Mental health

Good mental health is vital for people to be able to lead healthy, productive lives (OECD, 2021[19]). During the COVID-19 crisis, when OECD populations experienced significant disruption to the way they live, learn and work, substantial impacts on mental health have been observed (see Chapter 2 for further analysis of the mental health impact of COVID-19). In March and April 2020, recorded levels of anxiety and depression in the general population were higher in almost all countries compared to previous years (Figure 3.19, Figure 3.20). These increases in mental distress have not been consistent across the health crisis, or across all population groups. In countries such as Canada, France, the Netherlands and the United Kingdom, where mental health status was tracked throughout the pandemic it improved in the period June to September 2020; this coincided with lower case rates of COVID-19 and fewer infection containment measures (OECD, 2021[20]). People who were unemployed or experiencing financial difficulties reported higher rates of anxiety and depression than the general population during the COVID-19 crisis, which is a trend that pre-dates the crisis but seemed to have accelerated in some countries (OECD, 2021[20]). Young people's mental health was also hit particularly hard during the pandemic, with prevalence of symptoms of anxiety and depression rising dramatically, especially in late 2020 and early 2021 (OECD, 2021[21]).

Without effective treatment or support, mental health problems can have a devastating effect on people's lives. While there are complex social and cultural reasons affecting suicidal behaviours, suffering from a mental health problem also increases the risk of dying by suicide (OECD, 2021[19]). The rate of deaths by suicide varied nearly six-fold across OECD countries in 2019, with the lowest rates found in Turkey (4.4 per 100 000 population) and Greece (4.7 per 100 000). Between 2000 and 2019, deaths by suicide fell overall by 29% (Figure 3.21). The rate of death by suicide per 100 000 population fell or remained fairly stable in all but five OECD countries (Greece, Mexico, Portugal, the United States, Korea). In Lithuania and Korea, where suicide rates were the highest (21.6 per 100 000 in Lithuania, and 24.6 per 100 000 in Korea), the trend in suicide deaths was very different. In Korea, deaths by suicide increased by 46% between 2000 and 2019. In contrast, in Lithuania, deaths by suicide fell by 55% between 2000 and 2019. As in many neighbouring countries, suicide rates in Lithuania increased during the period of significant social and economic change following the fall of the Soviet Union, reaching a high of 51.0 deaths per 100 000 population in 1996. The Lithuanian Government is committed to bringing down suicide rates further through suicide prevention campaigns and mental health system strengthening (OECD/European Observatory on Health Systems and Policies, 2019[22]) To date, significant changes in the rate of deaths by suicide since the start of the COVID-19 crisis have not been observed in OECD countries.

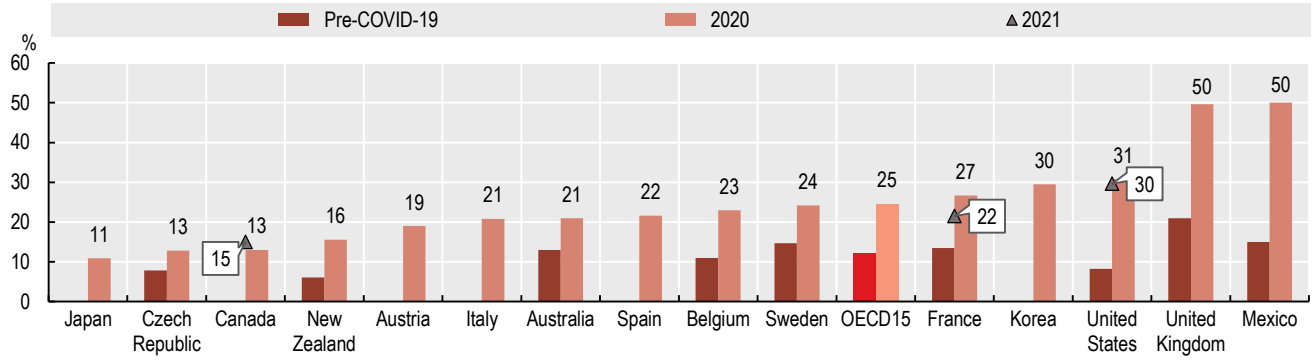
OECD countries have significantly stepped up their mental health support since the start of the COVID-19 crisis. Most countries have developed new mental health information and/or phone support lines giving tips on coping measures, and some countries have increased access to mental health services and/or mental health funding (OECD, 2021[20]). For example, Canada introduced Wellness Together Canada in April 2020, which offers no-cost wellness self-assessment and support and counselling by text or phone, while Australia doubled entitlement to reimbursed sessions of talking therapy. In 2021, Chile – which in 2018 spent just 2.1% of government health spending on mental health – announced that the budget for mental health would increase by 310% (OECD, 2021[19]). Despite the significant social and labour market impacts of mental ill health, mental health support remains weakly integrated into social welfare, labour and youth policies. In line with the OECD Recommendation on Integrated Mental Health, Skills and Work Policy, a whole-of-society approach to mental health is needed (OECD, 2015[23]).

Definition and comparability

The registration of suicide is a complex procedure, affected by factors such as how intent is ascertained; who is responsible for completing the death certificate; and cultural dimensions, including stigma. Caution is therefore needed when comparing rates between countries. Age-standardised mortality rates are based on numbers of deaths divided by the size of the corresponding population. The source is the WHO Mortality Database; suicides are classified as ICD-10 codes X60-X84 and Y870.

Figure 3.19 and Figure 3.20 use national data sources from multiple years, and may not be directly comparable across countries. The survey instruments used to measure depression and anxiety differ between countries, and therefore may not be directly comparable, and some surveys may have small sample sizes or not use nationally representative samples. Differences in the openness of populations to discussing their mental state also hampers cross-country comparability. Where possible, to measure prevalence of depression, surveys using the Patient Health Questionnaire (PHQ-9) instrument have been selected. Where possible, to measure anxiety surveys using the General Anxiety Disorder-7 (GAD-7) instrument have been selected. Data for the 'pre-COVID' year varies based on national data availability; the most recently available data was selected, up to the year 2019. For all national data sources, see OECD (2021[20]). Updated or further national data was used for Canada (Statistics Canada SCMH survey), and the United Kingdom (ONS Statistical Bulletin – Coronavirus and depression in adults, May 2021; ONS Statistical Bulletin – Personal and economic well-being in Great Britain: May 2020).

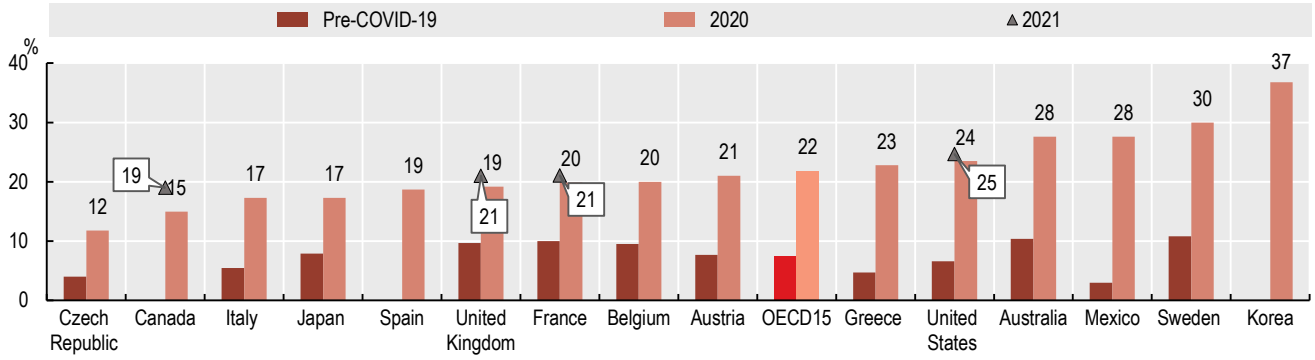
Figure 3.19. **National estimates of prevalence of anxiety or symptoms of anxiety, pre-COVID-19, 2020 and 2021**



Note: 2020 and 2021 data are from March/April 2020 and 2021 where possible. Survey instruments and population samples differ between countries and in some cases across years, which limits direct comparability.
Source: National data sources reported in OECD (2021[20])), "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 are included for Canada and the United Kingdom.

StatLink https://stat.link/9kunb6

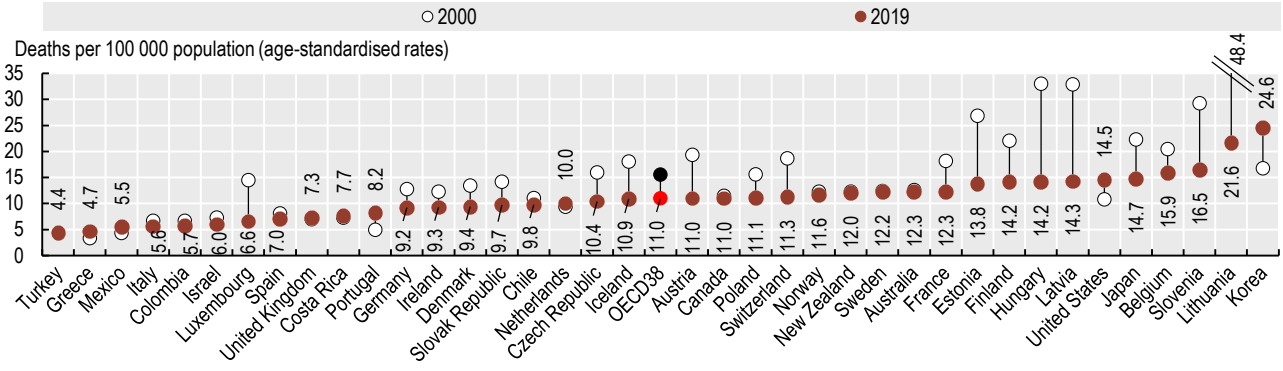
Figure 3.20. **National estimates of prevalence of depression or symptoms of depression, pre-COVID-19, 2020 and 2021**



Note: 2020 and 2021 data are from March/April 2020 and 2021 where possible. Survey instruments and population samples differ between countries and in some cases across years, which limits direct comparability.
Source: National data sources reported in OECD (2021[20])), "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 are included for Canada and the United Kingdom.

StatLink https://stat.link/mw2xro

Figure 3.21. **Death by suicide, 2000 and 2019 (or nearest year)**



Source: OECD Health Statistics 2021.

StatLink https://stat.link/32avy1