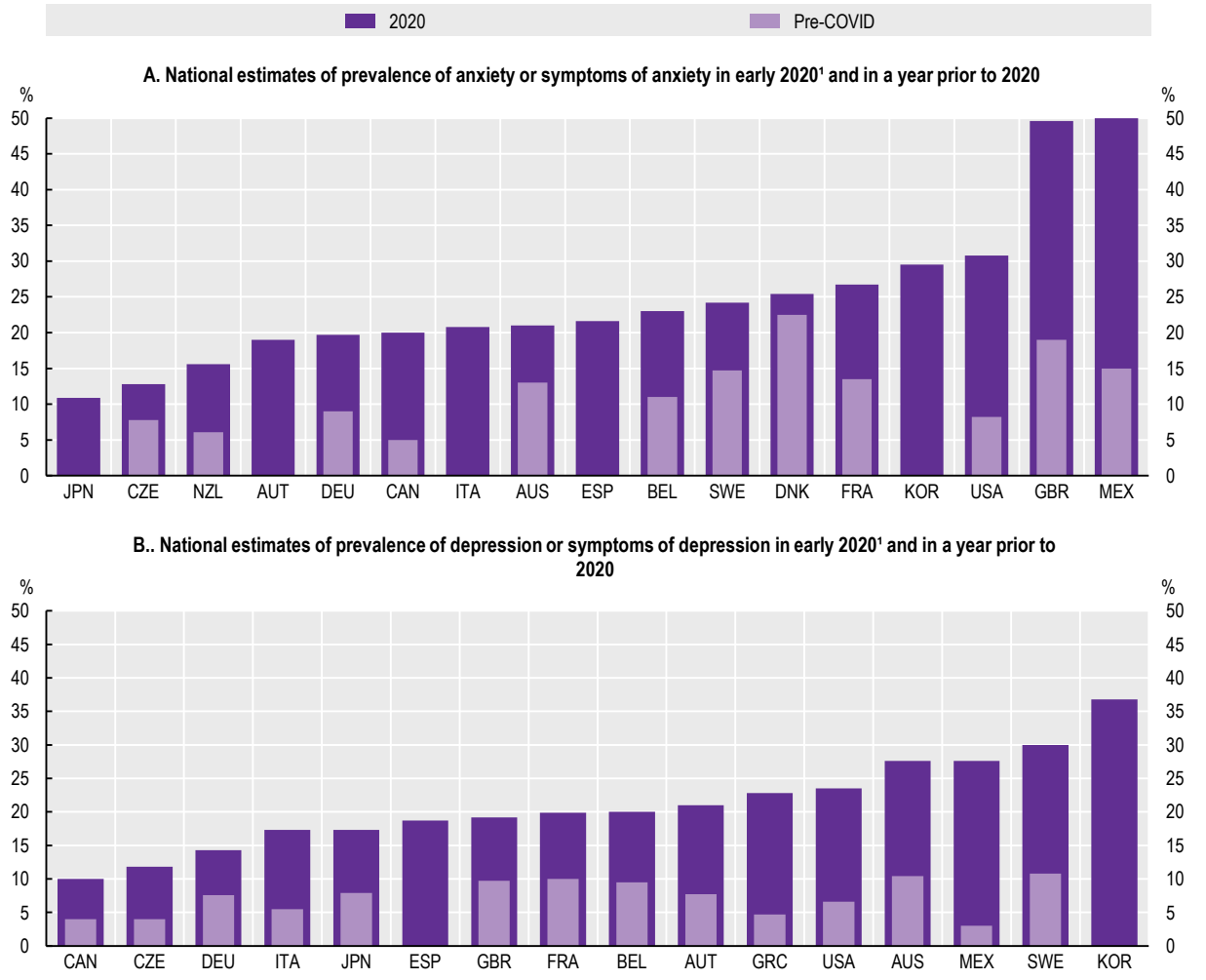
4 What are the implications and lessons of the COVID-19 pandemic for integrated mental health, skills and work policy?

This chapter summarises the latest findings on the impact of the COVID-19 crisis on mental health and the corresponding implications for an integrated policy approach. It considers how the mental health impact has varied over time and across groups of the population, with a focus on young people who are among those most affected by the pandemic. The chapter also looks at policy responses that countries have put into place to address disruptions to education and disruptions to work (through widespread teleworking and use of short-time work schemes). Finally, it identifies emerging priorities such as improving data collection, assessing levels of stigma, addressing the impact of the digital transformation, and understanding the challenges of rising loneliness, and discusses how these priorities could affect the implementation of integrated mental health, skills, and work policies.

Population mental health deteriorated at the start of the COVID-19 pandemic

At the onset of the COVID-19 crisis in 2020, population mental health deteriorated**.** This runs counter to the fairly consistent prevalence of mental health conditions among adults across the OECD since the early 2000s (OECD, 2015[1]). As shown in Figure 4.1, prevalence of symptoms of anxiety and depression in March to April 2020 was higher across all countries where data are available compared to previous years. A meta-analysis of studies published in May 2020 found that the prevalence of symptoms of anxiety and depression stood at 31.9% and 33.7% respectively during the COVID-19 crisis (Nochaiwong et al., 2021[2]). In another analysis of studies from January 2020 to January 2021 on the prevalence of anxiety and depression, researchers have estimated that prevalence of anxiety and depression in 2020 was 28% and 26% higher respectively than would have been expected without the pandemic (Santomauro et al., 2021[3]).

Figure 4.1. Large increases in prevalence of anxiety and depression at the onset of the pandemic



Note: The survey instruments used to measure depression and anxiety differ between countries and therefore are not directly comparable. Differences in the openness of populations to discussing their mental state also hampers cross-country comparability. Where possible, surveys using the GAD-7 instrument to measure the prevalence of anxiety issues and the PHQ-9 instrument to measure the prevalence of depression symptoms have been selected.

1.To the extent possible, 2020 prevalence estimates were taken from March-April 2020.

Source: National Data sources reported in OECD (2021), "Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-society response", https://doi.org/10.1787/0ccafa0b-en. Updated national data is included for Canada and the United Kingdom.

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Box 4.1. Measurement of prevalence of symptoms of mental health conditions during COVID-19

As this chapter looks at how mental health status has fluctuated and changed during the COVID-19 crisis, it uses estimates of prevalence of mental health conditions and mental distress collected through surveys. This differs from Chapter 2, where the focus was on assessing the labour market and social inclusion of people experiencing high levels of mental distress compared to the general population over time. In this chapter, where possible, surveys using validated instruments are used as a proxy for mental health status. Samples are not necessarily representative, especially for rapid surveys undertaken during the COVID-19 crisis, and survey methods differ between studies, limiting the possibility for cross-country comparisons. As symptoms are self-reported, increases in prevalence may partially reflect changes in awareness or levels of stigma towards individuals experiencing mental health issues, which can influence different national trends and trends across time.

The surveys referred to in this chapter are self-reported unless otherwise specified and typically use one of the following validated instruments:

- Generalised Anxiety Disorder-7 (GAD-7): a seven item questionnaire to assess the extent to which an individual is experiencing symptoms of anxiety. A score of 10 or higher is typically considered to be consistent with symptoms of anxiety in studies. The survey has a four-point scale for each item and scores can range from 0 to 21.
- Patient Health Questionnaire-9 (PHQ-9): a nine item questionnaire to assess the extent to which an individual is experiencing symptoms of depression. The last question on suicidal ideation may also be removed from the PHQ-9 resulting in the PHQ-8. A score of 10 or higher in the PHQ-9 is typically considered to be consistent with symptoms of depression in studies. The survey has a four-point scale for each item and scores can range from 0 to 27.
- Patient Health Questionnaire-4 (PHQ-4): a four item questionnaire that combines two questions on anxiety from the GAD-7 and two questions on depression from the PHQ-9. A total score of 3 or higher indicates symptoms of mental distress. The survey has a four-point scale and total scores can range from 0 to 12. A combined score of 2 or higher on the first two questions indicates risk of anxiety, and a combined score of 2 or higher on the last two indicates risk of depression. The two components of the PHQ-4 are often separately referred to as the GAD-2 (first two questions) and the PHQ-2 (last two questions).
- Kessler Psychological Distress Scale (K10): a ten item questionnaire used to assess psychological distress. A score of 22 or above is considered a high or very high level of distress. The survey may also be abbreviated to a six question survey resulting in the K6.
- WHO-5 Well-being Index (WHO-5): a five item questionnaire that contains only positively phrased questions on psychological well-being. Whereas the PHQ-9 asks for frequency of feeling “tired or having little energy”, the WHO-5 asks for frequency of waking up feeling “fresh and rested”. To calculate the final score, the sum of raw scores is multiplied by 4. Respondents scoring 50 or lower are sometimes considered at risk of depression.
- Hospital Anxiety and Depression Scale (HADS): a 14-item survey with the first seven items on anxiety (HADS-A), and the latter seven on depression (HADS-D). The survey has a four-point scale for each item and total scores can range from 0 to 21 for HADS-A and HADS-D. Unlike other scales, HADS combines questions on the presence of mental distress (e.g. PHQ-9 or GAD-7) and psychological well-being (WHO-5).

More details on instruments and surveys on mental health can be seen in the forthcoming publication, *COVID-19 and well-being: Life in the pandemic* (OECD, 2021[4]).

Monitoring of factors related to mental health – including loneliness, sleep quality, and self-harming behaviour and suicide – also provides insights into the impact of the COVID-19 crisis on population mental health, given the interaction of these factors with mental health status. Box 4.2 takes at glance at some of the findings on trends in levels of loneliness, sleep quality and suicide during the COVID-19 crisis. The interaction between well-being and mental health is also addressed in more detail in the forthcoming publication, *COVID-19 and well-being: Life in the pandemic* (OECD, 2021[4]).

Box 4.2. Loneliness, sleep quality and suicide during the COVID-19 crisis

A selection of findings on the impact of the COVID-19 crisis on a number of factors related to mental health (loneliness, sleep quality and suicide) suggest the following:

- **Loneliness:** loneliness is defined as the gap between desired and actual degree of social connectedness, and is a well-established risk factor for a range of health issues, including mental health conditions such as anxiety and depression (Beutel et al., 2017[5]). In the EU, the proportion of people reporting feeling lonely 'more than half the time' in the early months of the pandemic (25%) was more than double the proportion reporting the same feeling in 2016 (Baarck et al., 2021[6]).
- **Sleep quality:** while the relationship is bi-directional and complex, sleep and mental health are closely associated with one another, with individuals experiencing sleep problems and low sleep quality more likely to report symptoms of anxiety and depression (Freeman et al., 2017[7]). In Italy, a survey during the initial COVID-19 lockdown from March to May 2020 found that more than half of the population was experiencing impaired sleep quality (Franceschini et al., 2020[8]).
- **Suicide:** while social and cultural factors play an important role, experiencing a mental health condition can increase the risk of death by suicide (OECD/European Union, 2018[9]). Although there were concerns that suicide rates may surge during the COVID-19 crisis, a time-series analysis found no increase in suicide rates in 21 high-income countries between April and July 2020 (Pirkis et al., 2021[10]). Further monitoring will nonetheless be required to see if this trends hold through different stages of the pandemic and across countries.

Prevalence of symptoms of anxiety and depression have not recovered to pre-crisis levels in most OECD countries in 2021, but trends differ across countries and surveys

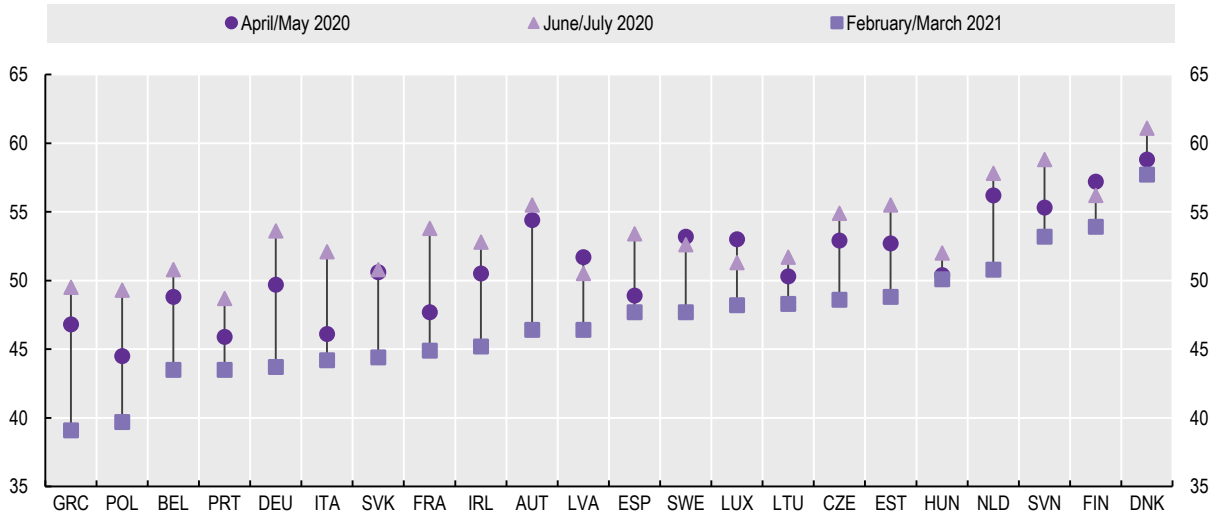
Surveys in most OECD countries in 2021 show that population mental health is yet to recover to levels seen before the onset of the COVID-19 pandemic. Yet data from a select number of OECD countries point to a notable recovery in population mental health in 2021, and in some cases, a return to pre-crisis levels. The data therefore suggest that as of mid-2021, not all OECD countries were *still* experiencing a mental health crisis at the population level. Whereas the initial negative mental health impact at the onset of the COVID-19 in 2020 was evident across all OECD countries, trends in population mental health since and throughout 2021 have therefore differed widely across OECD countries.

A challenge with interpreting data from surveys is that findings may differ between cross-national and national surveys on mental health as discussed in this chapter. Whereas cross-national surveys alone point to a further deterioration of mental health in early 2021, national surveys suggest signs of recovery. To some extent, this may be due to the availability of more granular and recent data in national surveys. Data from both cross-national and national surveys nonetheless both show that specific groups continue to experience poorer mental health than others, and thus may be at risk of experiencing longer-term mental health impacts from the pandemic.

As of early to mid-2021, cross-national surveys in OECD countries pointed to a lasting deterioration of mental health. As shown in Figure 4.2, an online survey by Eurofound has found that mental well-being recovered from April/May 2020 (onset of COVID-19 crisis) to June/July 2020, but then declined significantly, reaching the lowest levels during the COVID-19 crisis in February/March 2021 in all European OECD countries where data are available (Eurofound, 2021[11]). Analysis of data from the *COVID-19 Behaviour Tracker* (Imperial College London YouGov, 2020[12]), which is presented in *COVID-19 and well-being: Life in the pandemic*, also finds that the share of respondents at risk of anxiety and depression in 15 OECD countries increased marginally when comparing data from 2020 (April to December 2020) to data from early to mid-2021 (January to May 2021) (OECD, 2021[4]).

Figure 4.2. Cross-national data for Europe point to a worsening of mental well-being in 2021

Mean score for mental well-being from April/May 2020 to February/March 2021 for adult population



Note: A lower value indicates poorer mental well-being, and the survey instrument used is the WHO-5. A cut-off ≤ 50 is often used to screen for risk of depression. Low reliability for June/July 2020 survey results for Latvia and Luxembourg. Low reliability for February/March 2021 results for Luxembourg.
Source: Eurofound (2021), Living, working and COVID-19 dataset, Dublin, http://eurofound.link/COVID-19data.

StatLink https://stat.link/0gl7kz

Data from national surveys, however, indicate significant variation across OECD countries, especially in 2021, and in a number of countries (including the United Kingdom, the United States, Germany and the Netherlands), mental health has returned (partially) to pre-crisis levels. The *Lancet Commission Mental Health Taskforce* cites evidence from the United Kingdom and the United States to argue that levels of population psychological distress declined after a sudden rise at the onset of the pandemic (Aknin et al., 2021[13]). In the United Kingdom, data from the UCL Social Study, which uses the GAD-7 as its item on anxiety, show that prevalence of symptoms of anxiety decreased in summer 2020, then rose slightly from September 2020 through to early 2021, before declining again thereafter (UCL, 2021[14]; Office for National Statistics, 2021[15]). In the United States, two pre-eminent nationwide surveys, namely the USC Center for Economic and Social Research's Understanding Coronavirus in America tracking survey, and the Household Pulse Survey, both of which use the PHQ-4, find that the prevalence of symptoms of anxiety and depression at the population have declined since a peak in spring to summer 2020, although the former survey finds greater improvements (USC, 2021[16]; NCHS, 2021[17]). Significant recoveries in population mental health have also been seen in Germany and the Netherlands. In Germany, by January to February 2021, average levels of psychological distress, captured by the PHQ-4, had returned to pre-crisis levels (Entringer and Kröger, 2021[18]). In the Netherlands, analysis of a survey using the five

question Mental Health Inventory suggested that by December 2020, population mental health had returned to levels reported in 2019 (Siflinger et al., 2021[19]).

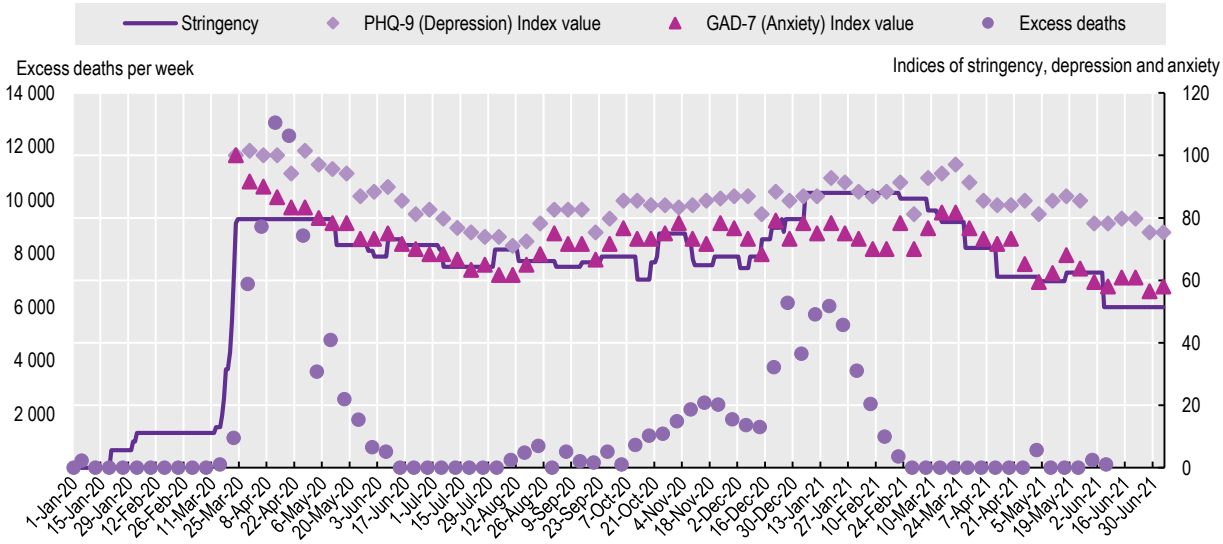
In many other countries and regions, however, levels of anxiety and depression peaked later into the pandemic, have remained high, or may still be rising. Although levels of anxiety and depression in Belgium and France declined after the sharp increase at the onset of the crisis, mental health deteriorated significantly again from the end of 2020, with both countries reporting high levels of anxiety and depression in spring 2021. In France, the proportion of the population reporting symptoms of depression exceeded one in five for the first time in November 2020, and remained above this level through to April 2021 (Santé Publique France, 2021[20]). In New Zealand, prevalence of psychological distress (K10) appears to have increased in early to mid-2021. Since data collection for this survey in New Zealand began in September 2020, psychological distress was in decline until March 2021, when it began to rise again, reaching the highest levels recorded in May 2021, when 11.9% of the population reported symptoms of high psychological distress (Ministry of Health, 2021[21]).

One contributing factor to the variation across countries is the differences in strictness of containment measures put in place, as well as variations in the evolution of the pandemic across OECD countries. Previous OECD analysis based on survey data from March to December 2020 has shown that, across a number of countries (Canada, France, the Netherlands, New Zealand, United Kingdom), prevalence of symptoms of anxiety and depression showed a fair degree of correlation with the stringency of policies to contain the spread of the virus, as measured by the Oxford University/Blavatnik Stringency and Policy Index (OECD, 2021[22]). A recent study of data on anxiety and depression between January 2020 to January 2021 has also found that daily infection rates of the coronavirus were associated with increased prevalence of symptoms of anxiety and depression (Santomauro et al., 2021[3]). Extending the data for this analysis to July 2021, at least for the United Kingdom (Figure 4.3), suggests that this correlation still largely holds more than one year on from the onset of the pandemic, although less closely for symptoms of depression. More details on the collection of mental health data in the United Kingdom are found in Box 4.3. There is also supporting within-country evidence of the impact of containment measures on mental health in Australia. A survey (K10) conducted as Victoria had exited lockdown in June 2021 showed that more than one in four people living in Victoria were experiencing high psychological distress (27%), compared to less than one-fifth (18%) among the rest of Australia (Australian Bureau of Statistics, 2021[23]).

The prevalence of symptoms of anxiety and depression typically increased *before* or immediately as lockdown measures were put in place, but there is no evidence to suggest that mental health deteriorated further *during* periods of lockdown (Banks, Fancourt and Xu, 2021[24])**.** In Germany, a survey to track levels of psychosocial distress (PHQ-4) found that during a two-month lockdown from March to May 2020, mental health remained largely unchanged (Ahrens et al., 2021[25]). In Denmark, survey results (WHO-5) show that prevalence of symptoms of depression decreased from March 2020 to July 2020 in a period when the country was under a lockdown (Andersen, Fallesen and Bruckner, 2021[26]). Evidence from France, and to some extent, the United States, also suggests that population mental health can rebound quickly upon the relaxation of containment measures. When containment measures were gradually lifted in France in May 2021, levels of anxiety and depression declined. Prevalence of symptoms of depression, for example, decreased from 22% in late April 2021 to 13% in mid-July 2021 (Santé Publique France, 2021[20]).

Figure 4.3. Mental distress, confinement measures and excess deaths are closely interrelated

Relationship between mental health status, confinement measures and excess deaths in the United Kingdom



Note: The Stringency Score is based on the Oxford University/Blavatnik Stringency and Policy Index. The stringency tracker comes from the Blavatnik School of Government, which calculates a stringency value using school closing, workplace closing, cancel public events, restrictions on gathering size, close public transport, stay at home requirements, restrictions on internal and international movement, and public information campaigns in each country. Excess deaths are based on OECD data – COVID-19 Health Indicators – Excess deaths by week. The first point of mental health data collected on 23 March 2020 was assigned 100, and each subsequent data piece was defined in relation to the first data point in order to produce a comparable figure that tracked relative percentage change in data. The indices for anxiety and depression are based on mean scores in survey responses to the Generalised Anxiety Disorder Assessment (GAD-7) and Patient Health Questionnaire (PHQ-9) respectively, both widely used instruments for screening for symptoms of anxiety and depression.

Source: Oxford University/Blavatnik Stringency and Policy Index, www.bsg.ox.ac.uk/research/research-projects/COVID-19-government-response-tracker and OECD data on excess death rates (2021), http://stats.oecd.org//Index.aspx?QueryId=104676 (accessed 31 August 2021).

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Box 4.3. Collecting data on population mental health in the United Kingdom during COVID-19

A vast amount of data on population mental health during the COVID-19 crisis have been collected by a wide range of stakeholders in the United Kingdom, including the national statistical office, researchers, and mental health charities, through surveys using validated mental health instruments. The government acts as a hub that synthesises findings to inform policy practice, including a surveillance report which offers a summary of the latest findings of mental health and well-being of individuals in England (United Kingdom), and a monitoring tool on the wider impacts of COVID-19 on health (Public Health England, 2021[27]) that pools data from across surveys on metrics including mental health. For each of these surveys, data are collected by age, gender and ethnicity, as well as socio-economic factors such as housing circumstances, living arrangements, income and education, which allows for policy makers to assess how mental health impacts differ between groups.

Surveys using validated instruments that allow for breakdown by age, gender, and other factors include:

- The *Understanding Society COVID-19 survey* is a web-based survey that has been implemented monthly or bi-monthly since April 2020 to collect data (General Health Questionnaire-12) on the impact of the pandemic on individuals, families and communities in the United Kingdom. This COVID-19 study is funded by the Economic and Social Research Council and the Health Foundation. Since the survey has been sent to participants to the

Understanding Society study, a longitudinal household study that has collected data since 2009, data on population mental health can be compared with pre-crisis findings (University of Essex and Institute for Social and Economic Research, 2021[28]).

- The *COVID-19 Social Study* is a weekly survey operated by University College London on the impacts of the pandemic and social distancing measures on the lives of adults in the United Kingdom. This survey has been implemented since mid-March 2020, and includes questions on anxiety (GAD-7) and depression (PHQ-9), as well as on factors closely related to mental health (self-harm, suicidal ideation, loneliness and life satisfaction). Data from the study are analysed in real time with findings made available regularly (UCL, 2021[14]).
- The *Opinions and Lifestyle Survey* is a weekly survey operated by the Office for National Statistics to understand the impact of the pandemic on "people, households and communities" in Great Britain. This survey has been run since the onset of the pandemic in mid- to late-March 2020, and a regular bulletin is released on key findings. An item asking respondents how anxious they have felt the day before has been included in the battery of questions from the beginning of the pandemic, and the PHQ-8 has been included regularly to assess changes in prevalence of symptoms of depression among adults (Office for National Statistics, 2021[15]).
- The *Mental Health of Children and Young People* is a survey in England (United Kingdom) that was initially conducted in 2017. The government has since conducted follow-up surveys in July to August 2020 (Wave 1) and in February to March 2021 (Wave 2) to assess changes in the prevalence of mental health issues since 2017, and to capture the mental health impacts of the COVID-19 crisis. The surveys were funded by the Department of Health and Social Care, commissioned by the National Health Service, and carried out by the Office for National Statistics together with research institutions. Reports in October 2020 and September 2021 have set out the findings from the follow-up surveys (NHS Digital, 2021[29]).

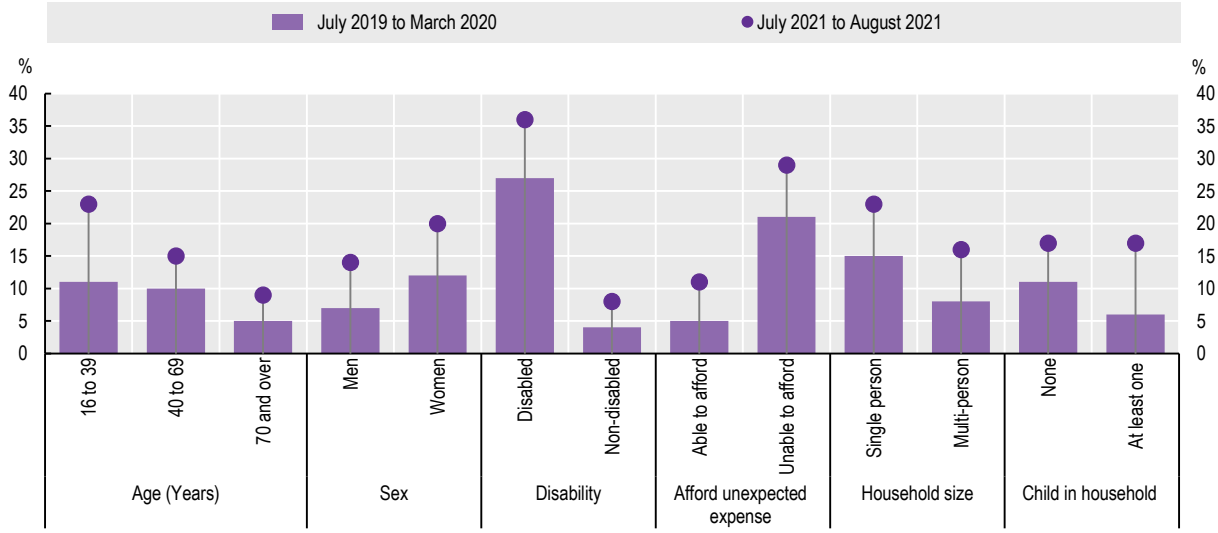
Women, young people and individuals from low socio-economic backgrounds continue to report higher levels of anxiety and depression

Across OECD countries, the mental health impact of the COVID-19 crisis has varied across population groups, and notably by age, gender, employment status, financial situation, and socio-economic status. Women and young people as well as individuals living alone, of lower socio-economic status, and the unemployed have all reported higher levels of anxiety and depression during the COVID-19 crisis than the general population (OECD, 2021[22]; OECD, 2021[4]). Although there is data from before the crisis on differences in mental health status across populations, the paucity of such data that is comparable with data collected since the onset of the pandemic poses difficulties when assessing whether these differences have widened or represent the continuation of pre-crisis trends.

The prevalence of mental health conditions differed between men and women before the crisis, with women more likely to report symptoms of anxiety and depression (Riecher-Rössler, 2017[30]), and these differences seem to have widened. In an analysis of studies on anxiety and depression between January 2020 to January 2021, researchers estimated that around two-thirds of the additional cases of anxiety and depression worldwide resulting from the COVID-19 crisis have been among women (Santomauro et al., 2021[3]). Looking at national surveys, in the United Kingdom, comparing the prevalence of depression in July 2019-March 2020 to July-August 2021, it appears that the difference between men and women has widened slightly (Figure 4.4). In the United States, one study found that stay-at-home measures in March to April 2020 had resulted in an increase in the gender differences in low mental well-being (WHO-5) by 66% (Adams-Prassl et al., 2020[31]). However, not all countries and regions show this trend. An analysis of a bi-weekly survey in Northern the Netherlands finds that while women reported greater increases in symptoms of depression than men during the COVID-19 pandemic, gender differences in the prevalence of symptoms of anxiety decreased (Vloo et al., 2021[32]).

Figure 4.4. Pre-existing differences in the prevalence of symptoms of depression have widened

Reported symptoms of depression in Great Britain[1] by population group, comparing pre-crisis to summer 2021



Note: Afford an unexpected expense: adults able/unable to afford an unexpected but necessary expense of GBP 850. Any individual under 16 years of age is considered a child.

1. Great Britain refers to all territories of the United Kingdom with the exception of Northern Ireland.

Source: Office for National Statistics, Opinions and Lifestyle Survey, https://www.ons.gov.uk/peoplepopulationandcommunity/well-being/datasets/coronavirusanddepressioninadultsingreatbritain.

StatLink https://stat.link/3hkr54

Parental status also appears to have an impact on mental health, with evidence pointing to parents of young children, and especially mothers, reporting declines in mental health compared to before the crisis. Based on a meta-analysis, researchers have estimated that the prevalence of symptoms of anxiety and depression among mothers of children under five stood at 27.4% and 43.5% respectively during the COVID-19 pandemic, significantly above levels before the onset of the pandemic (Racine et al., 2021[33]). The postpartum period and transition to motherhood was already associated with increased risk of mental health issues pre-crisis, especially for young mothers, yet the exceptional circumstances of the pandemic have resulted in additional pressures. Contributing factors include the loss of social support and suspension of early childhood education and care facilities, with the additional burden of childcare falling disproportionately on women (OECD, 2020[34]). In Italy, while men increased their contributions to childcare at the onset of the crisis, the burden of increased childcare still fell mostly on women (Farré et al., 2020[35]). A study of dual working parents in the United Kingdom has also found that mothers were responsible for almost two-thirds of the additional childcare resulting from the pandemic (Sevilla and Smith, 2020[36]).

Lower socio-economic status – including both lower levels of education and income – has also long been associated with higher risk of poor mental health (OECD, 2015[1]), and this trend has continued throughout the COVID-19 crisis in most countries. In a survey in Japan in March 2020, both men and women with annual household incomes less than JPY 2 million were more likely to report symptoms of psychological distress than those with annual household income above this level (Nagasu, Muto and Yamamoto, 2021[37]). In the United Kingdom, higher anxiety and depression scores have been reported by individuals in households with lower incomes and individuals with lower educational attainment in both the COVID-19 Social Study (UCL, 2021[14]) and the Opinions and Lifestyle as shown in Figure 4.4. In the United States, findings differ across surveys. While the Household Pulse Survey shows that individuals with less than a high school degree have reported almost 50% higher prevalence of symptoms of anxiety or depression than their counterparts who have achieved a Bachelor's degree or higher (Centers for Disease Control and

Prevention, 2020[38]), analysis of the American Life Panel found that individuals with higher education experienced larger increases in prevalence of depression than other individuals (Wanberg et al., 2020[39]).

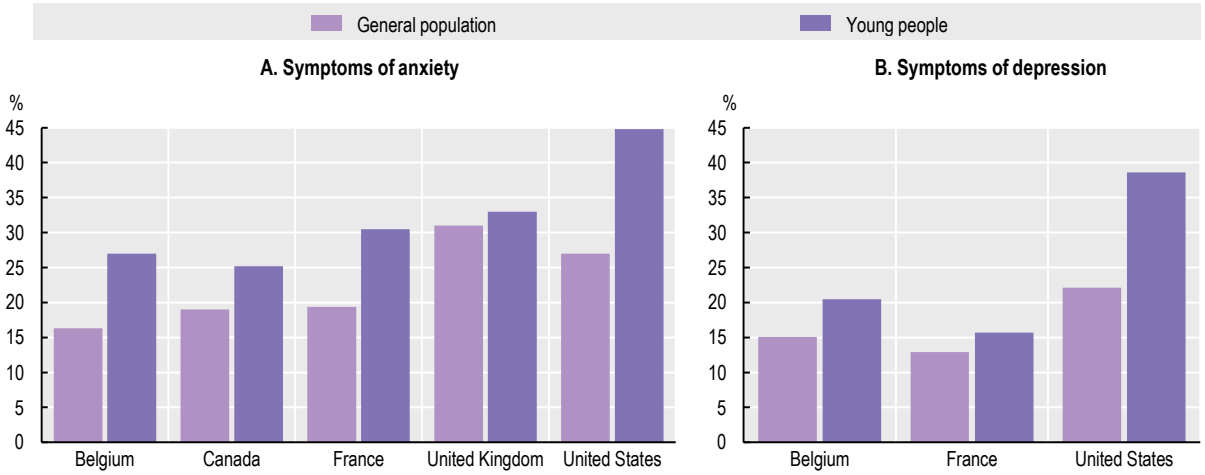
There is overwhelming evidence that young people's (15-29 year-old[1]) mental health has been significantly negatively impacted by the COVID-19 crisis, and this trend has continued through to mid-2021. The OECD previously reported that in a large number of OECD countries (Belgium, Canada, France, Italy, Japan, United Kingdom and the United States), analyses of survey evidence have shown that young people are reporting poorer mental health than the general population (OECD, 2021[40]). Survey results from other countries provide further evidence of the large impact on young people. In Austria, in April 2020, 25% of adults under the age of 35 reported symptoms of anxiety (GAD-7), compared to 19% among the general population, with a similar trend seen for depression. In November 2020, 32% of 18-34 year-olds reported high or very high levels of psychological distress in Australia (K10), compared with 21% among the general working population (Australian Bureau of Statistics, 2021[23]).

As shown in Figure 4.5, a number of countries have continuously tracked population mental health by age group during the pandemic, which provides close to real-time evidence and point to continued higher prevalence of symptoms of anxiety and depression among young people across most periods of the COVID-19 crisis. The OECD reported that in March 2021, in Belgium, France and the United States, young people were 30% to 80% more likely to report symptoms of depression or anxiety than the adult population (OECD, 2021[40]). These gaps have remained through to July 2021 as shown in Figure 4.5, and although prevalence has fallen across age groups in recent months, young people continue to report higher prevalence of symptoms of both anxiety and depression. There are also significant variations within different groups of young people, with young gender-diverse individuals and young women being among the groups reporting higher levels of mental distress as discussed in Box 4.4.

Data from a limited number of surveys from before the COVID-19 crisis show that these differences are new, or represent a significant widening of differences between young people and other age groups. In the European Union, in 2014, 15-24 year-olds were 40% less likely to report symptoms of chronic depression (PHQ-8) than the general population, although with variation across countries (Eurostat, 2014[41]). According to a national health survey in Belgium, 15-24 year-olds were no more likely to report symptoms of anxiety (GAD-7) or depression (PHQ-9) than other age groups prior to the crisis (Sciensano, 2020[42]). In Austria, there was no evidence of higher prevalence of symptoms of depression among 15-29 year-olds (PHQ-8) (Statistics Austria, 2015[43]). Yet since the onset of the pandemic, young people have become the age group most likely to report symptoms of anxiety and depression in both Austria and Belgium. In the United Kingdom, although young people were already the most likely age group to report mental health conditions before the crisis, the gap has widened substantially during the pandemic (Figure 4.4).

Figure 4.5. Young people report higher prevalence of mental health conditions

Prevalence of symptoms of anxiety and depression for selected OECD countries July 2021, young people vs. adults



Note: Data refer to June 2021 for Belgium. Young people refers to: age 18-24 (France), age 18-29 (Belgium, United Kingdom, United States) and age 18-39 (Canada). Survey findings based primarily on results from GAD-7 for anxiety and PHQ-9 for depression. France uses HADS for both anxiety and depression and the United States uses PHQ-4 for both anxiety and depression.
Source: Belgium – COVID-19 Dashboard (https://datastudio.google.com/embed/u/0/reporting/7e11980c-3350-4ee3-8291-3065cc4e90c2/page/ykUGC); Canada – COVID-19 National Survey Dashboard (www.camh.ca/en/health-info/mental-health-and-COVID-19/COVID-19-national-survey); France – Enquête CoviPrev (www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-COVID-19); United Kingdom – Coronavirus social impacts (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritaindata); United States: CDC Household Pulse Survey (www.cdc.gov/nchs/COVID-19/pulse/mental-health.htm).

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Box 4.4. Differences in mental health among young people

Young people, while often considered as one group, are highly heterogeneous. This point was also mentioned at a consultation of young people across OECD countries organised in September 2021 as part of the OECD Youth Week (OECD, 2021[44]). Life trajectories are diverse, and individuals go through transitions at different timings, with some young people in education, others already working, while others yet may not be in education, employment or training (NEETs). Much like with other groups, there is also high levels of diversity in sex and gender, income and socio-economic status, and race and ethnicity. Given wide differences within the population, collecting data by sub-group is key to assess which groups are being hardest hit by the COVID-19 crisis, and to fully take into account the intersection of characteristics that might lead to further disadvantages (OECD, 2020[45]). Given the disproportionate mental health impact of the COVID-19 crisis on young people, it is worth considering which sub-groups among young people have been most heavily affected.

An example of this is when looking at the mental health of the post-secondary student population amidst the COVID-19 crisis. Even prior to the pandemic, in a number of OECD countries, including Canada, the United Kingdom and the United States, students in tertiary education were reporting difficulties accessing mental health support, and calls have been made for universities to prioritise the mental health and well-being of their students. While there has been much talk of a student mental health crisis, it remains unclear as to whether this group of students have experienced greater declines in mental

health than their counterparts of the same age. Findings from surveys in Canada and the United Kingdom suggest that the prevalence of mental health conditions may be lower among young people in post-secondary education (Tabor, Patalay and Bann, 2021[46]; Wiens et al., 2019[47]). Yet one study in France has found that students in higher education were reporting higher levels of anxiety and depression than their non-student counterparts in May 2021 (Arsandaux et al., 2021[48]). Moreover, as only around half of young people in OECD countries pursue higher education by the age of 25, providing access to low-threshold support for tertiary students should be combined with efforts to support the mental health of young people who are not in education.

A limited set of evidence also shows that young Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI+) individuals in the United Kingdom and the United States are reporting particularly poor mental health during the COVID-19 crisis. In the United Kingdom, a survey of 11-18 year-olds found that LGBTI+ respondents were twice as likely to report symptoms of anxiety and depression as non-LGBTI+ respondents (Just Like Us, 2021[49]). In the United States, a survey of 13-24 year-olds identifying as LGBTI+ in October 2020 found that almost three-quarters (72%) were reporting symptoms of anxiety and almost two-thirds (62%) were reporting symptoms of depression (The Trevor Project, 2021[50]). The latter survey also found that half of the respondents wanted mental health care but could not get access, potentially indicating additional barriers that young gender diverse individuals may experience when seeking treatment for mental health issues.

Analysis and collection of further data on the mental health status of sub-groups among young people – such as young women; young LGBTI+ individuals; young carers; young people not in education, employment or training; young people from low socio-economic backgrounds; and young people with pre-existing mental health conditions – would provide an evidence base to assess where mental health policies for young people should be targeted. The importance of such disaggregated data is recognised by the OECD, as outlined in the updated Youth Action Plan, and was also raised by young people themselves specifically with regard to mental health in a consultation of young people organised by the OECD in September 2021 (OECD, 2021[44]).

People with pre-existing health conditions and disabilities have also reported higher levels of psychological distress throughout the crisis, although it is unclear – and may vary from country to country – as to whether there has been a widening of differences from before the crisis. A study in the Netherlands has found that while people with existing mental health conditions experienced a decline in mental health during the pandemic, there was no widening of the overall difference in the level of mental distress between people with pre-existing mental health conditions and the general population (Pan et al., 2021[51]). By comparison, in the United Kingdom, inequalities in mental health by health status appear to have widened, as shown in Figure 4.4. A study among older people in England (United Kingdom) has also found that individuals with a physical disability were more likely to report symptoms of anxiety and depression than those without such a disability, and that the gap had widened during the crisis, even when older people who were "shielding" during the crisis were excluded (Steptoe and Di Gessa, 2021[52]). Individuals with severe mental health conditions have also been at greater risk of hospitalisation and mortality from contracting the coronavirus in at least a number of OECD countries (OECD, forthcoming[53]).

It is more difficult to draw any generalised conclusions on the relationship between race and ethnicity and mental health impacts of the COVID-19 crisis. This is in large part due to the diversity and differences in circumstances of these groups across OECD countries. In Canada, while visible minorities[2] (when considered together) were more likely to report symptoms of anxiety than the white population, this gap seems not to have widened for most minority groups, with the exception of South Asians, who have reported poorer mental health than other visible minorities (Statistics Canada, 2021[54]). In the United States, the Hispanic/Latino and Black population have reported higher levels of anxiety and depression than the white population through most periods since the onset of the COVID-19 crisis. By comparison, the Asian population has reported lower levels of anxiety and/or depression than the white

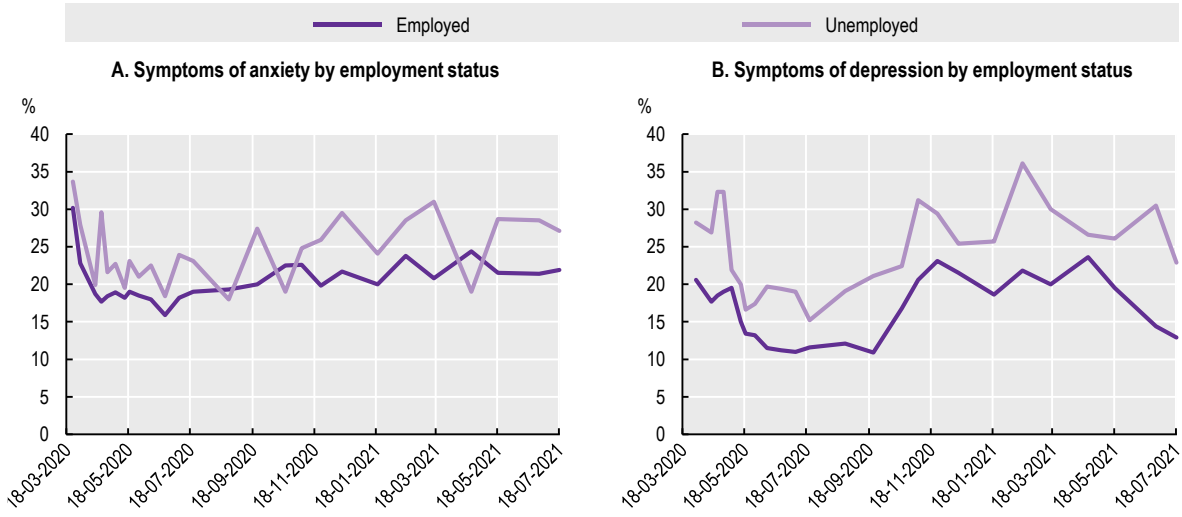
population (Centers for Disease Control and Prevention, 2020[38]). Varying practices on data collection across OECD countries also makes it hard to draw firm conclusions, with only around half of OECD countries systematically collecting data on ethnicity or race (Balestra and Fleischer, 2018[55]). Further analysis of the mental health impacts of the COVID-19 crisis on indigenous groups and for individuals of a migration background are covered in the forthcoming publication, *COVID-19 and well-being: Life in the pandemic* (OECD, 2021[4]).

Employment status and the nature of work shaped mental health in the COVID-19 crisis

Employment status during the COVID-19 crisis has also been a key factor in shaping mental health status, which is consistent with previous findings (OECD, 2015[1]). In Canada, since the onset of the pandemic, prevalence of symptoms of anxiety has been consistently higher among people who have lost their job or are no longer working due to the pandemic, with prevalence as high as 44% in March 2021 (CAMH, 2021[56]). Evidence from France also shows that individuals in employment have been less likely to report symptoms of anxiety and depression than unemployed people throughout the pandemic, and this gap is particularly notable for depression (Figure 4.6). The paucity of comparable data from before the COVID-19 crisis makes it difficult to assess whether these gaps have widened or represent a continuation of trends from prior to the crisis.

Figure 4.6. Differences in the prevalence of mental health issues between jobseekers and workers are significant

Reported symptoms of anxiety and depression by employment status in France, March 2020 to July 2021



Notes: Results are based on a survey with a small sample size (2000 total respondents by survey wave) which may drive sharp drops and falls in some survey waves. The survey uses HADS, based on which scores can be calculated for both anxiety (HADS-A) and depression (HADS-D). Respondents with a score above 10 on each of these scales are classified as reporting symptoms.
Source: Santé Publique France, Enquête CoviPrev, www.santepubliquefrance.fr/etudes-et-enquetes/coviprev-une-enquete-pour-suivre-l-evolution-des-comportements-et-de-la-sante-mentale-pendant-l-epidemie-de-COVID-19 (accessed 5 September 2021).

StatLink https://stat.link/id7tjb

Working conditions during the COVID-19 crisis – which have differed across occupations and sectors – are also impacting workers' mental health. The sudden shift to telework at the onset of the crisis, and its continuation, has posed new challenges for mental health. While evidence on the mental health of workers who are teleworking remains limited, a representative poll of French employees in March 2021 found that

49% of employees working from home were experiencing psychological distress, compared to 43% among employees working uniquely at their physical workplace (OpinionWay; Empreinte Humaine, 2021[57]). The Centre for Addiction and Mental Health's COVID-19 National Survey in Canada and the CoviPrev survey in France have also collected information on mental health by work location during the pandemic. Data from both surveys show that employees who have been working from home have reported slightly higher levels of anxiety and depression than other employees during most periods of the pandemic (CAMH, 2021[56]; Santé Publique France, 2021[20]). Further evidence is needed to draw firmer conclusions on whether employees who are teleworking are at elevated risk of poor mental health, not least given the specific circumstances of teleworking during the COVID-19 crisis, which was often a decision made out of the hands of employees.

The scale of outbreak of the pandemic has also placed a heavy burden on health care workers, especially during periods of high pressure on the health system. It is thus unsurprising that meta-analyses find that health care workers are reporting very high levels of psychological distress (Li et al., 2021[58]). In Canada, workers at high risk of exposure to the coronavirus have reported higher rates of anxiety symptoms through most periods of the crisis (CAMH, 2021[56]). There has also been much discussion on the role of other key and front-line workers during the COVID-19 crisis, and analysis of survey evidence in the United Kingdom suggests that impacts also differ among this group, with workers in essential services, such as utility, transport and public security, reporting higher levels of symptoms of anxiety and depression through to February 2021 than public service workers and teachers (Paul et al., 2021[59]).

Job retention schemes, which were introduced or adapted in response to the pandemic to protect jobs, appear to have cushioned the mental health impacts of the labour market crisis, and moderated the impact of loss of work on mental health (OECD, 2021[60]). These schemes involve temporary financial support to employers to help them retain employees in cases where employees would otherwise work reduced hours or be laid off. In the United Kingdom, furloughed workers in long-term insecure jobs from before and during the pandemic reported no increase in mental distress, whereas workers who were not furloughed reported significant increase in mental distress, which suggests a strong protective effect of furlough (Smith, Taylor and Kolbas, 2020[61]). In Switzerland, analysis of a survey of young men showed that whereas job loss during the COVID-19 crisis was associated with symptoms of depression, psychological trauma and fear, partial unemployment was associated only with symptoms of depression (Marmet et al., 2021[62]).

Analysis of surveys from Australia and Germany offer a similar yet more nuanced picture, with findings suggesting that job retention schemes helped protect mental health, but were not able to fully offset the impact of reduced work. In Australia, the retention of employment while not working was estimated to have reduced the mental health impact of job loss by around a half (Griffiths et al., 2021[63]). Likewise, in Germany, these schemes alone were not able to fully offset the impact of reduced work on mental health, as individuals on job retention schemes have reported poorer mental health than individuals who are in employment and not supported by such schemes (Schmidtke et al., 2021[64]). Workers on job retention schemes may be reporting poorer mental health than their counterparts who are continuing to work, as the temporary nature of these schemes could be perceived as a sign of elevated job insecurity.

Cross-government policy responses to the emerging mental health crisis

Integrated and cross-sectoral policies are the key to responding effectively to the impact of the COVID-19 crisis on population mental health. This requires changes not only in the health system, but also in a range of other policies. The remainder of this section looks into cross-government responses taken across OECD countries in the past 18 months in selected areas of concern.

Providing emergency mental health support

Given the sudden and negative impact of the COVID-19 crisis on mental health, countries have had to increase the availability of mental health support provided outside of traditional health, educational, workplace and social protection settings. Such support has taken the form of provision of information and self-help materials, strengthening and establishing of mental health hotlines, and the reinforcement of drop-in centres and services.

Many OECD countries have developed and shared information and tips on how to manage mental health together with guidance on how to access support. In Finland, for example, the Institute of Health and Welfare provides information on maintaining everyday routines, managing risk and stress, and guidance on how to seek treatment (THL, 2021[65]). Multiple international agencies such as the World Health Organization, the Inter-Agency Standing Committee and the European Commission have produced guidance and tips on how to stay in good mental health during the pandemic (OECD, 2021[22]). These efforts have often been targeted at health care workers who have been at elevated risk of experiencing mental distress. In Mexico, a specialised website was set up to provide mental health guidance to health care workers during the COVID-19 crisis, through which users could also access online mindfulness sessions designed by psychologists from the Salvador Zubirán National Institute of Medical Sciences and Nutrition.

Most OECD countries have established, reinforced or increased funding to mental health and crisis hotlines, which have been heavily used across OECD countries (OECD, 2021[22]). In Portugal, for example, a free phone line providing 24-hour mental health support from 63 psychologists was launched by the Ministry of Health with the financial backing of the philanthropic foundation Fundação Calouste Gulbenkian. In Colombia, the 192 phone line was established in response to the COVID-19 crisis, including a line reserved for people seeking emergency mental health assistance. Mental health hotlines have also often targeted children and young people (OECD, 2021[66]). In Poland, a 24-hour hotline dedicated to providing mental health support to young people was launched in January 2021. In Austria, the Vienna Government provided additional funding to the RatAufDraht (Advice on the Wire) emergency hotline for children and young people in March 2021 to help increase access to confidential support and advice.

Drop-in centres providing easily accessible psychological support outside of the formal health system have also been strengthened in OECD countries, and especially for young people. Finland, for example, has provided additional funding to the Onni project, which provides low-threshold psychological support and services that are integrated into one-stop youth centres known as Ohjaamo centres that offer guidance and integrated support for young people under 30. In Australia, the government announced an additional AUD 5 million in funding in August 2020 to headspace centres, which offer non-stigmatising support to young people aged 12 to 25, specifically in order to increase outreach to young people experiencing distress in the state of Victoria, which was subject to regional lockdown measures in mid-2020 (OECD, 2021[67]).

Supporting young people in education

The closure of schools and the resulting disruptions to learning have had significant implications for mental health, as schools offer more than just a place for academic development. The sudden shift to remote learning eroded many protective factors offered by in-person attendance, including routine, social contact and sense of belonging to a community, as well as access to exercise (OECD, 2021[40]). Closures of schools and educational institutions has also increased risk of mental health issues among young people going unidentified. Schools serve as a primary point of access to mental health services for many young people, and front-line actors such as teachers are often well-placed to identify early symptoms of mental health issues through repeated absence and behavioural changes in day-to-day school activities.

While many young people have been able to maintain connection with peers through digital means, the loss of in-person interaction resulting from school closures could have long-term negative consequences

for mental health, not least as young people are particularly reliant on interaction with peers (Orben, Tomova and Blakemore, 2020[68]). Whereas early childhood is characterised by a reliance on parent-child attachment, as individuals emerge out of childhood, they become more reliant on peer interactions (Burns and Gottschalk, 2019[69]). This impact may be particularly relevant for students of older ages as higher levels of education have been subject to more disruption across the OECD. While there are significant differences across and within countries, across the OECD, on average, more than half (56%) of instruction days were not held in-person at upper-secondary level from January 2020 to May 2021, around double the share of instruction days closed at the pre-primary level over the same period (OECD, 2021[70]).

Disruptions to learning due to the COVID-19 crisis have put students at risk of becoming disengaged and leaving education altogether, with a disproportionate burden falling on young people from disadvantaged backgrounds. Keeping young people in school protects against poor mental health, and brings benefits for both the individual and society in terms of improved long-term employment prospects. Most OECD countries are reporting implementing such measures, often with a focus on disadvantaged groups and young people at risk of dropping out. Almost three-quarters (73%) of OECD countries reported implementing remedial measures at the upper-secondary level to make up for learning gaps between January and May 2021, and more than half reported introducing more targeted measures at students at risk of dropping out of education (OECD, 2021[70]).

While there may be consideration of use of grade repetition to address learning losses and close skills gaps for students experiencing mental distress, the broad use of such measures should be avoided. Policy makers and educational institutions should instead focus on supporting students through the crisis. There is no guarantee that grade repetition helps to close learning gaps, and it can place significant costs on the individual in terms of lost income due to delayed labour market entry. Moreover, grade repetition can disrupt social connections of students with their peer group and thus increase the risk of mental distress (La Greca and Harrison, 2005[71]). As outlined in Chapter 2, even prior to the crisis, students indicating mental distress were 35% more likely to have repeated a grade, and thus targeted support to make up for learning losses for this group are particularly important.

Supporting young people in education also requires policies to ensure teachers and front-line actors in the education system are appropriately trained, and the involvement of parents, especially for younger students. For example, in February 2021, the United Kingdom launched a free training course for people who work with or care for young people under the age of 25. The government also later announced a mental health grant of up to GBP 1 200 for schools and colleges to provide senior leaders with the skills and understanding to implement a whole-of-school approach in their educational institutions. More targeted interventions and treatments must also be made available for students experiencing clinically significant mental health conditions. This may take the form of provision of educational support with mental health services together, through close co-operation of educational institutions and mental health services.

Recognising the important role of educational institutions, many countries across the OECD have also allocated funding to expand mental health services available in education institutions, although the increases have often been moderate (OECD, 2021[66]). In Iceland, the government allocated ISK 150 million in April 2021 to strengthen mental health services in upper secondary schools, colleges and universities. In France and Austria, additional psychologists have been placed in the education system. In France, the government announced in late 2020 that 80 additional psychologists would be hired in university mental health services, while in Austria, the government allocated funding in June 2021 to hire 205 additional psychologists in schools. For countries seeking to adjust their budgets on education, this should not come at the expense of programmes that promote the mental health of students.

Adapting workplace policies to promote mental health

Since the onset of the COVID-19 pandemic, millions of workers have experienced job loss, and most have seen significant disruptions to how their work is organised and experienced. Some workers are still on job retention schemes, and may not have been at work for 18 months. Other workers such as those in essential

services have had to continue to work in-person throughout the pandemic, in some cases facing increased risk of exposure to COVID-19 infection and in all cases needing to take new steps to protect their health at work. Still others suddenly shifted to telework often full-time and across many months.

Given the increased risks to the mental health of employees amidst the COVID-19 crisis, employers can take proactive steps to provide and strengthen mental health support available to employees including for both in-person and remote employees. Many employees in the United States feel that their employers are not taking sufficient measures to address the mental health issues arising from the pandemic. In a recent survey of remote workers in the United States by PricewaterhouseCoopers, for example, employees were 26 percentage points less likely than executives to say their companies were successful or very successful in supporting the mental health of workers (PwC, 2021[72]). While large employers in the United States are reporting expanding access to virtual mental health services for their employees amidst the pandemic, small and medium size employers may face greater challenges in making mental health support available.

Whole-of-workplace initiatives – comparable to whole-of-school initiatives – can help ensure work contributes to better mental health. A key component of such initiatives is mental health training for line managers and executives. A Deloitte survey in the United Kingdom in 2017 found that while around half of line managers believed basic training in mental health would be useful, less than a quarter reported actually receiving training. Effective management by line managers can contribute to a workplace culture that is conducive to open discussion of mental health, help prevent workplace conflicts that are major risk factors for poor mental health, and promote earlier identification of potential mental health issues.

Given that teleworking rates are likely to remain above pre-crisis levels even once the COVID-19 pandemic subsides (OECD, 2021[73]), further examination of the impact of teleworking on mental health is necessary. Evidence from before the COVID-19 crisis on the interaction between teleworking and mental health was mixed. When well-managed, telework offers benefits such as flexible working arrangements, elimination of commuting time, and the possibility to balance work and family commitments. However, telework can also blur the boundaries between work and home, increase usage of digital technologies, and contribute to extended working hours, and result in a sense of detachment from the workplace, all of which can have a negative impact on mental health. A better understanding of the link between work-life balance and mental health may also provide valuable insights into the impact of the changing workplace on mental health. Data from a survey in the EU, for example, has found that teleworkers have been significantly more likely to report working during their free time compared to other workers (Eurofound, 2020[74]), which could have significant implications for mental health.

The rise of teleworking may demand new protections for workers' mental health, and policy makers have responded rapidly in a number of countries in this emerging policy area. In December 2020, lawmakers in the European Parliament called for a law to give workers the right to digitally disconnect outside working hours without repercussion. This measure followed in the footsteps of France, Italy, Spain and Luxembourg, which already had such legislation in place. While countries have moved to rapidly implement such policies in part due to the rise in telework amidst the COVID-19 crisis, this response also reflects policy makers' attempts to mitigate the negative mental health impacts of the digital transformation on the workplace.

Designing job retention schemes to promote the mental health of workers

The COVID-19 crisis has also profoundly impacted the employment landscape with the large-scale use of job retention schemes. In the early stages of the crisis, countries acted swiftly to put in place or modify these schemes, and in this process, supported over 60 million jobs across the OECD, accounting for around 20% of dependent employment. As explained earlier, job retention schemes have also indirectly contributed to protecting beneficiaries from a deterioration in their mental health.

From a mental health perspective, it appears preferable for individuals on job retention schemes to work reduced or partial hours, as opposed to seeing their hours cut to zero. An analysis of the United Kingdom and EU countries has found that employees can gain most of the mental health benefits that come with employment with just eight hours of work a week (Kamerāde et al., 2019[75]). While most OECD countries already had some form of job retention scheme in place, all new job retention schemes, with the exception of Iceland's, could only initially be used for employees whose work was cut to zero hours (OECD, 2020[76]). In some countries, including Denmark and the United Kingdom, schemes were later amended to make compensation for reduced hours, rather than for zero hours alone.

What is less known are the consequences of prolonged furlough or short-time work, with some workers having been on such schemes for over a year. Past OECD research has shown that returning to work becomes especially difficult for individuals after three months of sick leave (OECD, 2015[1]). Similarly, re-employment chances fall with the duration of unemployment. While being on job retention schemes may not entail the same circumstances, prolonged periods on such schemes could have a similar effect of increasing the risk of detachment of the employee from the workplace.

Moreover, policy makers across OECD countries should be wary of a potential increase in unemployment and demand for mental health services as they seek to phase out job retention schemes. Although the share of workers on job retention schemes has declined sharply since the early months of the crisis, 6.5% of dependent workers were still on these schemes in February to March 2021 on average across the OECD countries (OECD, 2021[60]). For individuals on these schemes who are able to find work, the transition back to work may bring significant mental health benefits, but some individuals will not be able to find work easily (ibid).

Addressing poor mental health through strengthening public employment services

Given the scale of unemployment and joblessness seen across OECD countries, promoting good mental health and providing access to mental health services for the unemployed should be considered a priority. There were 22 million more people who were jobless for more than six months at the end of 2020 compared to the end of 2019, indicating a significant increase across OECD countries in long-term unemployment (OECD, 2021[60]). Unemployment rates are also expected to remain above pre-crisis levels through to the end of 2022 in many OECD countries (OECD, 2021[77]), suggesting that tackling joblessness will remain a challenge beyond the short-term.

Supporting jobseekers back into employment through job-search support, counselling and training opportunities remains a key lever to promote better mental health among the working population. The mistakes of the global financial crisis must not be repeated, when the increase in unemployment far outpaced the rise in spending on active labour market policies, resulting in a 21% decrease in time spent with each client (OECD, 2011[78]). While employment services may still be stretched by the increase in clients during the pandemic, the provision of mental health support should not be compromised or reduced.

Even prior to the crisis, public employment services offered little access to support for individuals experiencing mental health conditions. Measures offered in employment services need to combine mental health support with employment support as evidence shows that mental health support is effective in improving employment prospects for individuals experiencing mental health conditions only when it is provided together with employment support (OECD, 2015[1]). As outlined in Chapter 3, large-scale implementation of integrated mental health and employment support still remains lacking in most OECD countries, and this has remained the case even during the COVID-19 crisis. In Norway, for example, an Individual Placement and Support programme has been launched for under 30-year-olds as part of the 2021 National Budget, to provide young people experiencing mental health issues with mental health and employment support together. Given the ample evidence that points to the effectiveness of such integrated supports from before the crisis, countries should go further than trials by scaling up and rolling out these schemes to reach out to a larger number of unemployed jobseekers.

Active labour market programmes themselves can also help to cushion the impact of damaging effects of unemployment on mental health. A study in the United Kingdom found that participants in these programmes are likely to self-report better mental health outcomes than other unemployed individuals, although still likely to report poorer mental health than those in work (Wang et al., 2020[79]). Participation in active labour market programmes shares some aspects of employment such as providing routine and structure to daily life, offering opportunities to meet new people and socialise, and supporting the development and maintenance of social networks. While supporting jobseekers back to work should remain the focus of active labour market policies, there is thus also scope to consider the mental health implications when assessing the effectiveness and success of such policies.

These challenges are particularly pronounced for young people. Young workers often hold less secure jobs due to shorter job tenure and greater reliance on non-standard forms of work, and are also over-represented in customer-facing industries – such as accommodation, tourism and food services – that have been hard hit by the COVID-19 crisis. New graduates, meanwhile, are often looking for work for the first time at a time of limited vacancies and high competition from jobseekers with experience, and account for a significant proportion of increase in joblessness among young people (OECD, 2021[60]). While all workplace and employment service policies to promote good mental health also apply to young people, the need for outreach of employment services is particularly pronounced for disadvantaged young people (OECD, 2021[66]). Opportunities to get in touch diminish over time, as young people become more disengaged from education and the labour market, and thus outreach is vital to support young people into training or work, and to strengthen future labour market outcomes.

Looking beyond the immediate impacts of the COVID-19 pandemic

The COVID-19 crisis has shed light and renewed attention on long-standing issues such as the paucity of data on mental health, and the scale of mental distress across OECD populations, while also showing the urgency of addressing the social determinants of mental health. The crisis has also accelerated trends such as the digital transformation, which presents both opportunities and risks for people's mental health, and resulted in new attention placed on policy issues related to mental health such as rising loneliness. Given the scale of the challenge facing OECD countries, an integrated approach to mental health policy that takes into account the education, employment and welfare dimensions of mental health is more urgent than ever, with a focus on groups hardest hit by the COVID-19 crisis, to ensure people across the OECD are able to lead mentally healthy lives.

The COVID-19 crisis has highlighted the continued relevance of an integrated approach to mental health policy and the principles set out in the OECD Recommendation on Integrated Mental Health, Skills and Work Policy (Box 4.5). Improved data collection on population mental health will provide countries, policy makers and researchers with greater insights into the value of education and employment interventions in promoting good mental health. Raising awareness of mental health issues and tackling continued stigma towards mental health will require action across health systems, educational institutions, workplaces, social protection systems and broader society as called for in the Recommendation. Increased attention to mental health during the pandemic should also facilitate the shift to more integrated policies and practices.

The OECD will continue its research into effective integrated mental health, skills and work policy, and follow the emerging policy priorities outlined in this chapter as countries look to recover from the COVID-19 crisis. As the impacts of the digital transformation and the emergence of loneliness as a policy priority are not explicitly mentioned in the Recommendation, further analysis and research of these long-term impacts will provide a picture of how these new developments could be reflected in the current version of the Recommendation if considered appropriate. The next scheduled review of the implementation, dissemination and usefulness of the Recommendation in five years' time will also provide an opportunity for amendments or updates to the Recommendation as the longer-term impacts of the COVID-19 crisis on integrated mental health, skills and work policy become clearer.

Box 4.5. Updating the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, endorsed in 2015, in light of the COVID-19 crisis

In June 2020, the OECD Secretariat asked member countries of the OECD how useful they are finding the Recommendation as part of its preparation of a report on the extent to which the Recommendation had been implemented five years after its adoption in 2015. A majority of responding countries stated that the Recommendation had been "somewhat useful" or "very useful" in policy discussions, as well as that the Recommendation would also be "highly relevant" for the years ahead. When asked how the context of the COVID-19 crisis had changed the importance of the Recommendation, 60% reported that the Recommendation had become "more important," indicating that OECD countries consider the implementation of integrated mental health, skills and work policies a priority. This confirms and implies that most OECD countries consider the Recommendation to be useful today but also going forward.

As part of the assessment of the implementation of the Recommendation in 2020/2021, there was also an opportunity to propose revisions to the Recommendation. Yet as the key principles of the Recommendation remained relevant, it was agreed by OECD countries – on suggestion of the OECD Secretariat – that no revisions would be made now. Moreover, while the COVID-19 crisis is undoubtedly having a substantial impact on mental health, and immediate policy responses have been required, it remains to be seen how policies will have to adjust or evolve as a result in the longer-term. It was thus agreed that the Recommendation should only be revised once consideration has been given to the longer-term consequences of the COVID-19 crisis.

The next opportunity to revise the Recommendation will take place in five years' time, and thus the emerging policy priorities outlined in this chapter will be of relevance in this process. The OECD Secretariat, in consultation with member countries, reported that the following four long-term policy issues could benefit from being included in a revised version of the Recommendation:

- Growth of digital mental health services and implications for access and availability of interventions and supports for people experiencing mental health issues;
- Disruptions to learning and working during the COVID-19 crisis, and the potential long-term impacts of this on integrated mental health policies;
- Transformation of modes of learning and working, and implications of the shifts towards remote learning and teleworking;
- Exacerbation of existing inequalities and the need for targeted policies to disadvantaged groups and those hit hardest by the COVID-19 crisis.

Source: Report on the Implementation of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (2021[80])

Tracking population mental health and awareness

Recognising the potential psychological and mental health impacts of the COVID-19 crisis, there has been a significant increase in country-level monitoring of population mental health status, and this should be sustained going forward. Across many OECD countries, as expanded upon in recent OECD work, most notably, *A New Benchmark for Mental Health Systems* (OECD, 2021[67]) and in the upcoming *COVID-19 and Well-being Evidence Scan* (OECD, 2021[4]), national statistical offices and researchers have collected stratified data on prevalence of symptoms of anxiety and depression, as well as on measures related to mental health status such as loneliness, sleep quality, and self-harming behaviour.

Such data has made it possible to examine how population mental health has changed during the COVID-19 crisis, as well as to show which population groups have been more heavily affected. This is a

welcome change, as availability of mental health status data was scarce prior to the pandemic (Hewlett and Moran, 2014[81]). Yet it will only be possible to see the long-term impacts of the COVID-19 crisis on mental health if countries strengthen and sustain these surveys and data collection efforts, including by integrating mental health questions within existing surveys. Through the *Mental Health and Well-being Project*, the OECD will work closely with national statistical offices to improve the availability of disaggregated data on mental health going forward.

There is also a shortage of trend data on public awareness and stigma surrounding mental health in OECD countries. Although most OECD countries reported having one or more national programmes on improving understanding of mental health and reducing stigma in the Mental Health Benchmarking Questionnaire, data on awareness and stigma is measured infrequently, with only a few exceptions, limiting the possibility for cross-country comparison (OECD, 2021[67]). In England (United Kingdom), the *Time to Change* campaign has collected data on attitudes on mental health regularly from 2016/2017 to 2020/2021, and found significant improvements in awareness and reductions in discrimination against people experiencing mental health issues (Time to Change, 2021[82]). Yet such country-specific data is not comparable with findings in other OECD countries, as each country has adopted different indicators of measurement. Meanwhile, although the data presented in Chapter 1 show that stigma surrounding mental health remained prevalent in many OECD countries in 2019, the data offer no insights into how levels of public awareness and stigma have changed over time.

Collecting evidence on changes in public awareness and stigma of mental health issues is crucial for at least two reasons. First, such evidence could be used to assess progress in tackling stigma and raising awareness of mental health, which in itself is highly valuable information for policy makers (OECD, 2021[67]). Second, since mental health surveys rely on self-reported data, increases in prevalence of self-reported symptoms of mental health conditions could be partially explained by a reduction of stigma. Such evidence is particularly important in the context of the COVID-19 crisis, as the widespread impacts of the crisis on mental health may have normalised discussions around mental health and resulted in increased public awareness, although evidence remains limited. In a survey commissioned by AXA and conducted in June 2020 on attitudes to mental health in 7 European OECD countries, 60% of respondents stated that their view on their own mental well-being had changed during the COVID-19 crisis (AXA, 2020[83]). It is only by accounting for and overcoming stigma that more robust data can be obtained on the prevalence of mental health conditions; data which reflect the true prevalence of mental health conditions and allow robust comparisons over time and between countries.

Addressing the impacts of the digital transformation

The COVID-19 crisis accelerated and amplified the ongoing digital transformation, resulting in significant changes in how we live, learn, and work, with significant implications for mental health. Stimulated by countries and employers putting in place facilitating measures, almost half of all employed persons reported teleworking at some point in 2020 in Australia, France and the United Kingdom (OECD, 2021[84]). In many cases, employees have been able to adapt rapidly, breaking perceptions about the ineffectiveness of teleworking, but for others, the transition has been more difficult. While evidence dating from before the COVID-19 crisis on the mental health impacts of teleworking compared to in-person work is mixed, concerns have been raised about evidence of longer and more irregular working hours, as well as the challenges associated with the blurring of boundaries between work and home (OECD, 2021[22]).

Tackling the mental health impact of teleworking has emerged as a priority for a number of OECD countries. While a majority of jobs are still difficult to perform from home (OECD, 2020[85]), surveys across a number of OECD countries also indicate that workers, executives, and employers would like to employ hybrid working arrangements that combine teleworking with in-person work beyond the pandemic (OECD, 2021[22]). There remains scope for further analysis on the implications of increased teleworking for mental health, and the changing organisation of work resulting from the broader digital transformation.

Given the scale and speed of the digital transformation, even workers whose jobs cannot be performed from home may be affected, and the flexibility provided by telework may result in additional inequalities.

The shift to remote learning has also opened up long-term opportunities and consequences for how learning is organised and experienced. Remote learning may have implications for mental health practice and policy in schools, universities and other educational institutions, including adult learning organisations (OECD, 2020[86]). This may include, for example, changes in the nature of risks that may be associated with harms to mental health, such as cyberbullying and online harassment as outlined in *Children & Young People's Mental Health in the Digital Age* (OECD, 2018[87]). Given the growing role played by the digital environment in daily lives and interactions, policies to ensure young people are able to safely and productively engage in the digital environment, such as those set out in the Recommendation of the Council on Children in the Digital Environment (OECD, 2021[88]), will be vital. Through such policies, countries will be able to realise the benefits and seize the opportunities offered by the digital transformation, including for young people experiencing mental health issues, while minimising the potential risks for mental health.

OECD countries are also looking to take advantage of the growth of digital mental health services, supports and tools. Digital mental health services – ranging from specialised services such as eCBT to lower-threshold services such as apps – were an area of rapid growth and expansion even before the COVID-19 crisis, and the importance of leveraging data and digital technologies to achieve health objectives was widely acknowledged (OECD, 2019[89]). As outlined in the *Mental Health System Performance Benchmark*, a key element of a future-focused and innovative approach to mental health policies is to embrace the possibilities offered by technological developments (OECD, 2021[67]). To ensure that the digitalisation of mental health services and supports benefits individuals of all backgrounds, policies to close inequalities in digital skills and access to internet and digital devices will also be vital.

Young people increasingly use digital platforms and tools, including social media and the Internet, yet assessing the impact of this trend on mental health is not straightforward. Almost 95% of 16-24 year-olds reported using the Internet every day or almost every day in 2019, and between 2012 and 2018, the time spent by 15-16 year-olds on the Internet outside of school rose by 50% (OECD, 2020[85]). While concerns have been raised about the mental health impacts of this transformation, existing research shows that the impact of digital technologies on mental health is mixed (OECD, 2018[87]). A meta-analysis on the mental health impacts of social media on 13-18 year-olds has also found that while there is a correlation between social media and mental health issues, the impacts are likely to depend also on the nature of use, with moderate use correlated with higher mental well-being (Keles, McCrae and Grealish, 2019[90]). The impact of factors that explain the heterogeneity of social media usage such as time spent, nature of use (e.g. comparing passive use of social media to use of social media for engagement), and addiction or dependence on social media should be examined in further detail.

Loneliness as a public health challenge for people of all ages

As people across the world have limited physical contact to limit the spread of the coronavirus, loneliness has been a subject of public conversation, and emerged as a renewed policy priority across many OECD countries. In the EU, for example, the proportion of people reporting feeling lonely 'more than half the time' in the early months of the pandemic (25%) was more than double the proportion reporting the same feeling in 2016 (Baarck et al., 2021[6]). As loneliness – defined as the gap between desired and actual degree of social connectedness – is a risk factor for a range of health issues including mental health conditions such as anxiety and depression (Beutel et al., 2017[5]), interventions that tackle loneliness can play an important role in preventing the development of mental health issues. Such interventions should thus be seen as a key pillar of integrated mental health policies going forward.

Policies to address loneliness should recognise that loneliness affects all age groups. While it is a commonly held belief that older age groups are at highest risk of loneliness, this is not necessarily the case. Loneliness appears to peak at two different life stages, namely youth and early adulthood, and very

old age (80+ age group) (Qualter et al., 2015[91]). The drivers of loneliness also differ significantly across age groups (Jopling and Sserwanja, 2016[92]). Loneliness among young people is often driven by challenges of establishing one's identity, as well as the school-to-work transition, which typically involves displacement from established social networks. By comparison, loneliness among older age groups is primarily driven by factors such as the loss of partners and friends and reduced mobility resulting from health conditions (Qualter et al., 2015[91]). As expanded on in *All the lonely people: Education and loneliness*, schools play an important role in protecting against loneliness at young age, as well as in developing socio-emotional skills that can help combat loneliness (OECD, 2021[93]). Loneliness among older adults is better understood, yet there is a shortage of research and knowledge on loneliness for all age groups, and especially for young people (Eccles and Qualter, 2020[94]).

A number of OECD countries are newly prioritising addressing loneliness amidst the COVID-19 pandemic and increasing international co-operation. Before the pandemic, loneliness measures were largely implemented at the local level, and could be broadly divided between community support programmes that treat loneliness as a public concern, and individual measures focused on addressing the psychological impacts of loneliness (Baarck et al., 2021[6]). The United Kingdom launched its *Let's Talk Loneliness* campaign in April 2020 to tackle loneliness and social isolation during the pandemic through a GBP 750 million funding package and the establishment of a network on tackling loneliness involving more than 70 organisations (Macdonald and Kulakiewicz, 2021[95]). Japan appointed a Minister of Loneliness in February 2021, driven in part by a spike in suicide rates among young people and women, and outlined the direction for measures to address loneliness and social isolation in its Basic Policies on Economic and Fiscal Management and Reform 2021. In summer 2021, Japan also signed agreements with both the European Commission and the United Kingdom to raise awareness of loneliness in the global community and share knowledge and best practices on policy interventions going forward (European Commission, 2021[96]; UK Government, 2021[97]).

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Notes

[1] The definition of 15-29 year-olds as "young people" is consistent with the definition used in the updated Youth Action Plan, and is mentioned here without prejudice to other definitions used by OECD member countries. It is understood as the age range at which young people experience "youth", which resembles the period of transition from childhood into adulthood. The lower age limit of 15 falls under the age range at which compulsory education typically ends, and the upper age limit of 29 reflects socio-economic trends of recent generations of young people continuing education for longer, entering the labour market later, and marriage and parenthood occurring at an older age. Where possible, evidence cited on the mental health of young people looks at 15-29 year-olds, but this is limited by differences in categorisation of age ranges by countries. Data on young people cited in this chapter therefore ranges from 15-24 year-olds for the European Health Interview Survey to 18-39 year-olds for the COVID-19 National Dashboard in Canada. Different instruments to those cited in this chapter (PHQ-8, GAD-7 and PHQ-4) are also often used to examine the mental health of children under the age of 15.

[2] The term "visible minority" is widely used in Canada, including by Statistics Canada, and is defined under the Employment Equity Act as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Statistics Canada, 2021[98]).