

OECD Health Policy Studies

# The Economic Case for Preventing Mental Ill Health





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# Foreword

Good mental health contributes to people's well-being, social inclusion and economic participation. Yet mental ill health affects more than one in five people across OECD and EU countries, making it one of the most significant public health and economic challenges today. Anxiety and depressive disorders account for most cases, particularly affecting young people, women and individuals with lower socio-economic status. Recent shocks such as the COVID-19 pandemic, geopolitical instability, economic crises and increasing climate-related stressors have intensified existing vulnerabilities and contributed to record levels of mental distress.

The consequences for health systems, economies and societies are substantial. Across the EU, major depressive disorders, generalised anxiety disorders and alcohol use disorders together are projected to reduce healthy life expectancy by 2.5 years during 2025-2050, and to account for health system costs equivalent to around 6% of total health expenditure. Mental ill health also reduces workforce participation and productivity, leading to projections of an estimated annual GDP loss of 1.7% over the period.

Focusing on targeted and scalable interventions in primary healthcare, schools and workplaces helps to narrow the significant gap in receiving support for mental ill health. Interventions such as psychological and behavioural therapies, mental health literacy, and digital support tools are estimated to improve quality of life, reduce healthcare expenditure and enhance productivity. Such interventions are cost-effective or even cost-saving, and several generate benefits that exceed the costs of implementation. However, effective interventions are necessary but not sufficient to fully address the challenges posed by mental ill health. Meaningful progress will require coverage of interventions to be expanded significantly by implementing best practices, consisting of evidence-based actions delivered at scale and supported by the governance, workforce and financing arrangements required for sustained implementation. This should also go hand in hand with stronger welfare interventions outside the health sector to address the root social and economic determinants that drive poor mental health.

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# Executive summary

## Mental ill health affects more than one in five people across OECD and EU countries

Mental health conditions are remarkably prevalent, with estimates indicating that slightly over 20% of individuals in OECD and EU countries experienced a mental disorder in 2023, resulting in one of the most significant public health and economic challenges. This figure is likely to underestimate the true scale of the problem, as many milder conditions go undiagnosed or remain unreported due to persistent social stigma and limitations within existing health systems. Among diagnosed cases, anxiety disorders are the most common, accounting for approximately 40% of all cases. These are followed by depressive disorders at 20% and substance use disorders – which include alcohol use disorders – at 17%. Other less prevalent disorders include severe conditions such as schizophrenia and bipolar disorders, as well as eating disorders, autism spectrum disorders and intellectual disabilities, which are not the focus of this publication.

Certain population groups are more affected than others. Women consistently report higher rates of anxiety and depression, while men more often experience substance and alcohol use disorders. In recent years, the increase in mental health conditions has been particularly evident among adolescents and young adults, with more than one in four individuals aged 15-24 currently experiencing a mental disorder. This is a cause for concern because when such conditions emerge early in life and remain untreated they often persist into adulthood, with lasting consequences for health and productivity.

## Multiple societal and environmental shocks are driving the trend in mental disorders

Mental ill health reflects a complex interplay of social, economic and environmental factors. The restrictions and social isolation imposed during the COVID-19 pandemic had a profound impact on well-being – particularly for children and adolescents. Beyond the pandemic, broader macroeconomic shocks and increasing economic disparity also contribute to worsening mental distress. Evidence from high-income countries suggests that rising income inequality is associated with approximately 19% higher rates of mental health problems across the population.

Environmental and geopolitical instability also play a critical role. Climate change anxiety has emerged as a significant concern for the younger generation, with 84% of young people globally reporting moderate to extreme worry about the future of the planet. Furthermore, recent wars and geopolitical conflicts have had an alarming effect on mental health, resulting in elevated rates of post-traumatic stress and generalised anxiety that can affect multiple generations. The problematic use of social media is another emerging driver – particularly among young people – and is linked to increased levels of depression, although its impact can be mediated by factors such as sleep quality and physical activity.

## Poor mental health imposes a significant burden on individuals, health systems and the economy

The impact of mental ill health extends far beyond the individual, creating substantial costs for health systems, society and the wider economy. OECD microsimulation work estimates that major depressive disorders, generalised anxiety disorders and alcohol use disorders will lead to a 2.5-year reduction in healthy life expectancy across the EU during 2025-2050. At the population level, this equates to approximately 28 000 premature deaths every year. While mental disorders primarily affect quality of life, severe cases of depression and alcohol use also contribute to increased fatality rates and a reduction in overall life expectancy.

The financial implications are equally stark. Mental health conditions are estimated to account for roughly EUR 76 billion in annual healthcare costs across the EU, which represents approximately 6% of total health budgets. A significant portion of these costs arises because mental disorders often exacerbate other physical health conditions, leading to more complex and expensive treatments. Furthermore, the impact on the labour market is profound, with poor mental health estimated to result in an average annual reduction in GDP of 1.7% during 2025-2050. This means that GDP forecasts for any year in the range would be 1.7% higher in the absence of mental ill health. This loss is primarily driven by decreased workforce participation, higher rates of absenteeism and “presenteeism”, where employees are physically present but unable to function at full productivity.

## Severe gaps in access to healthcare persist despite the widespread adoption of national mental health policies

Most OECD and EU countries have recognised the scale of the challenge and have implemented national mental health policies. Currently, 41 out of 43 surveyed countries have a formal policy in place, and 38 have developed specific implementation strategies. Efforts to integrate mental health into primary healthcare, schools and workplaces are becoming more common.

However, despite these policy frameworks, a massive treatment gap remains. Nearly two-thirds of individuals in the EU who require mental healthcare are estimated to face inadequate access to services. This stands in sharp contrast to the 3.8% of people who report unmet needs for general medical treatments. Beside persisting stigma, several barriers prevent individuals from receiving the help they need: many therapies require out-of-pocket payments; specialised services are harder to access in rural areas; and shortages of professionals result in long waiting times.

## Scaling up evidence-based interventions offers a cost-effective pathway to better health outcomes

This report identifies several highly effective interventions that can be delivered across primary care, school and workplace settings. Cognitive behavioural therapy remains a cornerstone of treatment and prevention, helping individuals reframe negative thinking patterns. Other successful approaches include mental health literacy programmes, mindfulness-based techniques and digital tools that provide remote support for mild to moderate symptoms.

OECD modelling demonstrates that scaling up these interventions in the EU between 2023 and 2050 would generate significant health and economic gains. Interventions in primary healthcare settings tend to be the most effective – particularly face-to-face psychotherapy. Most of these interventions are highly cost-effective, falling well below the threshold of EUR 50 000 per disability-adjusted life year gained. In many cases, the economic gains from improved workforce productivity and reduced healthcare spending would

exceed the costs of implementing the programmes. However, the current aggregate impact of these interventions remains modest because of limited coverage; for instance, even the most effective primary care intervention would only reduce mental health-related costs by 4% at current implementation levels.

## **Achieving a greater impact requires addressing the root causes of mental ill health and setting more ambitious coverage targets**

To address the burden of mental ill health effectively, health systems must move beyond isolated interventions and adopt a more systemic approach. This report outlines three priority areas for future policy action:

1. **Enhancing intervention design and implementation:** policymakers should focus on “best practice” designs that combine clinical services with destigmatisation campaigns and peer-based support to encourage help-seeking.
2. **Expanding coverage and investment:** more ambitious targets for service coverage are necessary to achieve meaningful population-level health improvements. Achieving universal access would require a 41% increase in mental health spending and a significant expansion of the professional workforce in the EU during 2025-2050.
3. **Tackling the root causes:** public health efforts must be complemented by social and economic policies that address the underlying drivers of mental distress. Strengthening social welfare systems and addressing economic insecurity and unemployment are critical steps, as countries with more generous social protections consistently report better mental health outcomes.

While the challenge of mental ill health is extensive, it is not insurmountable. By investing in cost-effective interventions and addressing the socio-economic factors that drive poor mental health, countries can improve the lives of millions and secure a more resilient and productive future.

# **1**

## **Bringing the evidence together: Findings on the economic case for preventing mental ill health**

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Mental ill health places a major burden across OECD and EU countries, with mild to moderate depressive symptoms affecting one in five adults. This chapter synthesises the key findings of the publication and highlights the policy implications derived from new OECD analyses of the health, social and economic impact of mental ill health. It outlines recent trends, presents the economic case for stronger investment in mental well-being, and reports the expected effectiveness, impact on health expenditure and value for money of six priority interventions.

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## Key findings

- Mental ill health affects a significant proportion of the population. According to modelled data, in 2023 slightly over one in five individuals in OECD and EU countries experienced a mental disorder. This figure is likely to be an underestimate, as milder conditions often remain undiagnosed or unreported. Among diagnosed cases, anxiety disorders are the most common (around 40%), followed by depressive disorders (around 20%), substance use disorders (17%) and other mental health conditions (24%).
- The prevalence of mental disorders is high and has been rising in certain population groups, such as children and young people. Across OECD countries, the rate of mental disorders has increased by nearly 21% over the past two decades. A notable acceleration occurred following the COVID-19 pandemic, potentially due to both increased incidence and improved reporting. Particularly affected groups include individuals aged 15-24, those with low socio-economic status and women, who are more likely to report depression and anxiety. Men, on the other hand, are more likely to report alcohol and substance use disorders.
- Multiple societal and environmental factors are driving this increase – particularly among young people. Available evidence suggests that the early pandemic restrictions, climate change anxiety (which affects 84% of young people globally), war, geopolitical instability and economic crises have all contributed to worsening mental health. Additionally, problematic social media use is emerging as a significant concern, especially among younger populations.
- Access to mental health services remains a major challenge. Despite the growing need, nearly two-thirds of individuals across EU countries who require mental healthcare are estimated to face inadequate access. This stands in stark contrast to the 3.8% of people reporting unmet needs for general medical examinations and treatment, highlighting a critical gap in mental health service provision.
- All these factors negatively affect mental health, placing a heavy burden on both individuals and the wider economy. For example, in the 27 countries in the EU alone, OECD microsimulation work estimates that over a 25-year horizon (2025-2050), major depressive disorders, generalised anxiety disorders and alcohol use disorders will result in:
  - a 2.5-year reduction in healthy life expectancy and a 3-month reduction in overall life expectancy, equivalent to approximately 28 000 premature deaths annually
  - additional healthcare costs of around EUR 76 billion per year, or 6% of total health budgets, comparable to the annual healthcare budget of Belgium – with about one-quarter of these costs stemming from mental disorders exacerbating other health conditions
  - an average annual GDP reduction of approximately 1.7%, primarily due to decreased workforce participation and productivity.
- In light of the significant impact of mental ill health, countries are stepping up efforts to address it. A survey by the OECD and the WHO Regional Office for Europe of 43 OECD and EU countries in 2023 showed that 41 had a national mental health policy and 38 also had an implementation strategy or action plan. Mental health interventions in primary healthcare (PHC), school and workplace settings, which are the focus of this publication, were relatively widespread: 35 out of 42 responding countries had implemented actions in PHC settings, 35 out of 39 in schools, and 27 out of 31 in workplaces.
- Evidence-based interventions to tackle depression and anxiety are available across these three settings. Cognitive behavioural therapy (CBT), which helps individuals reframe negative thinking patterns, is widely used for both prevention and treatment. Other effective approaches include mental health literacy programmes, psychological interventions, mindfulness-based techniques

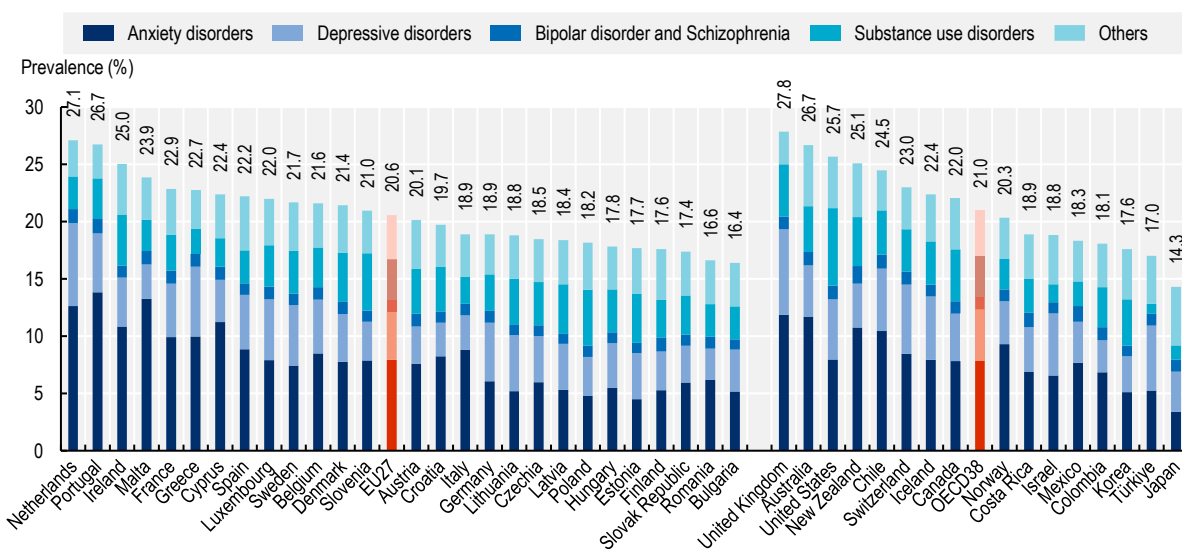
(such as meditation) and pharmaceutical treatments, which are typically delivered only in clinical settings.

- Drawing on this evidence, the OECD microsimulation model evaluated the impact of six scalable interventions. In PHC settings, these include a web-based programme for adults with mild to moderate depression or anxiety; group psychotherapy delivered by trained nurses for adults with depression; and combined psychotherapy and medication for severe depression cases not responding to treatment. Workplace interventions comprise an online programme for employees with mild to moderate symptoms and a universal CBT programme. Finally, the intervention in schools is a resilience-focussed CBT programme.
- If implemented in 2025 and sustained to 2050, these interventions are estimated to improve population health and quality of life, reduce healthcare expenditure, and enhance workforce productivity, thereby supporting economic growth. Interventions in PHC settings tend to be most effective, followed by school-based programmes. Face-to-face delivery generally outperforms online formats.
- Most of these interventions offer good value for money: they are cost-effective under a EUR 50 000 per disability-adjusted life year threshold and, in some cases, even cost-saving. The main exception is workplace CBT, which is not cost-effective in about two-thirds of countries, and is the only adult-focussed intervention where implementation costs exceed the GDP gains expected from improved workforce productivity.
- The potential of these interventions to have a positive impact on health, social and economic factors is good news. However, despite their benefits, the aggregate impact of the interventions remains modest relative to the overall burden of mental ill health. For example, the most effective intervention (a combination of psychotherapy and pharmacotherapy in PHC settings) would reduce mental health-related healthcare costs by only 4%, assuming that 10% of general practitioners (GPs) deliver it.
- These findings indicate that, to achieve a greater impact and address poor mental health, health systems need to go beyond implementing the interventions identified in the analysis. Efforts should concentrate on three key areas:
  - First, the design and implementation of interventions should be improved by focussing on best practice design. In particular, improving access to mental health services is more impactful when paired with complementary measures such as communication campaigns and peer-based programmes to destigmatise mental ill health.
  - Second, more ambitious coverage targets than those currently used for modelling the impact of interventions should be set. Expanding access to effective mental health services could deliver greater benefits at equal or better cost-effectiveness. However, such expansion would require careful upfront planning and substantial investment. For example, treating all individuals with mental disorders would demand a 41% increase in spending and a strengthened mental health workforce.
  - Third, the root and persistent causes of mental ill health must be addressed. Public health efforts should be complemented by policies tackling underlying drivers of mental ill health, such as economic insecurity and unemployment. For example, evidence shows that countries with more generous social welfare systems tend to have better mental health outcomes.

## The scale of mental ill health is a serious concern

Modelled data indicate that in 2023 slightly over one in five individuals across OECD countries were estimated to experience a mental disorder – about the same proportion as in the 27 countries in the EU (Figure 1.1). The most prevalent conditions are anxiety disorders, accounting for around 39% of all cases, and depressive disorders, accounting for around 20%. These are followed by substance use disorders – which include alcohol use disorders – at 17% of all cases, and a heterogeneous group of other disorders at 24% (Box 1.1). These estimates are generally considered conservative, partly due to underreporting linked to stigma and limitations within health systems. In fact, many individuals with mild to moderate conditions may go undiagnosed because they do not meet formal clinical criteria (Annunziata, Krupsky and Lee, 2023<sup>[1]</sup>). There is some variability in the estimated prevalence level of these mental disorders across OECD and EU countries, with the lowest proportions in Japan (14.3%), Bulgaria (16.4%) and Romania (16.6%), and the highest levels in the United Kingdom (27.8%) and the Netherlands (27.1%). However, when comparing cross-country differences, it is important to recognise that these patterns may also reflect other factors, such as variations in reporting – for example, driven by differing levels of stigma, as well as methodological differences – rather than true differences in underlying prevalence.

Figure 1.1. Estimates of prevalence of mental disorders in EU and OECD countries, 2023



Note: Prevalence data are presented cumulatively, which may overestimate total mental disorder prevalence because individuals with multiple conditions can be counted more than once. Conversely, underreporting – for example, driven by stigma and health system limitations – may lead to underestimation of single-condition prevalence. The data presented are modelled using a range of country-specific sources, which may limit the degree of cross-country comparability.

Source: IHME (2026<sup>[2]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

StatLink  <https://stat.link/d5lvao>

### Box 1.1. Understanding common mental disorders and their impacts

Mental disorders are a heterogeneous groups of diseases characterised by a clinically significant disturbance in an individual's cognition, emotional regulation or behaviour, and are typically associated with impairment in important areas of functioning (WHO, 2022<sup>[3]</sup>). Mental disorders can be occasional or long-lasting (i.e. chronic) and can affect someone's ability to relate to others and function each day.

This publication focusses only on the most common mental disorders that, taken together, account for approximately three-quarters of all mental health conditions across OECD countries:

- **Depressive disorders** are characterised by a depressed mood, such as feeling of sadness, irritability or emptiness, or by a loss of pleasure in activities (WHO, 2026<sup>[4]</sup>; APA, 2013<sup>[5]</sup>). Major depressive disorders are the most common subtype of depressive disorders (Li et al., 2023<sup>[6]</sup>). It is characterised as an episodic mood disorder, involving the experience of one or more major depressive episodes, which is either a depressed mood or loss of interest/pleasure, for most of every day, for at least two weeks. Major depressive disorders vary across levels of severity, ranging from mild through moderate to severe.
- **Anxiety disorders** are characterised by excessive fear, anxiety and associated behaviours. This disorder spectrum covers separation anxiety disorders, selective mutism, specific phobias, social anxiety disorders, panic disorders, agoraphobia and generalised anxiety disorders (APA, 2013<sup>[5]</sup>). Generalised anxiety disorders are among the most common. These are characterised by persistent and excessive worry about a number of domains in a person's life, which is present for at least six months and causes significant distress and/or impairment in an individual's functioning (Spitzer et al., 2006<sup>[7]</sup>; Mortazavi et al., 2014<sup>[8]</sup>).
- **Substance use disorders** are characterised by a cluster of cognitive, behavioural and physiological symptoms. These symptoms include the individual persisting in using the substance despite adverse consequences (APA, 2013<sup>[5]</sup>). Alcohol use disorders are a type of substance use disorder defined by an inability to control alcohol consumption, compulsive drinking behaviour and a negative emotional state during periods of abstinence. Drug use disorders are also a type of substance use disorder. Ten separate classes of drugs come under this umbrella – including, for example, cannabis, hallucinogens and opioids.

Other less prevalent disorders include severe disorders such as schizophrenia and bipolar disorders, as well as eating disorders and intellectual disabilities, among others. In addition, the landscape of mental health conditions includes neurodevelopmental disorders such as autism spectrum disorders and attention deficit hyperactivity disorders.

Research suggests that mental ill health has been increasing in recent decades (ten Have et al., 2023<sup>[9]</sup>; Richter et al., 2019<sup>[10]</sup>). Some countries saw an increase in prevalence of mental disorders between 2006 and 2019, and most, if not all, saw even greater increases during the COVID-19 pandemic, when prevalence of anxiety and depression peaked. For example, according to modelled data, average prevalence of mental disorders in EU countries increased by 21.1% – from 17.0% in 1990 to 20.6% in 2023. Young people (OECD, 2026<sup>[11]</sup>), adult women and older adults (Eurofound, 2025<sup>[12]</sup>) are among the population groups for which the increase has been most noticeable. While identifying high-quality data using standard measures remains challenging, data from non-EU countries show a similar picture. Recent data from the United Kingdom and the United States indicate an overall upward trend over time, peaking during COVID-19, followed by a partial recovery to levels higher than before the pandemic (NHS, 2025<sup>[13]</sup>; Saad, 2025<sup>[14]</sup>). Various shocks and factors – such as the impact of COVID-19, climate change, war, conflict, political unrest and economic stressors – are considered to have negatively affected mental health

in recent years. Other research argues, however, that mental ill health may have remained constant over this period, and that the rise in prevalence is a result of demographic changes and increased reporting of mental ill health due to increased mental health literacy, reduced stigma and other factors that have led to more accurate diagnosis and reporting – particularly of mild and moderate cases (Richter et al., 2019<sup>[10]</sup>; Baxter et al., 2014<sup>[15]</sup>).

### ***Women, young people and people with lower socio-economic status are at higher risk of mental disorders***

Well-documented evidence shows that not everyone in the population has the same risk of developing mental disorders, and that certain groups are at higher risk. Consistent with results previously identified in the literature, the findings from OECD analyses of data from the Institute for Health Metrics and Evaluation (IHME) identify the following patterns of inequalities:

- Women exhibit higher rates of depression and anxiety than men, while men have higher rates of alcohol use and substance use disorders (Vargas Lopes and Llana-Nozal, 2025<sup>[16]</sup>). The factors driving these gender differences are complex; they involve both biological elements, such as genetics and hormonal changes, and social elements, such as higher rates of sexual and domestic violence and societal norms (Farhane-Medina et al., 2022<sup>[17]</sup>). Additionally, interview techniques and self-reporting instruments may underdetect depressive symptoms in men, and women are more likely to seek help and report their symptoms, contributing to the observed disparities in mental health (Addis, 2008<sup>[18]</sup>; Kuehner, 2003<sup>[19]</sup>).
- Over one in four adolescents and young adults (aged 15-24) experience a mental disorder; prevalence declines consistently after this age, except for a slight increase among those aged 95 and above – particularly men. Mental disorders starting before the age of 24 are more likely to persist into adulthood, if untreated, with life-long consequences. Accumulated adversities across the life course increase the risk of mental ill health. The accumulation of multiple adverse events has an additive and interactive effect, increasing the risk of mental disorder onset.

Recent OECD analyses of data from the European Health Interview Survey confirm previous evidence identifying income and education level as consistent predictors of mental ill health (Eurostat, 2019<sup>[20]</sup>; Eurostat, 2019<sup>[21]</sup>). Socio-economic status disparities are more pronounced among men: those in the lowest income quintile are 5.3 times more likely to report depressive symptoms than their peers in the highest quintile (compared to a 3.7 times greater likelihood among women). Disparities by education level are smaller, and are more significant among women; women in the lowest education quintile are 3.3 times more likely to report depressive symptoms than their peers in the highest quintile (compared to 2.3 greater likelihood among men).

### ***Several causes may lie behind the high burden of mental ill health***

A rapid literature review undertaken for this publication identified several social, economic, environmental and lifestyle factors contributing to the observed trends. In some cases – such as recent conflicts and events – evidence is provided by ad hoc studies, although this may not yet be fully reflected in the available population-level statistics, which do not cover the most recent period. Overall, the evidence points to a worsening situation, with a peak during the COVID-19 pandemic, and several factors probably contributing to a continued rise in prevalence of mental disorders over time, although the evidence on long-term trends in adult mental ill health prevalence remains unclear.

- The COVID-19 **pandemic** triggered anxiety and stress as a major public health crisis, and measures to contain the virus also had a significant impact on mental health (OECD, 2023<sup>[22]</sup>; Holmes et al., 2020<sup>[23]</sup>). Limitations on mobility and other measures had an impact on social lives, economic security and housing stability, significantly affecting quality of life and mental health

(OECD, 2021<sup>[24]</sup>; OECD, 2021<sup>[25]</sup>). This led to an increase in mental disorders following the onset of the pandemic. At the time of writing, it is still too early to determine whether levels of mental ill health have returned to their pre-pandemic state. Different analyses offer contrasting perspectives: while some evidence indicates some degree of recovery to pre-pandemic levels, at least in Europe, other research – including OECD analyses presented in Chapter 2 – suggests lingering effects, especially among children and adolescents (Ahmed et al., 2023<sup>[26]</sup>; Kiviruusu et al., 2024<sup>[27]</sup>; Ma, Yao and Hao, 2022<sup>[28]</sup>).

- **Economic crises** have consistently been associated with a rise in mental health issues. Emerging evidence suggests that recent macroeconomic shocks – such as the economic downturn triggered by the COVID-19 pandemic and its impact on unemployment (Lordan and Stringer, 2022<sup>[29]</sup>; Simonse et al., 2022<sup>[30]</sup>), as well as the 2022 inflation surge in OECD countries affecting individuals on low incomes (Causa et al., 2022<sup>[31]</sup>) – have contributed to higher rates of mental ill health, especially among vulnerable groups. A meta-analysis of 26 studies from high-income countries revealed that rising income inequality is associated with approximately 19% higher rates of mental health problems across the population, with more pronounced effects on women and low-income groups (Patel et al., 2018<sup>[32]</sup>). Income and wealth inequality have been increasing since the 1980s; these trends are likely to contribute to the ongoing rise in mental health issues (Guschanski and Onaran, 2021<sup>[33]</sup>; Bourquin, Brewer and Wernham, 2024<sup>[34]</sup>).
- **Housing quality, affordability and stability** are recognised as important determinants of mental health: inadequate or insecure housing is linked to heightened stress, anxiety and depressive symptoms – particularly among vulnerable groups (The Lancet Public Health, 2025<sup>[35]</sup>). Beyond the home itself, features of the surrounding built environment – such as access to green spaces and safe public areas – also support lower stress and improved well-being (Xian et al., 2024<sup>[36]</sup>). Higher levels of social cohesion and opportunities for social participation further strengthen these patterns by helping to protect against loneliness and isolation, which are both strongly associated with poor mental health. In particular, robust social support and larger social networks reduce the risk of depression and anxiety, whereas loneliness is predictive of more severe symptoms over time (Bogar, 2016<sup>[37]</sup>).
- **Extreme weather events**, such as flooding and heatwaves, along with anticipated future risks, have been linked to rising levels of mental ill health, ranging from elevated stress to severe mental conditions. Children are particularly at risk: a global survey revealed that 84% of young people are moderately or extremely worried about climate change, and over 45% report negative impacts on their daily lives (Hickman et al., 2021<sup>[38]</sup>). Vulnerable populations are also at high risk of trauma caused by extreme weather events and the chronic stress of climate uncertainty. For instance, migration, driven by the loss of habitable land, exacerbates these issues, leading to grief, anxiety and loss of identity (Kanthee et al., 2024<sup>[39]</sup>). The impact of extreme weather events on population mental health is likely to worsen if these events become more frequent.
- **War, conflict and geopolitical unrest** are strongly linked to increased rates of mental ill health, including generalised anxiety disorders, depression and post-traumatic stress. Recent conflicts in Ukraine, the Middle East and beyond have exacerbated these issues, with impacts on both the regions directly affected and others (Charlson, van Ommeren and Flaxman, 2019<sup>[40]</sup>; Carpiello, 2023<sup>[41]</sup>). Studies confirm that exposure to war has a scarring effect on mental health, affecting individuals over their lifetime – including professional combatants and civilians. Children and adolescents are particularly vulnerable, with exposure to war significantly increasing their risk of developing mental disorders (Akbulut-Yuksel, Zimmer and Pandey, 2024<sup>[42]</sup>). Evidence also suggests that wartime events create long-term effects and intergenerational trauma, potentially affecting mental health for decades. Consequently, the mental health impacts of war and conflict are vast and far-reaching, extending beyond wartime into subsequent generations.

- **Problematic use of social media** is increasingly a cause for concern regarding its impact on mental health – particularly among children and adolescents. A meta-analysis of 143 studies identified a small but significant correlation between higher social media use and elevated levels of anxiety and depression (Fassi et al., 2024<sup>[43]</sup>). However, the evidence is not conclusive – for example, some longitudinal studies have not found a significant link (Coyne et al., 2020<sup>[44]</sup>). In parallel, recent legal action in the United States found major platforms liable for harms linked to addictive design features, setting an important precedent (Taylor, 2026<sup>[45]</sup>). Other research suggests that negative effects may be the result of factors such as poor sleep, lack of physical activity, online harassment, low self-esteem and poor body image, all of which may be exacerbated by social media use (Viner et al., 2019<sup>[46]</sup>; Kelly et al., 2019<sup>[47]</sup>). On the positive side, social media was also found to foster a sense of community (Ulvi et al., 2022<sup>[48]</sup>).

### ***Suboptimal access to mental healthcare services contributes to the high burden of mental ill health***

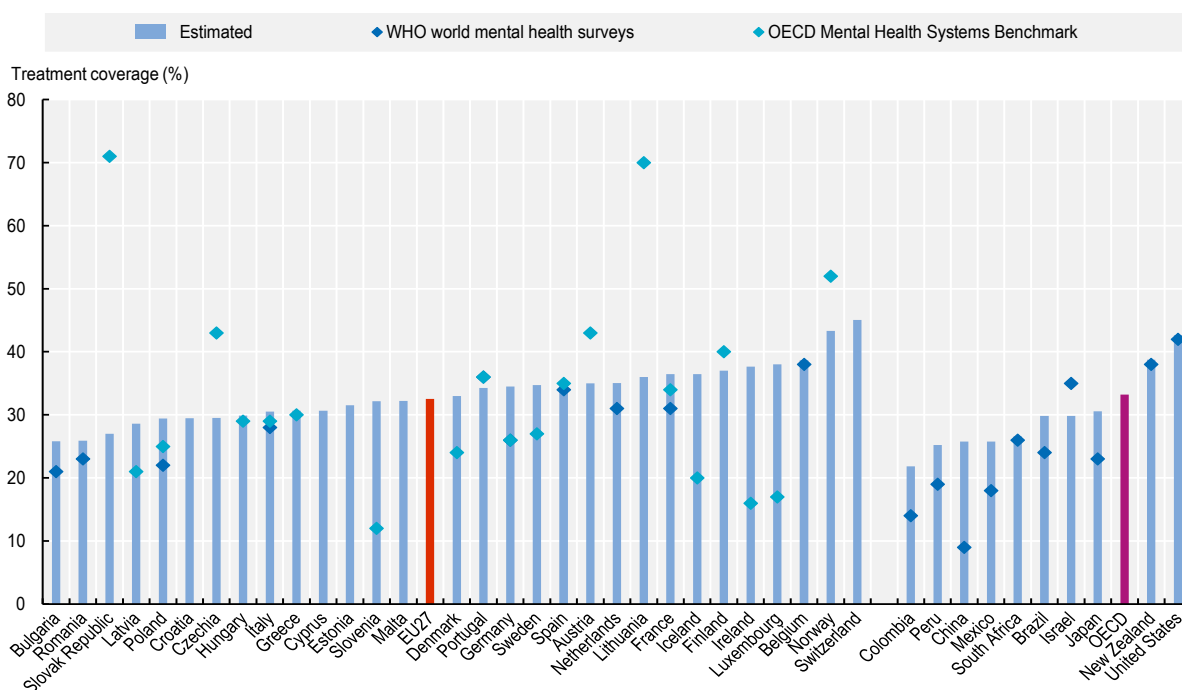
An additional important pattern contributing to the increasing burden of mental ill health is the suboptimal access to healthcare services for those in need. Many countries have attempted to improve access to mental health services in recent years, shifting the focus from hospitals to community and other non-medical settings. Despite these efforts, however, a substantial proportion of individuals with mental ill health still report significant unmet healthcare needs for their condition.

For example, 67.5% of individuals needing mental healthcare in EU countries are estimated not to have access to treatment (Figure 1.2). While potential caveats regarding the comparability of the underlying measures should be acknowledged, this proportion nevertheless appears to be almost 18 times higher than the share of unmet needs for medical examinations and treatment across the same group of countries. According to recent Eurostat estimates based on self-reported data from the EU statistics on income and living conditions (EU-SILC) survey for 2024, 3.8% of people aged 16 and over in the EU reported an unmet need for a medical examination or treatment. The two most frequently cited reasons were waiting lists, which accounted for 37% of cases, followed by high costs, representing around 26% (Eurostat, 2025<sup>[49]</sup>).

Understanding the extent of unmet mental health needs is challenging owing to inconsistent data definitions. Without a standardised and uniformly adopted definition, this publication approximates the treatment gap using two complementary sources:

- Previous OECD work (OECD, 2021<sup>[50]</sup>) investigated unmet needs for mental healthcare due to financial reasons, waiting times or transport availability. Based on that analysis, this publication calculates rates of access to mental health services as 100% minus the proportion of individuals identified as having unmet needs.
- Treatment coverage was identified by the World Mental Health survey of the World Health Organization (WHO) (Evans-Lacko et al., 2018<sup>[51]</sup>), which asked respondents whether they had sought professional help for emotional, mental health, nerve or substance use disorders, and whether they had received treatment within the past 12 months.

Figure 1.2. Treatment coverage for mental ill health across OECD and EU countries



Note: Extrapolation for countries lacking data was performed using an ensemble model based on a lasso regressor, incorporating the following country-specific indicators: suicide rates, depression rates, world happiness index, number of mental health professionals, universal healthcare service coverage index and GDP. Extrapolated data should only be considered as a high-level indicator of the possible coverage of services for mental ill health.

Source: OECD Mental Health Systems Performance Benchmark survey (OECD, 2021<sup>[50]</sup>), WHO World Mental Health survey (Evans-Lacko et al., 2018<sup>[51]</sup>).

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Although the two surveys examine slightly different issues and cover marginally different mental disorders, comparing data from both sources for countries included in both analyses suggests very similar conclusions, as shown in Figure 1.2. After excluding a few countries with outlying results (such as Lithuania and the Slovak Republic) in one of the two datasets, the analysis supports broad comparability of data.

Various barriers contribute to unmet mental health needs, including financial, geographical and organisational obstacles (OECD, 2021<sup>[50]</sup>). Mental health services – especially psychological interventions – may not be covered by health insurance or public health coverage, requiring individuals to pay out of pocket. This financial burden is a significant barrier, particularly for those on low incomes. Geographical barriers also play a role, as individuals in rural areas are less likely to receive treatment than those in urban areas. Organisational barriers, such as a shortage of healthcare professionals, further hinder access as they lead to long waiting times and scarcity of available services; this can result in increased hospitalisations and higher risks of disability and suicide. Administrative requirements, like referrals from GPs, are often necessary for specialised care, and poor co-ordination is also likely to result in longer waiting times. In several OECD countries, waiting-time targets or guarantees have been established for at least one area of mental healthcare, with most aiming to start treatment or make the first service contact within 1-3 months.

## Mental ill health places a significant burden on health, quality of life and the broader economy

Mental ill health places a heavy burden on people and the economy. Beyond the direct health and well-being impacts on individuals, poor mental health also causes significant costs on the economy through reduced employment, lower productivity and a range of other factors that impede economic growth. To assess the health and economic impacts of mental ill health for depressive disorders, anxiety disorders and alcohol use disorders, the OECD used its Strategic Public Health Planning for Non-Communicable Diseases (SPHeP-NCDs) microsimulation model, enhanced with a dedicated mental health module (Box 1.2). This analysis focusses on 30 EU and European Free Trade Association countries; however, findings from the cost-effectiveness assessment and subsequent discussions also provide evidence and insights that are broadly applicable across all OECD countries.

### Box 1.2. The OECD Strategic Public Health Planning for Non-Communicable Diseases model

The OECD SPHeP-NCDs model is an advanced systems modelling tool for public health policy and strategic planning. It is used to predict the health and economic outcomes of the population of a country or a region up to 2050. The model uses a comprehensive set of key behavioural and physiological risk factors and their associated non-communicable diseases, including mental ill health. For the analyses of mental health, the model covers 30 countries: the 27 EU Member States, Iceland, Norway and Switzerland. Results also include averages for the 27 EU countries.

For each modelled country, the model uses demographic and risk factor characteristics by age and gender-specific population groups from international databases. These inputs are used to generate synthetic populations, in which each individual is assigned a profile with a certain risk of developing a disease each year. Incidence and prevalence of diseases in a specific country's population are calibrated to match estimates from international datasets.

The model produces yearly cross-sectional representations of the population that can be used to calculate health status indicators such as life expectancy, premature deaths (including as a result of suicide), disease prevalence and disability-adjusted life years using disability weights. Healthcare costs of disease treatment are estimated based on a per case annual cost, which is extrapolated from national health-related expenditure data. The additional cost of multimorbidity, which is an important factor in the case of mental disorders, and the extra cost of end-of-life care are also considered. The labour market module uses relative risks relating disease status to absenteeism, presenteeism (where sick individuals, even if physically present at work, are not fully productive), early retirement and employment. These changes in employment and productivity are estimated as numbers of full-time equivalent workers and, with other parameters, contribute to calculating the impact on GDP by applying a Cobb-Douglas production function.

The model includes three leading mental health diseases: major depressive disorders (including three different levels of severity: mild, moderate and severe), generalised anxiety disorders (including three different levels of severity: mild, moderate and severe) and alcohol use disorders. Although these mental disorders represent over 72% of the total prevalence of mental health conditions across the 30 countries, the model's results should be viewed as conservative since 28% of conditions remain excluded, and the model does not account for upstream determinants of mental health such as well-being and resilience. In addition, the model does not capture the burden suffered by people exposed to individuals with mental disorders, such as family and friends.

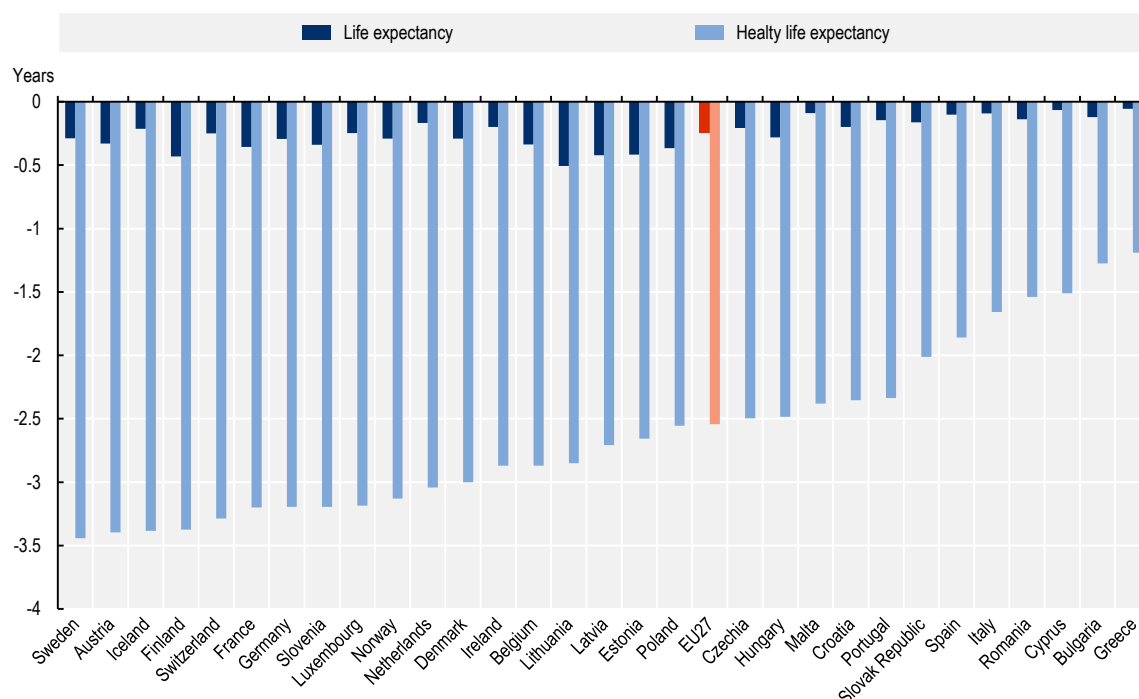
Mental disorders are modelled via specific modules created for each disease. Major depressive disorders and generalised anxiety disorders are modelled through the distribution of two international scales used for diagnosis: the 8-item Patient Health Questionnaire (PHQ-8) for major depressive disorders and the 7-item Generalised Anxiety Disorder (GAD-7) questionnaire for generalised anxiety disorders. Alcohol use disorders are modelled according to the pattern and volume of alcohol consumption, with higher consumption corresponding to a higher risk of developing the condition. All modules are calibrated to match prevalence data for the simulated diseases.

For more information on the OECD SPHeP-NCDs model, see the SPHeP-NCDs Technical Documentation, available at: <http://oecdpublichealthexplorer.org/ncd-doc>.

### **Depression, anxiety and alcohol use disorders reduce healthy life expectancy by an average of 2.5 years across EU countries**

Unlike other non-communicable diseases (NCDs) such as cancer and cardiovascular diseases, mental disorders like major depressive disorders, generalised anxiety disorders and alcohol use disorders primarily affect quality of life rather than life expectancy. According to modelled data, mental ill health will reduce healthy life expectancy – which takes into account time spent in ill health – by an average of 2.5 years across EU countries over the period 2025-2050 (Figure 1.3). Approximately half of this reduction is due to major depressive disorders; generalised anxiety disorders contribute 36% and alcohol use disorders 15% of the burden. The overall reduction in life expectancy is about 0.25 years – roughly 3 months. Evidence indicates that only major depressive disorders (65% of the reduction in life expectancy) and alcohol use disorders (35%) increase patient fatality rates.

**Figure 1.3. The impact of depression, anxiety and alcohol use disorders on healthy life expectancy and life expectancy**



Source: OECD analyses using the SPHeP-NCD model.

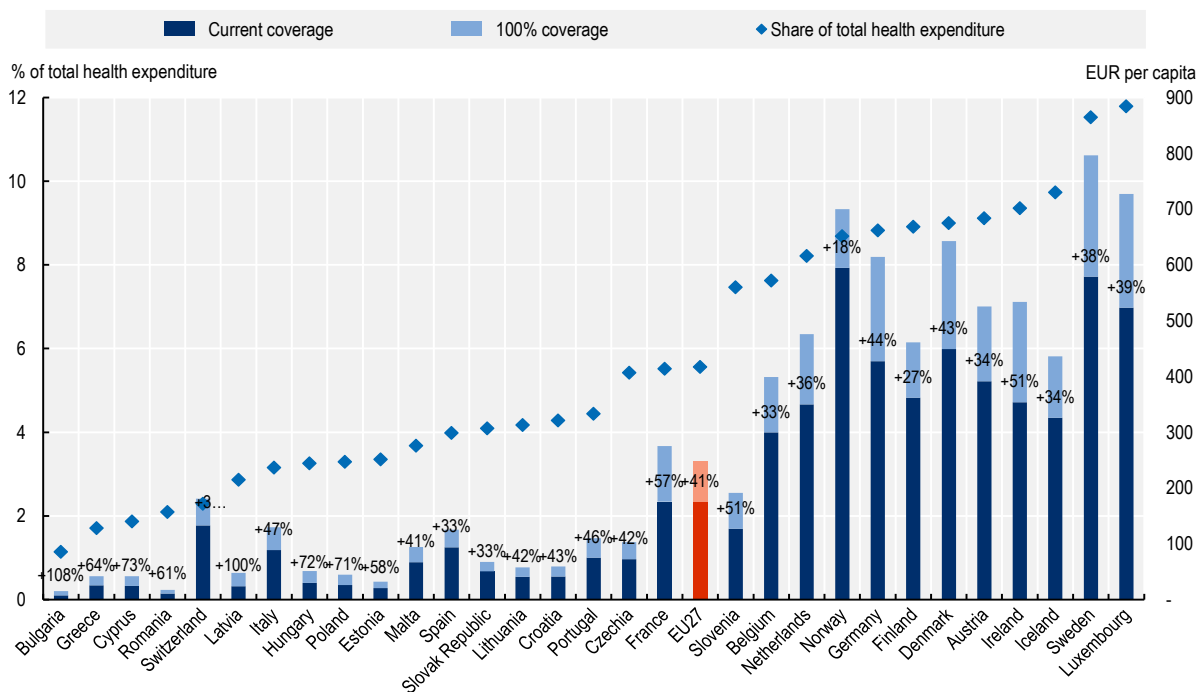
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While a 3-month reduction in life expectancy may seem a minor detrimental impact, it should be noted that this value is calculated at the population level; it equates to nearly 783 000 premature deaths (among people aged under 75) in EU countries between 2025 and 2050, or around 28 000 premature deaths per year (equivalent to 9 per 100 000 people). The highest reductions are found in Lithuania, Estonia and Latvia, each with a reduction in life expectancy of over 5 months. Conversely, Malta, Cyprus and Greece show the smallest reductions – each lower than 1 month.

**Mental disorders are estimated to account for 6% of total health expenditure in EU countries**

In a business-as-usual scenario where major depressive disorders, generalised anxiety disorders and alcohol use disorders maintain current age-specific prevalence and treatment levels, mental ill health is estimated to cost EUR 76 billion per year in EU countries from 2025 to 2050. This is comparable to the annual healthcare budget of Belgium (Eurostat, 2023<sup>[52]</sup>), and is equivalent to about a 6% share of total healthcare spending across EU countries (Figure 1.4). The estimate for EU countries is broadly comparable to what the literature suggests for other OECD countries such as Canada (Milliken et al., 2024<sup>[53]</sup>) and the United States (SAMHSA, 2014<sup>[54]</sup>).

**Figure 1.4. Impact on mental-health-specific health expenditure, assuming a hypothetical scenario with 100% treatment coverage, per year, average over 2025-2050, including percentage change from current levels**



Note: The light blue segment of each bar represents the additional costs countries would incur if mental health service coverage were expanded to reach all individuals in need (i.e. 100% coverage). This increase in healthcare spending is shown as a percentage relative to the current, business-as-usual scenario. For example, achieving full coverage would require a 41% increase in mental health expenditure across EU countries. It is important to note that the share of total healthcare expenditure shown refers only to the current level of coverage.

Source: OECD analyses using the SPHeP-NCD model.

Treating major depressive disorders, generalised anxiety disorders and alcohol use disorders represents the bulk of direct costs, but a substantial proportion of overall expenditure also stems from the adverse impact of mental ill health on other physical health conditions (or the cost of mental disorders as comorbidities) (Cortaredona and Ventelou, 2017<sup>[55]</sup>). Model outputs indicate that approximately 75% (EUR 131 per capita per year) of total mental healthcare expenditure in EU countries goes on treating mental disorders, while the remaining 25% (EUR 45 per capita per year) goes on the extra costs of mental disorders as comorbidities.

Treating all people with these three mental disorders would increase mental healthcare costs by 41% compared to current levels of expenditure. As discussed above, it is estimated that only 31% of those in need are currently receiving treatment in EU countries. The OECD SPHeP-NCD model was therefore used to estimate the costs of achieving full treatment coverage. While this remains a theoretical goal, as practical constraints currently prevent countries from achieving full coverage, this analysis is useful in highlighting the financing gap for mental disorders, and can be used for resource mobilisation and planning. The analysis suggests that to achieve full coverage, an additional 67% of patients – mainly with mild to moderate mental disorders – would need to be treated, at a cost increase of EUR 72 per capita per year, bringing the total mental health expenditure for major depressive disorders, generalised anxiety disorders and alcohol use disorders to EUR 247 per capita per year across EU countries. Countries with lower current coverage, such as Bulgaria and Latvia, would need to more than double their mental health expenditure to achieve full coverage (Figure 1.4).

### ***Mental ill health has a negative impact on workforce productivity and the economy due to absenteeism, presenteeism, unemployment and early retirement***

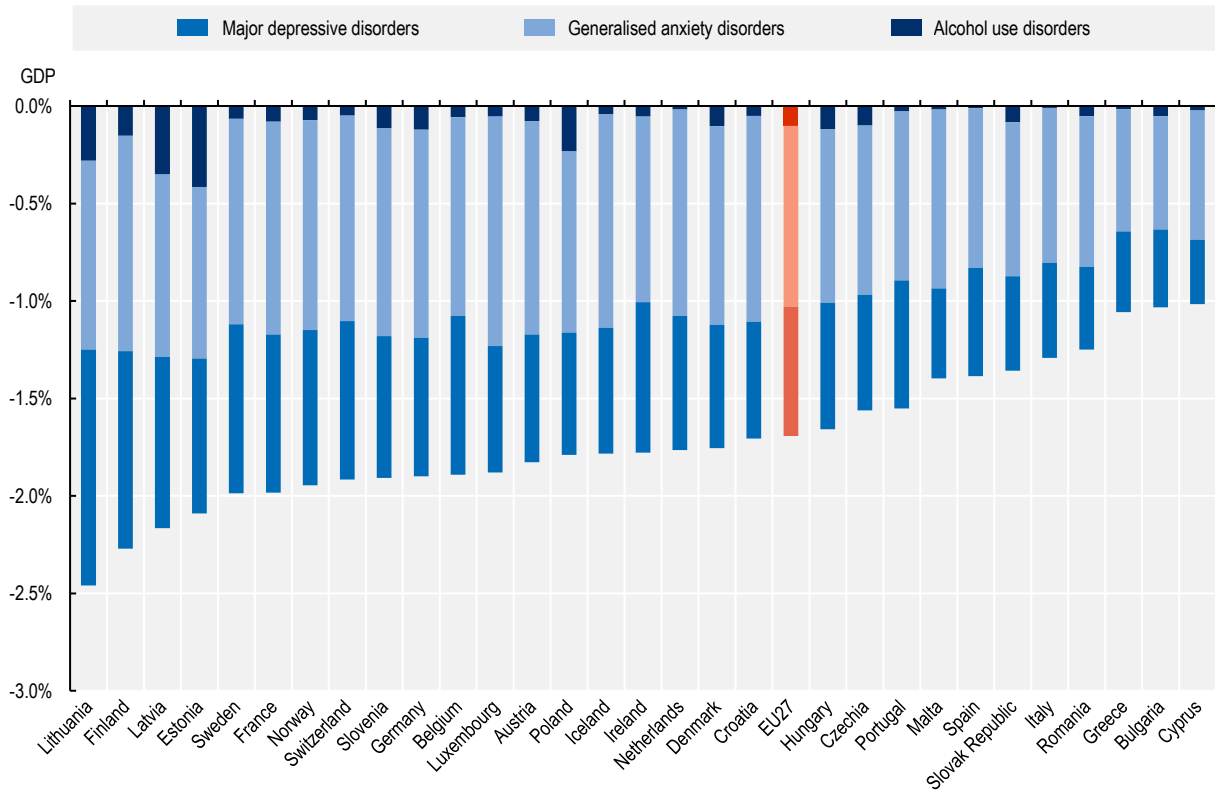
Mental ill health also creates broader economic costs through its detrimental impacts on workforce productivity and human capital. People with mental disorders are less likely to be employed; if they have a job, they are more likely to be absent from work or less productive than if they were in good health (also known as presenteeism), and to retire before the usual retirement age (OECD, 2021<sup>[56]</sup>). The cumulative impact of mental ill health due to major depressive disorders, generalised anxiety disorders and alcohol use disorders on all these factors and their consequent reduction in human capital has been calculated by the OECD SPHeP-NCDs model to represent almost 2.4 million workers per year, expressed in full-time equivalent workers. The model estimates that, across EU countries, the costs of mental ill health to the labour market are:

- overwhelmingly driven by a reduced employment rate (48% of the reduction in full-time equivalent workers), followed by presenteeism (36%) and absenteeism (14%), while early retirement seems to account for a tiny fraction of the whole burden, corresponding to 3% of the total
- caused primarily by generalised anxiety disorders (56%), followed by major depressive disorders (39%) and alcohol use disorders (5%).

The reduction in human capital and productivity has direct consequences for the economy (Figure 1.5). Outputs from the OECD SPHeP-NCD model were fed into the Long-Term Growth Model of the World Bank to calculate the impact of mental ill health on GDP. The resulting analysis suggests that in the business-as-usual scenario, the GDP of EU countries would be depressed by an average of 1.7% compared to a situation with no mental ill health, ranging from around 1.0% in countries including Bulgaria and Cyprus to 2.5% in Lithuania. This finding aligns with earlier OECD research indicating that, in 2015, reduced workforce productivity across the EU represented approximately 1.6% of GDP, out of an estimated total mental health cost of around 4% (OECD/European Union, 2018<sup>[57]</sup>).<sup>1</sup> Studies from other OECD countries outside the EU, such as Australia (Beyond Blue and PwC, 2014<sup>[58]</sup>) and the United States (Abramson, Boerma and Tsyvinski, 2024<sup>[59]</sup>), indicate a comparable impact of mental ill health, once methodological differences and underlying assumptions are taken into account.

**Figure 1.5. The impact of depression, anxiety and alcohol use disorders on the GDP of EU countries**

Average annual impact as a share of GDP due to major depressive disorders, generalised anxiety disorders and alcohol use disorders, 2025-2050



Source: OECD analyses using the SPHeP-NCD model and the World Bank Long-Term Growth Model.

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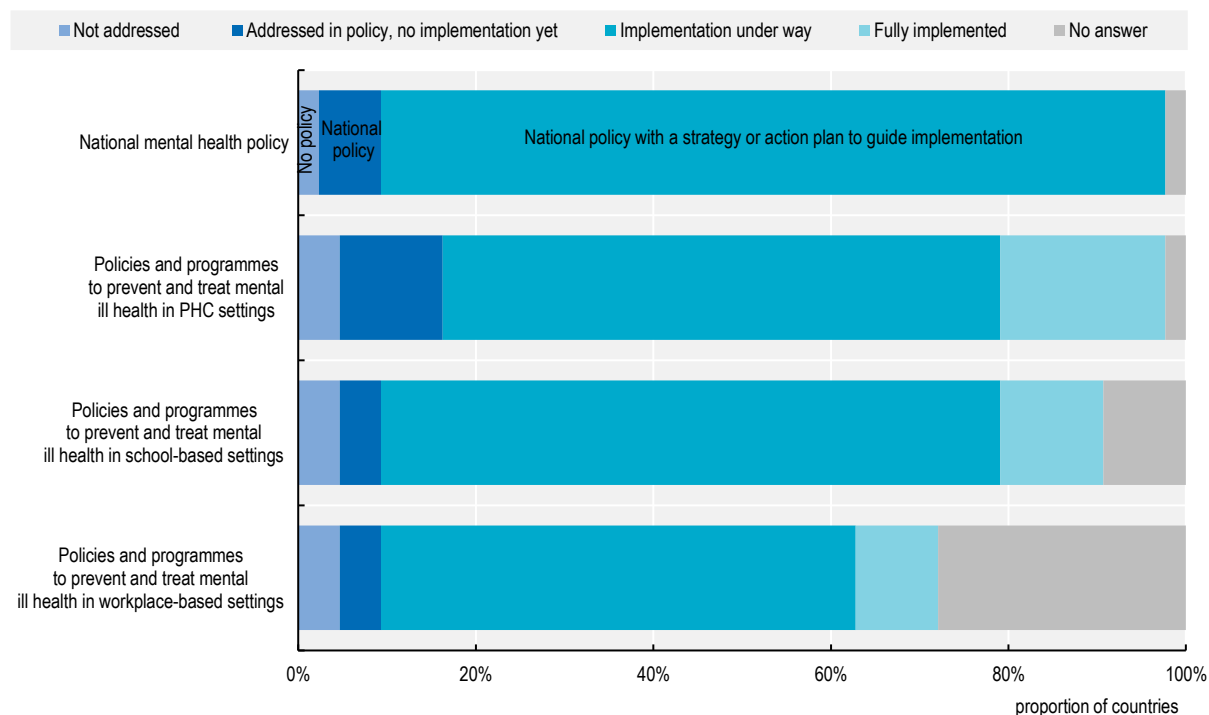
## Policies and strategies are in place to improve mental health across OECD countries, with a focus on schools, workplaces and primary care settings

Given the extensive and growing impact of mental disorders on population health and the economy, the need for policies to improve mental well-being is evident. Significant development and implementation of international strategies and action plans have occurred to support increased investment in mental health policies. In 2015, 38 OECD countries endorsed the Council's Recommendation on Integrated Mental Health, Skills and Work Policy (OECD, 2015<sup>[60]</sup>), which provides guidelines to address the effects of mental ill health on health, education, employment and social outcomes. Similarly, the WHO's Comprehensive Mental Health Action Plan 2013-2030 outlines objectives to guide international health systems and leaders in addressing mental ill health through policy (WHO, 2021<sup>[61]</sup>).


At the national level, governments in OECD and EU countries have placed an increased focus on mental health policy. This has been reflected in a substantial number of countries developing and implementing national strategies and action plans on mental health. In 2023, the OECD and the WHO Regional Office for Europe, with support from the European Commission's Directorate-General for Health and Food Safety, carried out a survey on mental health system capacity across EU countries, Iceland and Norway (WHO Regional Office for Europe, 2024<sup>[62]</sup>). The OECD thereafter extended the survey to all OECD Member

countries (referred to in this report as the WHO/OECD Mental Health Survey). According to the survey, 41 of 43 (95%) national governments across OECD and EU countries reported that they had a national mental health policy in place and, in the vast majority of cases (88% of countries), that they also had a strategy or action plan in place to guide the implementation of the national mental health policy (Figure 1.6).

**Figure 1.6. Policies to improve mental well-being across 43 OECD and EU countries**



Source: WHO/OECD Mental Health Survey.

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### ***Proven evidence-based policies are in place to improve mental well-being and managing mental disorders***

At the patient level, national policies have led to implementation of a diverse range of interventions. These vary in terms of place of implementation (such as in PHC settings), intervention mechanisms (for example, psychological or pharmacological), delivery mode (including face-to-face and phone-based delivery) and intended outcomes (whether prevention or treatment). In terms of place of implementation, this report specifically focusses on interventions implemented in schools, workplaces and PHC settings. Emphasis is also placed on actions to prevent major depressive disorders and generalised anxiety disorders, although some interventions may also include some therapeutic component. The final criteria for selecting interventions were based on country priorities – in particular, availability of evidence, as evidence was often scarce, and it proved difficult to model many promising policies due to the lack of necessary quantitative inputs. At the same time, it is important to recognise that countries also implement other types of interventions beyond those selected for this analysis. These include, for example, parenting programmes and suicide prevention programmes, some of which are examined in the OECD publication on best practices in public health for mental health promotion and prevention (OECD, 2025<sup>[63]</sup>).

As shown in Figure 1.6, the vast majority of OECD and EU countries surveyed in 2023 were implementing mental health interventions in PHC settings: 8 of the 42 responding countries had fully implemented such

interventions; 27 were in the process of implementation. The majority of countries (30 of the 39 responding countries) also reported that they were in the process of implementing school-based interventions; an additional 5 countries had fully implemented such programmes and policies. Although some form of workplace interventions had been implemented by the majority (27 of 31 responding countries), this option remained relatively underutilised.

Each of the three settings analysed in this report has unique characteristics, with both advantages and disadvantages. Various types of interventions (Box 1.3) can be also delivered in each setting.

- **Interventions in PHC settings** are generally recognised as a potentially effective approach to reduce the burden of mental disorders such as major depressive disorders, generalised anxiety disorders and alcohol use disorders and, at least in some OECD countries, most mental disorders are treated in PHC settings. Patients prefer receiving treatment in PHC settings due to the flexibility, familiarity, lower cost, reduced stigma, comfort and immediate access to care provided by this setting. CBT and other psychosocial interventions have been found to be effective in mitigating symptoms of depression, anxiety and alcohol use disorders (Butler et al., 2006<sup>[64]</sup>). Research also suggests that patients often prefer psychosocial treatments over pharmacological ones, which, although effective, can have side effects (McHugh et al., 2013<sup>[65]</sup>). Several mental health promotion and prevention interventions are typically delivered in PHC settings, including mental health literacy interventions (Magallón-Botaya et al., 2023<sup>[66]</sup>) and mindfulness- and exercise-based interventions (Demarzo et al., 2015<sup>[67]</sup>). When delivered online or via telehealth platforms, PHC interventions can be as effective as face-to-face methods, and have been found to offer better cost-effectiveness (Hoifodt et al., 2011<sup>[68]</sup>). Common constraints in adopting PHC interventions include lack of resources, training and time among frontline workers (Weisberg et al., 2013<sup>[69]</sup>).
- **School-based interventions** are ideal for mental health initiatives, as adolescents spend much of their time at school. These interventions can remove barriers to accessing mental health treatment, such as cost and time. They are generally delivered as either universal or targeted programmes: universal programmes are easier to implement, less stigmatising and less costly, although they are also less effective (Calear and Christensen, 2010<sup>[70]</sup>). Interventions can be delivered by school staff or medical professionals, with the latter typically showing a larger effect but being more costly. Implemented interventions include psychosocial education, skill-building, mindfulness, exercise-based programmes, mental health literacy, stigma reduction and CBT, which is particularly effective in preventing depression and anxiety (Hetrick and Merry, 2015<sup>[71]</sup>). Evidence suggests that school-based interventions often have a small impact. A meta-analysis showed improvements in depression by 1.2% and in anxiety by 1.1% (Werner-Seidler et al., 2017<sup>[72]</sup>).
- With nearly 60% of the global population employed, and about 15% of working-age adults living with a mental disorder, **workplace interventions** can play a crucial role in improving mental well-being (OECD, 2021<sup>[50]</sup>). Health and well-being initiatives at work can boost employee productivity and reduce absenteeism, benefiting both governments and employers (OECD, 2022<sup>[73]</sup>). Intergovernmental organisations, including the OECD, have highlighted a wide range of evidence-based workplace interventions. Commonly implemented strategies include physical activity, mindfulness, meditation and psychosocial interventions like CBT, all of which are effective for depression and anxiety (Harris, Harris and Cavanagh, 2017<sup>[74]</sup>). These interventions are equally effective whether delivered in person or online. Interventions can be tailored to individual workers or implemented at the organisational level. While most evidence focusses on targeted interventions, organisation-level strategies are also valuable for addressing psychosocial risk factors such as unsafe working conditions and long working hours (Rugulies, 2019<sup>[75]</sup>). Some countries have also enacted legislation to protect workers' mental well-being, such as the "right to disconnect" from work-related communications during non-work hours (Fricke, 2023<sup>[76]</sup>).

### Box 1.3. Common interventions to improve mental well-being

Various intervention mechanisms can be implemented to improve mental well-being. A review of the most common interventions in school, workplace and PHC settings identified several key strategies. It is important to note that the following list of five categories of interventions does not aim to be exhaustive but simply highlights commonly implemented interventions. These can be delivered face to face; increasingly, since the COVID-19 pandemic, they can also be delivered online via digital platforms, which in some cases has improved their cost-effectiveness.

- **Mental health literacy and stigma-reduction interventions** aim to promote individuals' social and cognitive skills, resulting in personal motivation and ability to access, understand and apply information that promotes and maintains good mental health. These interventions are generally implemented as awareness-raising activities, training or media campaigns. Often, they are associated with stigma-reduction activities that seek to reduce or remove embarrassment and shame associated with seeking mental healthcare, thus increasing health promotion and help-seeking behaviours (Moreira, 2018<sup>[77]</sup>).
- **Mindfulness-based interventions** have gained popularity, with growing evidence supporting their role in promoting mental well-being. These practices involve paying attention purposefully and non-judgementally to the present moment; they include meditation training, mindful activities like body scans and sitting meditation, and participatory learning processes. Mindfulness-based interventions have shown efficacy in reducing psychological distress, anxiety and depression. Studies indicate that these interventions can be as effective as other standard treatments, offering potential cost savings due to their less resource-intensive nature (Zhang et al., 2022<sup>[78]</sup>).
- **Psychological interventions** encompass a wide and heterogeneous range of approaches, including cognitive, behavioural, humanistic and systemic methods. Commonly used interventions include psychodynamic therapy and eye movement desensitisation and reprocessing (Lovelock et al., 2018<sup>[79]</sup>), along with CBT. Utilising frontline actors such as teachers and social workers to deliver these interventions has proved effective. Overall, psychological interventions are valuable for both preventing and treating mental ill health.
- **CBT** is widely used to prevent and treat a range of different mental health conditions such as depression, generalised anxiety disorders, panic disorders and posttraumatic stress disorders. CBT involves targeted strategies to alter negative thinking and behavioural patterns, such as problem-solving therapy, dialectic behaviour therapy and meta-cognitive therapy. Some evidence suggests that CBT has a similar effect size to pharmacotherapies in the short term, but could be more effective over 6-12 months (Cuijpers et al., 2023<sup>[80]</sup>).
- **Pharmaceutical interventions** are essential for treating mental disorders, including depression, anxiety disorders and substance use disorders. These treatments are typically administered in clinical settings, as opposed to a broader community context such as a school, owing to the need for prescriptions. Efficacy varies depending on a range of factors, such as the treated condition and its severity and the treatment used (Cheng et al., 2020<sup>[81]</sup>). Combining pharmaceutical treatments with psychological interventions, such as CBT, can enhance efficacy, and patient preference for treatment type has a significant impact on completion rates (Cuijpers, 2017<sup>[82]</sup>).

Note: For a detailed overview of the various interventions, please refer to Chapter 4.

## Investments in evidence-based actions to prevent mental ill health contribute positively to population health and the economy

To improve the mental well-being of the population, countries should consider stepping up their efforts by introducing new policy options and strengthening existing ones. The focus of the analysis in this report is on improving mental well-being and, specifically, addressing major depressive disorders and generalised anxiety disorders in PHC settings, schools and workplaces, as these have been shown to be especially well suited to implementation of effective interventions that improve mental well-being. The analysis assumes that these interventions will be implemented at the beginning of 2025, and their impact assessed over a 25-year period to 2050 (Box 1.4).

### Box 1.4. Modelling interventions to tackle major depressive disorders and generalised anxiety disorders

The OECD used its SPHeP-NCDs microsimulation model, based on available evidence, to assess the impact of policy actions on population health, health expenditure and the broader economy. The policies were selected based on several criteria, including alignment with global guidelines and national policy priorities. Availability of quantitative evidence showing a statistically significant improvement for the targeted mental disorder was also a key factor determining the inclusion of an intervention in the modelling-based analyses, given that evidence was often scarce: it proved difficult to model many promising policies due to the lack of necessary quantitative inputs.

Simulation models, such as the one employed in the OECD analysis, offer numerous advantages. They can generate evidence in areas where direct empirical investigation is challenging or unfeasible, and they enable estimation of population-level impacts from interventions that are typically evaluated at the individual level within small groups. Additionally, these models can integrate data from various sources, allowing for conclusions that individual studies might not achieve. However, modelling-based analyses come with limitations. They require assumptions and depend on diverse input data, which can vary in quality. This is particularly true for mental health studies, where data on the longer-term impact of interventions is often limited. Moreover, models simplify certain aspects based on available data, such as underestimating the total impact of interventions by not fully capturing very mild forms of disease and overall “happiness”. Finally, it is also important to note that a 25-year simulation period may be limited in terms of full assessment of the impact of interventions targeting children – especially in terms of improvements in human capital.

### ***Interventions carried out in schools, workplaces and primary healthcare settings help to enhance people’s mental health***

A total of six interventions were modelled, including three in PHC settings, two in workplaces and one targeting children in school environments. These interventions align with the criteria outlined above – their aim is to improve mental well-being and, specifically, to address major depressive disorders and generalised anxiety disorders – and aim to provide a comprehensive set of options. For example, the analysis includes a mix of face-to-face and online interventions. Similarly, both interventions targeting high-risk individuals and universal interventions were modelled. Moreover, the analysis encompasses mental well-being-promoting interventions for conditions at various stages of severity and development, adopting a comprehensive prevention approach from primary prevention (preventing disease development) to tertiary prevention (preventing further exacerbation of the condition in already affected individuals).

A brief overview of each intervention, highlighting its main features, is provided below, while more detailed descriptions are available in Chapter 5. Key input data used to model the interventions are detailed in Table 1.1.

- A web-based intervention in PHC settings targets adults with mild to moderate major depressive disorders or generalised anxiety disorders, recruited by GPs. The 6-week programme includes weekly 30-minute CBT-based sessions such as self-monitoring and relaxation techniques.
- A psychological treatment in PHC settings involves 12 one-hour group sessions led by trained nurses for adults with mild to moderate major depressive disorders, referred by primary care physicians. It reaches patients not currently covered by any service, and transitions eligible patients from traditional care.
- A combined psychotherapy and pharmacotherapy intervention in PHC settings targets adults with severe major depressive disorders who are not responding fully to medication. The intervention consists of adding 12 individual CBT sessions, delivered in ambulatory care, to existing pharmacological treatment.
- A web-based intervention in workplace settings supports employees with mild to moderate major depressive disorders or generalised anxiety disorders through a 4-8-week online programme. Activities include CBT, mindfulness and stress management, and it is accessible via the web or a mobile app.
- A CBT intervention in workplace settings is organised as a universal programme managed by human resources. The intervention is delivered in 4 half-day sessions by trained staff, and includes stress management, acceptance and commitment therapy, and mental health first aid; it focusses on preventive action for major depressive disorders.
- A resilience-focussed CBT intervention in school settings is organised as a universal intervention for students aged 8-18, delivered by trained teachers in 10 classroom sessions. Activities focus on resilience, problem-solving, communication and coping skills, supported by a workbook. This intervention focusses on preventive action for both major depressive disorders and generalised anxiety disorders.

**Table 1.1. Interventions modelled in the analysis, including actions in primary healthcare, workplace and school settings**

	PHC			Workplace		School
Intervention	Web-based intervention	Psychotherapy treatment by clinicians	Combined psychotherapy and pharmacotherapy intervention by clinicians	Web-based intervention via mobile app	CBT intervention	Resilience-focussed CBT intervention
Targeted disorders	Mild and moderate MDD and GAD	Mild and moderate MDD	Severe MDD	Mild and moderate MDD and GAD	MDD	MDD and GAD
Target population	Adults aged 15+	Adults aged 15+	Adults aged 15+	Adults employed within large companies	Adults employed within large companies	Students aged 8-18
Target group	Individuals with PHQ-8 score between 5 and 15 (for MDD) and/or GAD-7 score between 5 and 15 (for GAD)	Individuals diagnosed with MDD and with PHQ-8 score lower than 15	Individuals diagnosed with MDD and with PHQ-8 score equal to or higher than 15	Individuals with PHQ-8 score between 5 and 15 (for MDD) and/or GAD-7 score between 5 and 15 (for GAD)	Universal intervention	Universal intervention

	PHC			Workplace		School
Target coverage	10% of primary care physicians participating (~1.12% of eligible)	All the individuals already in treatment and an additional 5% among those untreated	All the individuals already in treatment	68% of large companies offering the intervention, and 14% of those eligible participating	68% of large companies offering the intervention and 14% of those eligible participating	75% of schools offering the intervention and 90% of students participating
Effectiveness (absolute delta score)	-1.03 for PHQ-8; -1.58 for GAD-7	-1.81 (treated) and -3.58 (untreated) for PHQ-8	-2.88 for PHQ-8	-1.28 for PHQ-8; -1.68 for GAD-7	-0.49 for PHQ-8	-0.41 for PHQ-8; -1.12 for GAD-7
Effectiveness timeframe	Effective at 6 months and no longer effective after 12 months	Effective at 6 months and no more effective after 12 months	Effective at 6 months and maintained over 27 months; no more effective after 3 years	Effective at 6 months and no more effective after 12 months	Effective at 6 months and no more effective after 12 months	Effective at 6 months and no more effective after 12 months
Programme cost in EUR per capita (country range)	0.203 (0.025-1.174)	1.229 (0.163-2.911)	2.016 (0.339-4.556)	0.329 (0.069-0.775)	3.131 (1.26-6.545)	1.301 (0.536-3.284)

Note: MDD is major depressive disorders; GAD is generalised anxiety disorders.  
Source: OECD analyses of the literature: see Chapter 5 for full details.

### ***Scaling up the six interventions to increase population coverage enhances people's lives***

All the modelled interventions are estimated to have a positive impact on population health. As with the findings related to the burden of mental ill health, most of the impact of interventions is on quality of life – measured in disability-adjusted life years (DALYs) – rather on life expectancy (Figure 1.7). PHC interventions tend to have a larger impact on population health than interventions implemented in other settings. Combined psychotherapy and pharmacotherapy treatment by clinicians is the most effective intervention (yielding gains of approximately 27 DALYs per 100 000 population, on average across countries, which is equivalent to 27 people per 100 000 living an additional year in good health). The resilience-focussed CBT in school settings is the second most effective intervention, producing a gain of 15 DALYs per 100 000 population on average across countries. Psychotherapy treatment in PHC settings also results in gains in population health, with an average increase of 11 DALYs per 100 000 population across countries. Workplace-based interventions have a lower impact on people's quality of life, and web-based interventions (6 DALYs per 100 000 population) are marginally more effective than universal CBT interventions (5 DALYs per 100 000 population).

**Figure 1.7. Health and economic impact of interventions to prevent mental ill health**

Annual average across countries, 2025-2050

Interventions	DALYs gained per 100 000 population per year	Health care expenditure saved per year (EUR per capita)	GDP	Benefit-cost ratio
PHC web-based	1	0.1	0.001%	3.9
PHC psychotherapy	11	2.6	0.006%	2.6
PHC psychot-pharamt	27	10.4	0.013%	3.3
WP web-based	6	0.3	0.006%	10.3
WP CBT	5	0.1	0.004%	0.6
School CBT	15	0.1	0.001%	0.6

Note: Estimates for the benefit-cost ratio are the result of the total increase in GDP produced by the policy, divided by the total cost of implementing the policy in these countries.

Source: OECD analyses using the SPHeP-NCD model.

StatLink  <https://stat.link/ehlu74>

The overall impact of a mental health intervention depends on several factors, including how it is designed and put into practice. In general, the most effective approaches fall into two categories: highly effective targeted treatments for people with high mental health needs, and broader, lower-intensity interventions that reach very large parts of the population. Three main factors help to explain this pattern:

1. The most important factor is how effective the intervention is for individuals: how well it works for each person. If it helps people feel significantly better, like reducing symptoms of depression or anxiety, and for a longer period, it is likely to have a bigger impact overall. For example, combined psychotherapy and pharmacotherapy in PHC settings has an impact on the targeted individuals that is nearly seven times greater than school-based CBT.
2. The next factor is how many people the intervention reaches. Universal interventions available to more people tend to have a larger effect at the population level. For example, CBT in schools can reach all students aged 8-18, which is a large group. But because it is offered to everyone, many children who do not need it may not benefit much.
3. The third factor is how many people in the target group need help. Targeted interventions focussing on people who are likely to have more severe mental health problems, such as combined psychotherapy and pharmacotherapy in PHC settings, may reach fewer people, but they concentrate resources on those who need it most, which can lead to a stronger overall impact.

When compared to the size of the burden, the impact of the assessed interventions tends to be small. This suggests that, while helpful, actions to improve mental well-being can play a complementary role, but would be insufficient to address the overall burden of mental ill health on their own. On average across countries, at the modelled levels of implementation, the interventions can reduce the projected burden of mental disorders by around 1% in the case of the most effective intervention (combined psychotherapy and pharmacotherapy in PHC settings). While increasing population coverage beyond the modelled levels will further improve the gains in population health, the coverage targets used in these analyses are grounded in available evidence of what is realistically achievable in real-world settings. Further expansion of the simulated programmes may be hindered by factors such as limited availability of trained personnel, resource constraints in primary care and educational settings, and challenges in engaging target populations consistently over time.

### ***The interventions contribute to reducing healthcare costs and enhancing productivity, although the impacts are small relative to the size of the burden***

Implementation of the interventions produces a positive impact on the economy – both through a reduction in healthcare expenditure and, more consistently, through an increase in human capital that can positively contribute to economic growth.

The reduction in average healthcare expenditure at the population level during 2025-2050 is estimated to range from EUR 0.1 per capita per year for interventions such as web-based interventions in PHC settings to EUR 10.4 per capita per year for combined psychotherapy and pharmacotherapy treatment in PHC settings (Figure 1.7). For all other interventions, the impact ranges between EUR 0.1 and EUR 0.3 per capita per year, except for psychotherapy in PHC settings, which is estimated to produce a reduction of EUR 2.6 per capita per year. This estimate includes both the reduction in costs for other forms of treatment and the lowering of the costs produced by mental ill health as a comorbidity, but does not include the costs of scaling up the interventions. As noted for the impact on population health, overall, the impact of the interventions is small compared to the current cost of mental disorders: the intervention producing the largest impact only decreases the healthcare costs for mental ill health by 4.2%.

The impact on productivity is also positive, with interventions improving workforce participation and productivity equivalent to an additional 1 163 full-time equivalent workers per year across the 30 OECD and EU countries included in the analysis (for web-based interventions in PHC settings) and up to 18 230 full-time equivalent workers per year for combined psychotherapy and pharmacotherapy treatment in PHC settings. Most of this gain is produced by increased productivity, due to improvements in absenteeism and presenteeism, followed by increases in workforce participation and reductions in early retirements. When all these improvements in human capital are considered, the average improvement in yearly productivity is expected to equal 0.013% of GDP for combined psychotherapy and pharmacotherapy treatment in PHC settings, and less for the other considered interventions (Figure 1.7).

### ***Policies to improve mental well-being generally offer good value for money***

Governments and public health authorities usually rely on cost-effectiveness analyses and benefit-cost metrics to guide decisions about which health interventions to fund. These economic evaluations help to ensure that limited resources are allocated to programmes that deliver the greatest social benefits at the lowest cost. Cost-effectiveness analysis evaluates the improvement in quality of life, measured in DALYs gained, relative to the cost of an intervention, net of any potential savings in healthcare expenditure. In contrast, benefit-cost ratio is calculated as the increase in GDP resulting from enhanced workforce productivity, divided by the costs of implementing the intervention.

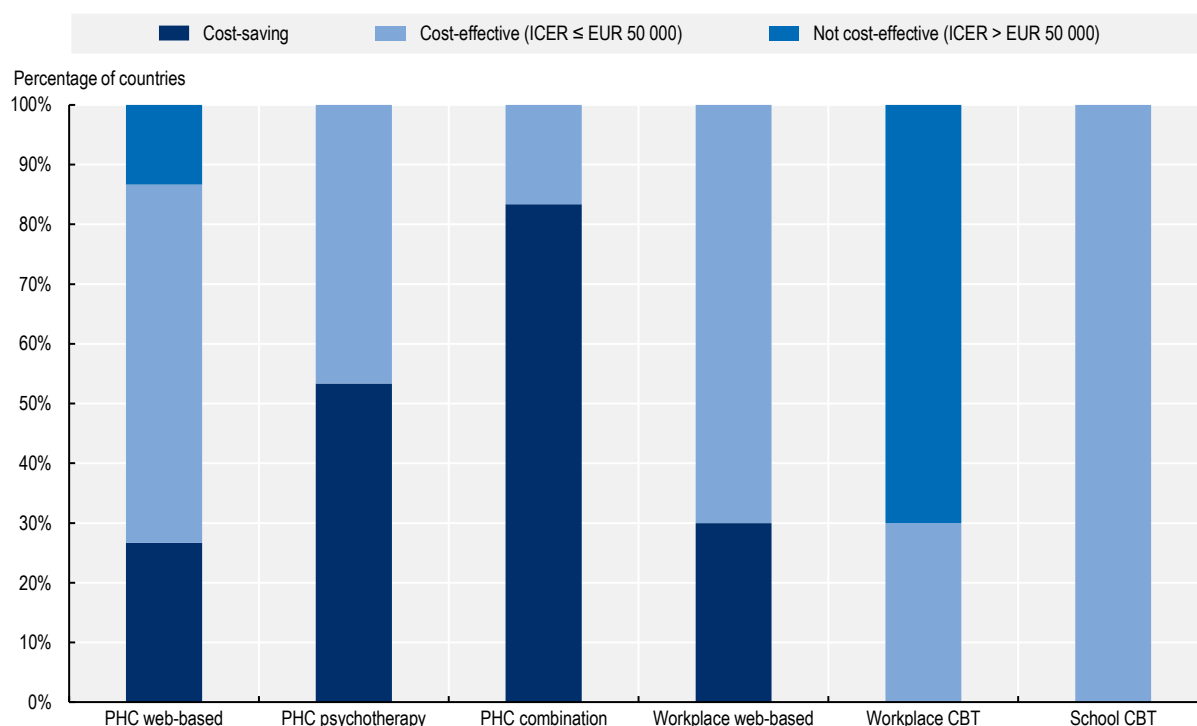
The economic evaluation of the assessed interventions reveals a case for scaling up investment in mental health promotion. Although, as discussed in previous sections, their impact on population health, healthcare expenditure and productivity appears relatively modest when compared to the overall burden of mental ill health, these interventions nonetheless perform well once implementation costs are considered. The majority of the assessed interventions demonstrate value for money, making them options for policymakers seeking efficient use of public resources.

- All interventions, apart from school-based and workplace-based CBT, yield a benefit-cost ratio greater than 1, meaning that their contribution to GDP surpasses the cost of implementation (Figure 1.7). The web-based intervention in workplace settings demonstrates the highest benefit-cost ratio, returning EUR 10.3 in GDP for every EUR 1 invested. This strong performance is largely due to its relatively low implementation cost, which is significantly lower than, for example, that of the workplace-based CBT intervention. Moreover, by targeting the workforce directly, it enhances productivity, further boosting economic returns. In contrast, the CBT intervention in school settings

yields a benefit-cost ratio below 1, as it targets young individuals who are not yet part of the workforce and therefore do not directly contribute to productivity gains in the short term.

- When assessing cost-effectiveness, which considers the cost of improving healthy life expectancy, interventions delivered in PHC settings generally offer the greatest health impact relative to investment. Psychotherapy and combined psychotherapy and pharmacotherapy in PHC settings consistently emerge as either cost-saving, where healthcare savings exceed implementation costs, or cost-effective, based on a threshold of EUR 50 000 per DALY gained. Other interventions that are largely cost-effective or cost-saving include CBT in school settings and web-based interventions in workplace settings. The remaining interventions present a more mixed picture, with cost-effectiveness varying by country. For example, workplace-based CBT is considered not cost-effective in up to 70% of countries (Figure 1.8).

**Figure 1.8. Percentage of countries where interventions are cost-saving, cost-effective or not cost-effective**



Note: ICER is incremental cost-effectiveness ratio.

Source: OECD analyses using the SPHeP-NCD model.

StatLink  <https://stat.link/gqczj>

### To achieve impact at scale, implementing effective interventions is not enough: Cross-sectoral action and a stronger focus on best practice design are needed

Analyses presented in this chapter suggest that initiatives implemented by health systems, including healthcare providers (particularly GPs), and public health initiatives implemented in workplaces and schools can contribute meaningfully to improving mental well-being across the population. Many of these interventions appear to be cost-effective, with some even generating cost savings, and they demonstrate value for money comparable to other public health measures. However, these analyses also suggest that

it is unlikely that the health system alone can make a fundamental difference in addressing the burden of mental ill health. The findings outlined here point to three key policy implications.

First, countries should prioritise investments in interventions that are designed and implemented according to best practices. While the interventions outlined in this report are generic models, their effectiveness and efficiency depend greatly on how they are designed and implemented in practice. OECD work on best practices for mental health promotion and prevention (OECD, 2025<sup>[63]</sup>) shows that efforts to improve access to mental health services must be accompanied by complementary measures, such as communication campaigns and peer-based programmes to destigmatise mental ill health. These actions are essential to enhance the impact of interventions – particularly by addressing stigma and other barriers to care (Box 1.5). Additional research, including rigorously designed clinical trials, is also required to advance the identification and validation of more effective mental health interventions.

### Box 1.5. Best practices, better results: Evidence from OECD mental health interventions

The OECD report *Mental Health Promotion and Prevention: Best Practices in Public Health* identifies 11 interventions that meet validated best practice criteria, co-developed by OECD Member countries. Each intervention demonstrates strong performance across five key indicators: effectiveness, efficiency, equity, evidence quality, coverage and transferability.

These assessed interventions focus on creating school environments that support mental well-being and resilience; enhancing mental health literacy and training frontline professionals to identify and support individuals in distress; preventing suicide; and improving access to mental healthcare.

OECD analysis suggests these approaches can deliver significant health benefits at costs that are manageable for many health systems, making them cost-effective. For instance, scaling up Norway's Prompt Mental Health Care programme could yield an average of 33 DALYs gained per 100 000 people annually across EU countries. This programme shares some broad design elements and characteristics with the standard psychotherapy intervention in PHC settings modelled in this report, which is estimated to deliver approximately one-third of the health impact observed in Norway's best practice.

The 2025 OECD report also highlights common features that contribute to the definition of the best practices, including:

- expanding low-threshold and specialised mental health services, such as multidisciplinary networks, teleconsultations and digital tools
- reducing financial barriers – for example, through psychotherapy reimbursement
- destigmatising mental ill health and improving mental health literacy across the population
- rolling out peer-based programmes to train students and frontline workers (such as teachers) to support individuals in distress, reduce stigma and encourage help-seeking
- investing in workforce planning and development, including creating new roles within existing professions.

Source: OECD (2025<sup>[63]</sup>), *Mental Health Promotion and Prevention: Best Practices in Public Health*, <https://doi.org/10.1787/88bbe914-en>.

Second, countries may choose to set more ambitious targets and scale up interventions beyond the coverage levels simulated in this analysis. For example, the model assumed that 10% of GPs would participate in primary care-based interventions – a pragmatic estimate based on current evidence and short-term feasibility. Expanding coverage beyond this level could generate greater health and economic benefits at the population level, probably with equal or improved cost-effectiveness if countries invest in

best practice interventions. However, such expansion would carry broader financial and planning implications. As discussed earlier in this chapter, providing treatment to all individuals with mental disorders would require a 41% increase in mental health spending compared to current levels. Moreover, any significant scale-up should be preceded by policies aimed at strengthening the capacity of the mental health workforce to ensure effective and sustainable implementation. In other words, achieving more impact requires significant upfront investments. One way to keep this additional cost at an affordable level would be to ensure that expanded services are deployed first where they are most needed. For example, targeting resources toward populations and settings with the highest unmet needs, rather than expanding services uniformly, can improve the efficiency of intervention delivery while containing overall expenditure.

Third, countries should address the root causes of mental ill health – for example, with strong welfare systems. The interventions analysed primarily aim to strengthen individual and population-level resilience to mental distress and support those already affected by mental disorders. While these efforts are essential for improving mental well-being, they do not address the root causes of mental ill health. To be fully effective, these actions should be complemented by broader policies that foster environments conducive to mental well-being (OECD, 2023<sup>[83]</sup>). The OECD literature review highlights several determinants of mental distress, some of which – such as economic crises and problematic social media use – are likely to persist in the future. Tackling these enduring factors can help to reduce incidence of mental health issues. For example, welfare systems with more generous social expenditure are generally associated with better mental health outcomes (Ribanszki et al., 2022<sup>[84]</sup>). Similarly, The OECD Council Recommendation on Integrated Mental Health, Skills and Work Policy (OECD, 2015<sup>[60]</sup>) recognises that integrating mental health, skills and employment services is essential to improve outcomes for individuals who are not in employment, and encourages multi-sectoral strategies that promote early engagement in education and work, and support the return to employment for people with mental health conditions.

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## Notes

<sup>1</sup> Beside indirect productivity losses such as those estimated in this publication, the estimates in *Health at a Glance: Europe 2018* report also included healthcare expenditure and social benefits, providing an estimate for indirect labour market costs of 1.6% of GDP, based on lower 2015 prevalence.

# 2 Trends and patterns in mental ill health

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This chapter investigates trends in mental ill health across OECD and EU countries from 1990 to 2021, focussing on four prevalent conditions: depressive disorders, anxiety disorders, alcohol use disorders and substance use disorders. The analysis considers factors often linked to the recent decline in mental well-being, such as the COVID-19 pandemic, the climate crisis and problematic use of social media. The chapter also examines the distribution of mental ill health across the population, looking at inequities by age, gender and socio-demographic group, and discusses the extent of unmet mental healthcare needs across these countries.

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## Key findings

- Mental ill health is a significant public health challenge. Modelled data suggest that in 2023 **slightly over one in five individuals in OECD and EU countries experienced a mental disorder**. The majority of these conditions were depressive and anxiety disorders.
- In OECD and EU countries, prevalence of mental disorders reached its highest point during the COVID-19 pandemic, and some long-term upward trends are also emerging. These **trends may be linked to increasing rates of depressive and anxiety disorders**. Prevalence of alcohol use and substance use disorders has remained relatively stable.
- A **range of factors are hypothesised to be contributing to these trends**, including the influence of the COVID-19 pandemic, the climate crisis, war and conflict, the cost-of-living crisis and growing economic inequality, and the rising use of social media among children and adolescents.
- In 2023, **prevalence of mental disorders was highest among individuals aged 15-19**. In most age groups (except children under 10 and adults aged 60-74), **women experienced higher levels of mental ill health than men**. Further, people on low incomes and those with lower levels of educational attainment experienced disproportionate levels of mental ill health.
- With rising levels of mental ill health, a range of barriers contribute to a lack of access to mental healthcare. It is estimated that **only one in three people with mental health needs received access to treatment for their condition in the last 12 months across EU countries**.

### Mental ill health is a public health concern and has negative impacts on both individuals and the broader economy

Mental health is a pivotal component of individuals' overall health and well-being. A state of good mental health enhances the capacity for interpersonal engagement, cognitive performance, adaptive coping mechanisms and holistic flourishing (WHO, 2022<sup>[1]</sup>). Conversely, mental ill health refers to a spectrum of conditions, ranging from mild forms of depression, anxiety, and alcohol and drug use disorders to severe disorders such as schizophrenia, bipolar disorders, and severe forms of depression and anxiety (Charlson et al., 2019<sup>[2]</sup>; Fagiolini and Goracci, 2009<sup>[3]</sup>). Mental ill health has negative effects on an individual's quality of life, as well as being associated with heightened risks of comorbidities such as diabetes and obesity; hypertension; respiratory, vascular, kidney and gastrointestinal diseases; and cancer (Pizzol et al., 2023<sup>[4]</sup>).

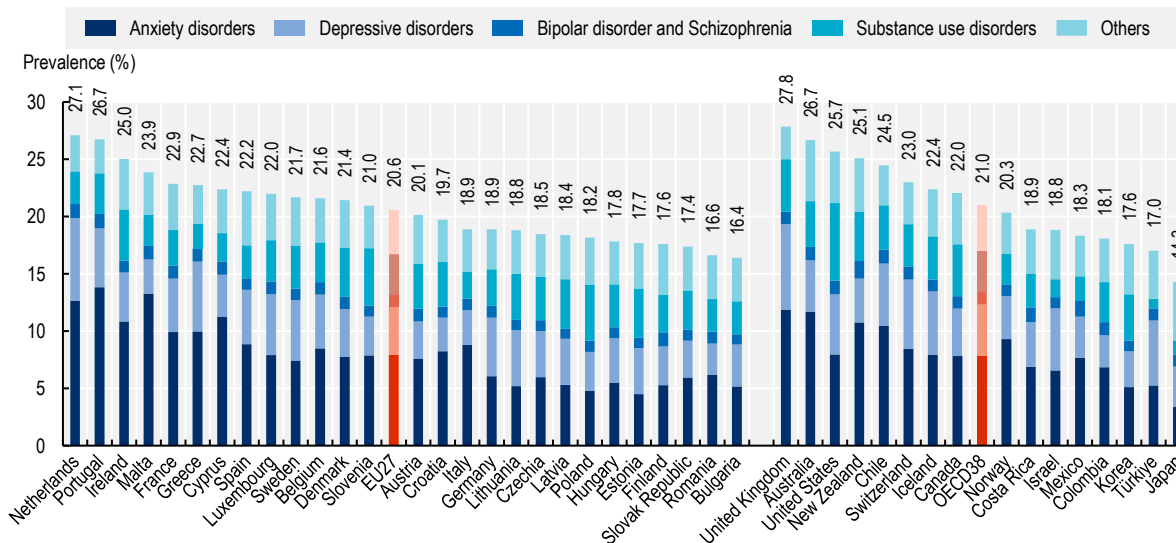
In addition to direct suffering and health impacts, mental ill health leads to significant economic costs. Costs arise both through health system expenditure associated with preventing and treating mental ill health and through costs associated with reduced workforce productivity. Chapter 3 delves deeper into these costs, providing detailed quantifications and projections of the health and economic impacts of mental ill health using the OECD SPHeP-NCDs model. It reveals that anxiety, depression and alcohol use disorders are expected to constitute about 6% of annual healthcare expenditure in the 27 EU Member States, Iceland, Norway and Switzerland from 2025 to 2050. Additionally, these conditions are estimated to reduce GDP by an average of 1.7% across these 30 countries, owing to their detrimental effects on productivity and human capital. Notably, the extent of the economic costs is related to the severity of mental ill health, with higher costs strongly associated with higher levels of severity (König et al., 2023<sup>[5]</sup>).

## Rates of mental ill health are high and trending higher

### *Slightly over one in five people in EU countries experienced a mental disorder in 2023*

A mental disorder is characterised by a clinically significant disturbance in an individual's cognition, emotional regulation or behaviour, and is typically associated with impairment in important areas of functioning (WHO, 2022<sup>[6]</sup>). Nearly 21% of people across EU countries and 21% across OECD countries experienced a mental disorder in 2023 (Figure 2.1) (IHME, 2026<sup>[7]</sup>).

Figure 2.1. Estimates of prevalence of mental disorders in EU and OECD countries, 2023



Note: Prevalence data are presented cumulatively, which may overestimate total mental disorder prevalence because individuals with multiple conditions can be counted more than once. Conversely, underreporting – for example, driven by stigma and health system limitations – may lead to underestimation of single-condition prevalence. Depressive disorders include major depressive disorders, along with other depressive disorders; anxiety disorders include generalised anxiety disorders, among other anxiety disorders. The data presented are modelled using a range of country-specific sources, which may limit the degree of cross-country comparability.

Source: IHME (2026<sup>[7]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

StatLink  <https://stat.link/d5lvao>

These figures include the following five categories of mental disorders:

- **Depressive disorders** are characterised by a depressed mood, such as a feeling of sadness, irritability or emptiness, or by a loss of pleasure in activities (WHO, 2026<sup>[8]</sup>; APA, 2013<sup>[9]</sup>). Major depressive disorders are the most common subtype of depressive disorders (Li et al., 2023<sup>[10]</sup>). They are characterised as episodic mood disorders, involving the experience of one of more major depressive episodes, which is either a depressed mood or loss of interest/pleasure, for most of every day, for at least two weeks. Like other depressive disorders, major depressive disorders vary across levels of severity, ranging from mild through moderate to severe.
- **Anxiety disorders** are characterised by excessive fear, anxiety and associated behaviours. This disorder spectrum covers separation anxiety disorders, selective mutism, specific phobias, social anxiety disorders, panic disorders, agoraphobia and generalised anxiety disorders (APA, 2013<sup>[9]</sup>). Generalised anxiety disorders are among the most common. These are characterised by persistent and excessive worry about a number of domains in a person's life, which is present for at least six

months and causes significant distress and/or impairment in an individual's functioning (Spitzer et al., 2006<sup>[11]</sup>; Mortazavi et al., 2014<sup>[12]</sup>).

- **Psychotic disorders** are a heterogeneous group of conditions – including bipolar disorders – that is characterised by episodic mood changes, where periods of mania, hypomania or mixed symptoms often alternate with episodes of depression or periods marked by depressive symptoms throughout the disorder (WHO, 2026<sup>[8]</sup>). Related conditions such as schizophrenia also include disturbance in a variety of mental functions, such as flow of thoughts, perception, self-experience, cognition, mood and behaviour.
- **Substance use disorders** are characterised by a cluster of cognitive, behavioural and physiological symptoms. These symptoms include the individual persisting in using the substance despite adverse consequences (APA, 2013<sup>[9]</sup>). Alcohol use disorders are a type of substance use disorder defined by an inability to control alcohol consumption, compulsive drinking behaviour and a negative emotional state during periods of abstinence. Drug use disorders are also a type of substance use disorder. Ten separate classes of drugs come under this umbrella – including, for example, cannabis, hallucinogens and opioids.
- The category of **other disorders** includes all other mental health conditions not captured in the categories above, such as eating disorders, autism spectrum disorders, attention deficit/hyperactivity disorders and conduct disorders, among others.

As shown in Figure 2.1, depressive and anxiety disorders account for more than half of mental disorders, with 8% of the population of the EU experiencing anxiety disorders and 4.2% experiencing depressive disorders. These are followed by substance use disorders at 3.5% and bipolar disorders and schizophrenia, which affect 1.0% of the population. Across EU countries, there is variability in the prevalence of these mental disorders: the lowest proportions were reported in Bulgaria (16.4%) and Romania (16.6%), while the Netherlands experienced the highest level (27.1%).

When interpreting epidemiological estimates for mental disorders, it is crucial to exercise caution due to various factors that limit the reliability of these estimates. In particular, the following factors should be considered when analysing the results presented in Figure 2.1:

- Prevalence rates may underestimate prevalence of mild to moderate conditions that may not be detected, for example, when they do not meet the clinical criteria for a diagnosis or due to underreporting caused by stigma (see Box 2.1).
- The cumulative figures are likely to overestimate the overall prevalence of mental disorders across the population, as individuals may experience multiple disorders simultaneously, leading to double counting.
- Cross-country differences may also reflect other factors, such as variations in disclosure and reporting – for example, driven by differing levels of stigma and self-reporting, as well as methodological differences – rather than true differences in underlying prevalence.

### Box 2.1. Screening tools to identify and assess mental ill health

Mental ill health is a continuum rather than a static state. Symptoms of mental disorders can emerge and fluctuate over time. A broad range of tools and symptom scales exist to assess the presence and severity of a mental disorder at a given time. Symptom scales have been increasingly incorporated into national health surveys to assess measure population mental health. For instance, PHQ-8 is used in the 2019 European Health Interview Survey, the Korea Community Health Survey 2019, and the United States National Health Interview Survey 2019. These tools provide an important way to measure current states of mental health and to identify trends and patterns in population mental health over time (OECD, forthcoming<sup>[13]</sup>). Examples of three frequently used screening tools for major depressive and anxiety disorders are summarised below.

#### Screening tools for symptom severity

Screening tools help to assess the severity of mental disorders such as major depressive and anxiety disorders, and to evaluate the impact of mental health interventions. For instance, the 9-item Patient Health Questionnaire (PHQ-9) and the shorter PHQ-8 are validated scales to assess the severity of depressive symptoms. Depressive symptom scales can be a good indicator to measure population-level mental health. An analysis of national survey data from 22 OECD countries shows a strong positive correlation between the share of people who reported having moderate and severe depressive symptoms and those who were diagnosed with depression by a doctor in the last 12 months (Wei et al., 2016<sup>[14]</sup>). Similarly, GAD-7 has been shown to be a valid tool for anxiety symptom severity (Kroenke et al., 2009<sup>[15]</sup>; Spitzer et al., 2006<sup>[11]</sup>). The Alcohol Use Disorders Identification Test (AUDIT), which is composed of 10 questions, and AUDIT-C – a shorter version, composed of 3 questions – are screening tools developed by the WHO, commonly used in the identification of alcohol use disorders in a primary healthcare setting (Babor et al., 2011<sup>[16]</sup>). Of course, in the absence of a full clinical diagnostic process, these tools can be subject to measurement error or risk of under- or over-diagnosis.

Table 2.1 provides a summary of the scales used by these three screening tools to identify the presence and/or severity of a mental disorder.

**Table 2.1. Example of symptom scales and thresholds of severity**

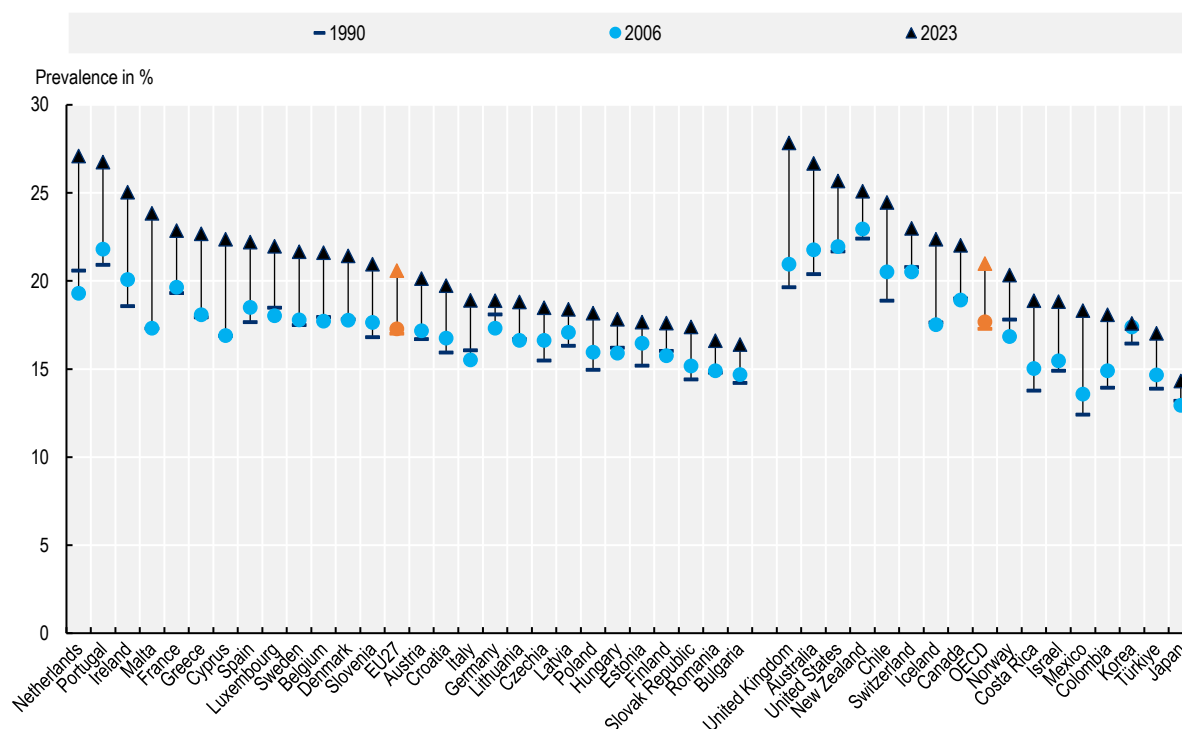
PHQ-9	GAD-7	AUDIT
0-4: Minimal depression	0-4: Minimal anxiety	0-7: Abstinence/lower-risk drinking
5-9: Mild depression	5-9: Mild anxiety	8-15: Hazardous use
10-14: Moderate depression	10-14: Moderate anxiety	16-19: Harmful use
15-19: Moderately severe depression	15-21: Severe anxiety	20-40: Possible dependence
20-27: Severe depression		

Sources: Kroenke et al. (2009<sup>[15]</sup>), “The PHQ-8 as a measure of current depression in the general population”, <https://doi.org/10.1016/j.jad.2008.06.026>; Spitzer et al. (2006<sup>[11]</sup>), “A brief measure for assessing generalized anxiety disorder: The GAD-7”, <https://doi.org/10.1001/archinte.166.10.1092>; Babor and Robaina (2016<sup>[17]</sup>), “The Alcohol Use Disorders Identification Test (AUDIT): A review of graded severity algorithms and national adaptations”, <https://doi.org/10.7895/ijadr.v5i2.222>.

## Prevalence of mental disorders peaked during the COVID-19 pandemic

OECD analysis of modelled data from IHME suggests that there was an upward trend in prevalence of mental disorders from 1990 to 2023, as shown in Figure 2.2 (IHME, 2026<sup>[7]</sup>). On average, prevalence of mental disorders in EU countries increased by 21.1% – from 17.0% in 1990 to 20.6% in 2023. The highest increase (37.9%) was found in Malta, where prevalence rose from 17.3% to 23.9%, followed by Ireland (34.8% increase). These findings align with previous research suggesting that mental ill health has been increasing over recent decades (Fu et al., 2013<sup>[18]</sup>; ten Have et al., 2023<sup>[19]</sup>; Compton et al., 2006<sup>[20]</sup>; Richter et al., 2019<sup>[21]</sup>). Most countries experienced the majority of the increase in prevalence of mental disorders between 2006 and 2023. This trend supports the hypothesis that various shocks and factors – such as the impact of COVID-19, climate change, war, conflict, political unrest and economic stressors – have adversely affected mental health in recent years, as discussed in the following section. Other research argues, however, that mental ill health may have remained constant over this period, but the rise in prevalence is a result of demographic changes and increased reporting of mental ill health due to increased mental health literacy, reduced stigma and other factors that have led to more accurate diagnosis and reporting – particularly of mild and moderate cases (Richter et al., 2019<sup>[21]</sup>; Baxter et al., 2014<sup>[22]</sup>).

Figure 2.2. Estimates of prevalence of mental disorders in EU and OECD countries, 1990-2023



Note: Anxiety disorders, bipolar disorders, depressive disorders, schizophrenia, substance use disorders and others (attention deficit and hyperactivity disorders, autism spectrum disorders, conduct disorders, eating disorders and other mental disorders) were included. It is likely that cumulative numbers are an overestimate, as individuals experiencing multiple disorders at once would be double counted in cumulative tallies.

Source: IHME (2026<sup>[7]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

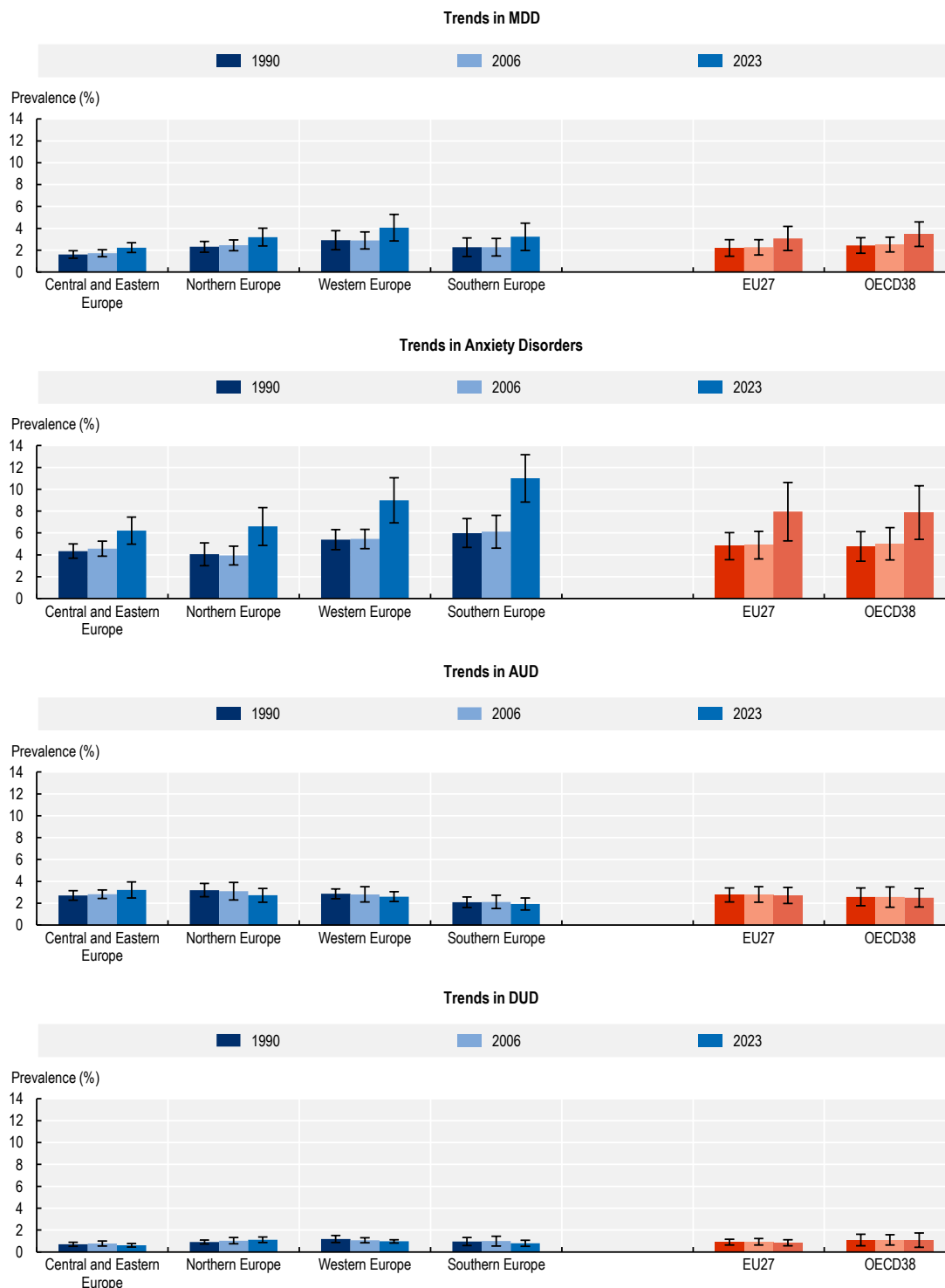
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### ***Major depressive and anxiety disorders are the leading contributors to the burden of mental ill health***

Understanding whether patterns are consistent across mental disorders is essential for identifying what drives them, and for targeting interventions toward the conditions with the highest prevalence and fastest acceleration. As the number of mental conditions is extensive, this chapter limits the scope of analysis to four of the leading conditions: major depressive disorders, anxiety disorders, and alcohol use and drug use disorders. Examining the trends for these four conditions reveals that prevalence of major depressive and anxiety disorders has increased throughout the study period, especially since 2006.

Figure 2.3 shows that prevalence of major depressive disorders in EU countries rose from 2.2% in 1990 to 3.1% in 2023, representing a 39.4% increase. These trends were consistent across most European regions<sup>1</sup> and OECD Member countries. Over the same period, prevalence of anxiety disorders increased from 4.8% to 8% in EU countries; a trend also mirrored across all European regions and OECD countries. However, these same trends were not observed in prevalence of alcohol use and drug use disorders. The rate of alcohol use disorders remained 2.8% between 1990 and 2006, then decreased to 2.7% in 2023. The highest decline was observed in the Northern Europe region, where the rate of alcohol use disorders decreased from 3.2% in 1990 to 2.7% in 2023; a reduction of almost 15.0%. Similarly, the average rate of drug use disorders remained 0.9% between 1990 and 2006, then declined to 0.8% in 2023. The highest decrease was observed in the Western Europe region, where the rate of drug use disorders declined from 1.2% in 1990 to 1.0% in 2023. Only the Northern Europe region experienced an important rise, from 0.9% in 1990 to 1.1% in 2023. Depressive and anxiety disorders together accounted for the majority of mental disorders; as such, the increases in these disorders seem to be driving the overall trend for rising levels of mental ill health.

**Figure 2.3. Estimated trends in major depressive disorders, anxiety disorders, alcohol use and drug use disorders in EU and OECD countries, 1990-2023**



Note: Error bars represent the standard deviation of prevalence, indicating cross-country variability of prevalence within each European region.  
 Source: IHME (2026<sup>[7]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

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## Several recent events and factors have adversely affected mental health

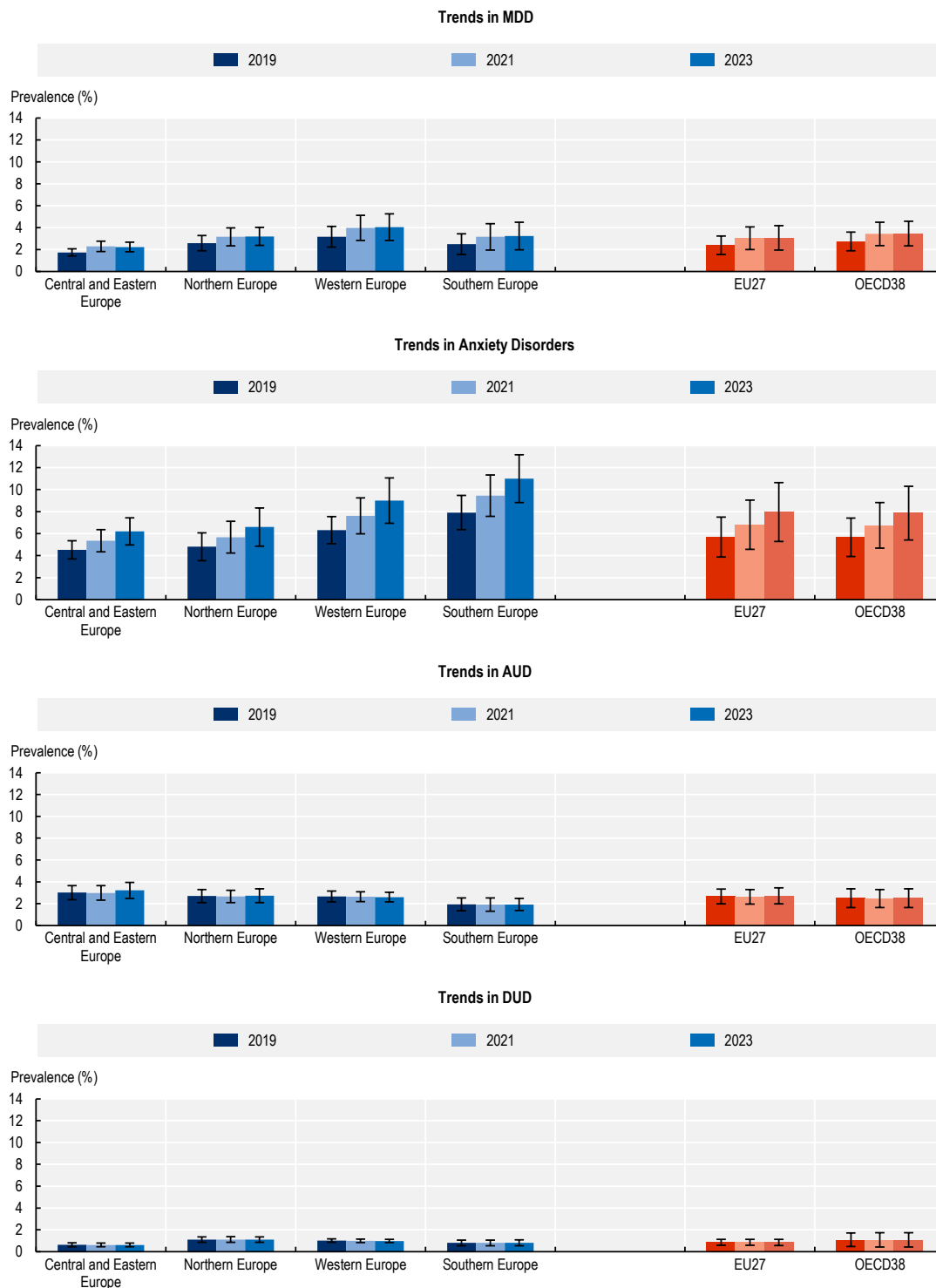
As highlighted, overall rates of mental ill health are high and have increased over recent decades, with most of the rise occurring in recent years. A rapid literature review highlighted several social, economic and lifestyle factors thought to have contributed to the observed trends. In some instances, such as in the case of recent wars and conflicts, the impact of these events is not yet reflected in the available statistics, suggesting that the situation may have worsened further. Some of these factors are discussed below.

### ***The COVID-19 pandemic had a significant influence on mental well-being***

The COVID-19 pandemic not only caused anxiety and stress as a major public health crisis; global measures imposed to control the spread of the virus also affected mental health (OECD, 2023<sup>[23]</sup>; Holmes et al., 2020<sup>[24]</sup>). Lockdowns, border closures, business and work closures, work-from-home mandates, and a broad range of other measures had significant impacts on social lives, economic and housing stability, significantly affecting quality of life and mental health (OECD, 2021<sup>[25]</sup>; OECD, 2021<sup>[26]</sup>). As shown in Figure 2.4, these substantial impacts appear to have had a significant impact on prevalence of depression and anxiety, which rose following the onset of the COVID-19 pandemic. In 2019, the rate of major depressive disorders in EU countries was 2.4%, and by 2023, this had increased to 3.1%. The highest increase was observed in Southern Europe, where prevalence of major depressive disorders increased from 2.5% (2019) to 3.2% (2023). At the same time, prevalence of anxiety disorders across EU countries also increased, from 5.7% in 2019 to 8.0% in 2023. The highest prevalences were observed in Southern Europe, where the rates reached to 11.0% in 2023. These detrimental mental health impacts are hypothesised to be associated with the international public health measures put in place to slow the spread of the virus, which resulted in social isolation, economic insecurity job precarity and other factors that were likely to contribute to declining mental health (Leung et al., 2022<sup>[27]</sup>). Recent evidence from various sources suggests that in Europe mental ill health may mostly have recovered to pre-pandemic levels, while other studies suggest there may be legacy effects – particularly among children and adolescents (Ahmed et al., 2023<sup>[28]</sup>; Kiviruusu et al., 2024<sup>[29]</sup>; Ma, Yao and Hao, 2022<sup>[30]</sup>). As subsequent waves of data become available, it is expected to become clearer whether, and to what extent, the COVID-19 pandemic has resulted in a “scarring” effect, increasing and keeping rates of mental ill health high over the longer term (Mitreá et al., 2024<sup>[31]</sup>; Zhu et al., 2024<sup>[32]</sup>).

Unlike major depressive and anxiety disorders, prevalence of alcohol use disorders stayed constant, and prevalence of drug use disorders declined slightly over the period 2019-2023. Prevalence of alcohol use disorders in the EU stayed at 2.7%, as shown in Figure 2.4. Moreover, prevalence of drug use disorders declined slightly between 2019 and 2023 across most EU countries. Indeed, an average 1.1% decrease in drug use disorders was observed between 2019 and 2021, and then a further 0.7% decrease to 2023. These trends appear to follow previous trends in drug use disorders in Europe (Rehm et al., 2019<sup>[33]</sup>). These changes have been argued to be a result of reduced availability of illicit drugs – a result of border closures, which reduced accessibility and demand for drugs typically used in recreational settings (Zaami, Marinelli and Vari, 2020<sup>[34]</sup>). While this would appear to be a positive outcome overall, it is potentially obscuring a change in types of drug use disorders, which could be damaging overall. For example, it may conceal substitution with other drugs, such as prescription drugs or narcotics, which are available online and which may have serious impacts on health and economic costs of drug use disorders.

**Figure 2.4. Estimated trends in major depressive disorders, anxiety disorders, alcohol use and drug use disorders in EU and OECD countries, 2019-2023**



Note: Error bars represent the standard deviation of prevalence, indicating cross-country variability of prevalence within each European region.  
 Source: IHME (2026<sup>[7]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

StatLink  <https://stat.link/ofigt>

### ***The climate crisis has contributed to worsening mental health***

Over the last decade, the impact of climate change is increasingly evident and salient, with extreme events such as wildfires, flooding and heat events becoming more frequent and severe. These events, and the understanding of the future risks associated with projected climate change, have been associated with increased levels of mental ill health – from elevated stress through to severe mental conditions (Ebi et al., 2021<sup>[35]</sup>; Makwana, 2019<sup>[36]</sup>; OECD, 2023<sup>[37]</sup>; Crimmins et al., 2016<sup>[38]</sup>). So-called “climate anxiety”, characterised by pervasive fear and worry about the future of the planet, has emerged as a significant concern and contributor to mental ill health (Sampaio and Sequeira, 2022<sup>[39]</sup>). Young people have been shown to be particularly affected by the psychological impacts of the climate crisis due to their unique and acute awareness of how climate change will affect their quality of life and the world around them (Whitlock, 2023<sup>[40]</sup>). Indeed, in an international survey of more than 10 000 children and young people, 84% were either moderately or extremely worried about climate change, and more than 45% stated that climate change negatively affected their daily lives and functioning (Hickman et al., 2021<sup>[41]</sup>). Further, climate migration driven by the loss of habitable land and resources compounds these challenges by disrupting lives and communities, leading to grief, anxiety and loss of identity for those forced to relocate (Kanthee et al., 2024<sup>[42]</sup>). Similarly, the trauma of living through extreme weather events, combined with the chronic stress of climate uncertainty, has been linked to worsening mental health – particularly among vulnerable populations (Filho et al., 2022<sup>[43]</sup>; Zhang et al., 2022<sup>[44]</sup>; Zhang, Zhang and Dai, 2022<sup>[45]</sup>). These combined effects of the climate crisis are already having a marked effect on population mental health, which is only expected to increase in severity as the impacts of climate change become more severe over coming decades.

### ***Housing, environment and social contexts are important determinants of mental health***

Housing quality, affordability and stability are increasingly recognised as important determinants of mental health. Inadequate or insecure housing is associated with elevated levels of stress, anxiety and depressive symptoms – particularly among low-income and vulnerable populations (The Lancet Public Health, 2025<sup>[46]</sup>), including children and young people (Schwartz et al., 2025<sup>[47]</sup>). Beyond the home itself, broader features of the built environment – including, for example, access to green spaces, pedestrian infrastructure and well-designed public areas – have also been linked to lower stress, improved well-being and increased opportunities for restorative experiences (Xian et al., 2024<sup>[48]</sup>). Growing evidence also indicates that safer neighbourhoods and reduced exposure to crime contribute to better mental health by supporting a greater sense of security, and facilitating community participation (Bogar, 2016<sup>[49]</sup>). Together, these environmental factors shape everyday experiences in ways that influence psychological resilience and mental well-being.

Social conditions beyond the built environment also play a central role. Higher levels of social cohesion and opportunities for social participation help to protect against loneliness and social isolation, which are factors increasingly associated with poor mental health. Evidence from recent longitudinal research shows that strong social connectedness – including social support, larger social networks and lower levels of loneliness – is consistently associated with reduced risks of depression, anxiety and other adverse mental health outcomes (Wickramaratne et al., 2024<sup>[50]</sup>). Findings from the analyses reviewed by that study suggest that higher social connectedness protected against later depressive symptoms and disorders, while loneliness at baseline was repeatedly linked to worse outcomes at follow-up, including increased risk of major depressive disorders and greater severity of depressive and anxiety symptoms.

## **War and conflict have a profound influence on mental health**

War, conflict and geopolitical unrest have long been understood to be associated with increased rates of mental ill health: conditions like generalised anxiety, depressive and post-traumatic stress disorders occur at higher rates in regions and at times of war and conflict (Suhaihan, Grasser and Javanbakht, 2019<sup>[51]</sup>; Charlson, van Ommeren and Flaxman, 2019<sup>[52]</sup>; Abudayya et al., 2023<sup>[53]</sup>). In recent years, the effects of war and conflict in Ukraine (see Box 2.2), the Middle East and beyond have been associated with increases in mental ill health – both within and outside the regions directly affected (Charlson, van Ommeren and Flaxman, 2019<sup>[52]</sup>; Carpiniello, 2023<sup>[54]</sup>). Studies of previous and ongoing war and conflict have confirmed that exposure to these events has a scarring effect, negatively affecting individuals' mental health over the life course (McFarlane, 2015<sup>[55]</sup>). This is true both for professional combatants exposed directly to frontline contexts and for civilians and broader populations, including civilians living in countries that are not directly engaged in war or conflict (Kalaitzaki et al., 2024<sup>[56]</sup>). The mental health effects of exposure to war and conflict are particularly pronounced for children and adolescents, for whom such exposure significantly raises their lifetime risk of developing a mental disorder (Akbulut-Yuksel, Zimmer and Pandey, 2024<sup>[57]</sup>). For example, Viet Nam War survivors who were aged 6-9 at the time of exposure to war were more than three times more likely to experience post-traumatic stress disorder than those who had no, or less, exposure to war. Furthermore, evidence suggests that exposure to wartime events leads to long-term effects and intergenerational trauma, meaning that the effects of current conflicts could adversely affect mental health for decades to come (Ventriglio et al., 2024<sup>[58]</sup>). As such, the impacts of any given war or conflict can be expected to have vast and far-reaching consequences for mental ill health – not only during wartime but over subsequent decades and generations.

### **Box 2.2. Mental health effects of the Russian Federation's invasion of Ukraine**

The Russian Federation's full-scale invasion of Ukraine, launched on 24 February 2022, has been associated with significant impacts to population mental health for Ukrainians living both within and outside Ukraine (Kurapov et al., 2023<sup>[59]</sup>). Indeed, one year after the invasion, a study of 2 364 adults aged 18-79 living in Ukraine found that 44.2% had depressive symptoms, 23.1% had anxiety symptoms and 14.4% had probable post-traumatic stress disorder (Wang et al., 2024<sup>[60]</sup>). Another study looked at the mental health of 8 096 Ukrainian adolescents living both in Ukraine and abroad since 2022. It found that almost half (49.6%) of adolescents living in Ukraine were directly exposed to war; 32.0% screened positive for moderate or severe depression, 17.9% for moderate or severe anxiety, 35.0% for clinically relevant psychological trauma, 29.5% for eating disorders and 20.5% for medium or higher risk of substance use disorders (Goto et al., 2024<sup>[61]</sup>). The psychological symptoms were of a similar magnitude for Ukrainian adolescents living abroad. Unfortunately, the ongoing war and associated high levels of need for mental healthcare has exposed weaknesses in the Ukrainian mental healthcare system, which is struggling to meet the needs of its population due to a lack of financial and human resources, as well as destruction of critical infrastructure (Seleznova et al., 2023<sup>[62]</sup>; Martsenkovskiy et al., 2024<sup>[63]</sup>). Another study found that the detrimental effects of the war are not limited to Ukrainians (Kalaitzaki et al., 2024<sup>[56]</sup>). Although Ukrainians' mental health was the most severely affected by the Russian Federation's full-scale invasion, among 11 countries with differing levels of proximity to Ukraine, non-Ukrainian citizens were also affected. The most significant impacts were found among those countries bordering Ukraine (such as Romania and Poland), with less significant mental health impacts among more distant countries (including Ecuador and Peru).

### ***The cost-of-living crisis and growing economic inequality are increasing rates of mental ill health***

Economic crises have long been known to be associated with increases in mental ill health: the effects of job precarity, job loss and prolonged unemployment all have a detrimental influence on mental well-being (WHO Regional Office for Europe, 2011<sup>[64]</sup>; The Lancet Regional Health – Europe, 2023<sup>[65]</sup>). Recent macroeconomic shocks and trends have been found to be associated with increased rates of mental ill health, including the economic effects of the COVID-19 pandemic, rising rates of income inequality, and increasing levels of job precarity and automatability (Lordan and Stringer, 2022<sup>[66]</sup>; Simonse et al., 2022<sup>[67]</sup>). In 2022, inflation in OECD countries reached the highest levels seen in four decades, resulting in a rapid increase in the cost of living as essentials such as energy, housing and food prices rose faster than real wages (Causa et al., 2022<sup>[68]</sup>). These effects disproportionately affect individuals on low incomes, who are particularly vulnerable to the effects of inflation on increasing costs of living (Bhat and Rather, 2012<sup>[69]</sup>; Barr, Kinderman and Whitehead, 2015<sup>[70]</sup>; Causa et al., 2022<sup>[68]</sup>).

Even in the absence of economic shocks and crises, however, recent research suggests that that increasing levels of income inequality are associated with increased mental ill health – not only among those who experience hardship and deprivation as a result of lower incomes but across the entire population (Tibber et al., 2022<sup>[71]</sup>; Ribeiro, Bauer and Andrade, 2017<sup>[72]</sup>). Indeed, a systematic review and meta-analysis of 26 studies from high-income countries revealed that the risk of depression was 1.19 times (risk ratio) higher among populations with higher levels of income inequality (Patel et al., 2018<sup>[73]</sup>). These effects were more pronounced for certain subgroups, including women and low-income populations. As income and wealth inequality in OECD countries has been rising since the 1980s, it is likely that that these trends are also detrimentally affecting mental well-being, thereby also contributing to the trends in mental ill health (Guschanski and Onaran, 2021<sup>[74]</sup>; Bourquin, Brewer and Wernham, 2024<sup>[75]</sup>).

### ***The influence of social media on children and adolescents’ mental health is of concern***

In recent years, concern has been growing about the impact rising use of social media is having on mental health – particularly for children and adolescents (Barry et al., 2017<sup>[76]</sup>; ANSES, 2025<sup>[77]</sup>). Some evidence suggests that problematic use of social media is associated with increased rates of anxiety, depression and other mental disorders, with increasing evidence that girls and young women are more vulnerable to these effects (Kelly et al., 2018<sup>[78]</sup>; Valkenburg, Meier and Beyens, 2022<sup>[79]</sup>). Indeed, a recent meta-analysis of 143 studies covering more than 1 million adolescents and nearly 900 effect sizes found a small but significant positive association between increased social media use and higher levels of anxiety and/or depression (Fassi et al., 2024<sup>[80]</sup>). Some research has found that there are windows of development in which the effects of social media may have a particularly detrimental effect on well-being, such as during early- to mid-adolescence (Orben et al., 2022<sup>[81]</sup>). Recent OECD interviews with policymakers and clinicians similarly highlighted concerns about mechanisms that may intensify emotional vulnerabilities among young people (Box 2.3). A recent legal development may further reinforce these concerns and accelerate policy responses: in March 2026, a California jury ruled that two major social media platforms were liable for designing addictive platforms that harmed a young woman’s mental health, setting a major legal precedent likely to prompt further claims, and potentially speeding efforts toward stronger regulation of social media (Taylor, 2026<sup>[82]</sup>).

Nevertheless, the evidence on the detrimental relationship between social media use and mental health is not yet considered to be conclusive (Orben and Blakemore, 2023<sup>[83]</sup>). Indeed, some longitudinal studies have not found a significant association between social media use and mental disorders among adolescents (Coyne et al., 2020<sup>[84]</sup>). Other research has suggested that the negative effects of social media may not be a direct result of the time spent on social media, but instead are mediated by mechanisms such as poor sleep, lack of physical activity, online harassment, low self-esteem and poor body image, which can result from higher social media use (Viner et al., 2019<sup>[85]</sup>; Kelly et al., 2018<sup>[78]</sup>). Some evidence, in fact,

suggests that social media use can be associated with an increased sense of community for users (Ulvi et al., 2022<sup>[86]</sup>). Overall, while there does appear to be a negative relationship between social media use and mental health, the causal nature of these effects remains unclear: it has yet to be demonstrated that those who use social media at higher rates are not those who already experience or have a predisposition to mental ill health.

### Box 2.3. Digital environments as intensifiers of emotional vulnerabilities

A recent OECD analysis based on interviews with policymakers and clinical experts confirms that views about the mental health impact of social media remain mixed. Of the 26 stakeholders interviewed, 12 reported a negative effect, while 9 (around one-third) felt they lacked sufficient evidence to judge, and an additional 5 expressed a neutral position.

Interviewed experts mentioned that social media can disrupt protective routines such as sleep, schoolwork and in-person social interaction, and that algorithm-driven feeds may increase exposure to harmful or distressing material. Clinicians noted that adolescents already experiencing anxiety, depression or low self-esteem can be particularly vulnerable, with body-image-related content highlighted as especially concerning for girls. A recurring theme was an “amplification effect”, whereby constant, real-time access to negative news and crisis-focused content heightens fear, worry and hopelessness among children and adolescents. Interviewees also warned that continuous exposure to global conflicts, violence or distressing imagery may intensify negative emotions and deepen existing vulnerabilities. Experts further expressed concern about misleading or inaccurate mental health information circulating on social media, noting that repetitive exposure can encourage self-diagnosis, over-pathologisation of normal emotions and, in some cases, increased emotional distress among young users.

Source: OECD (2026<sup>[87]</sup>), *Child, Adolescent and Youth Mental Health in the 21st Century*, <https://doi.org/10.1787/1092c3cb-en>.

## Mental ill health is inequitably distributed by gender, age, income and socio-economic status

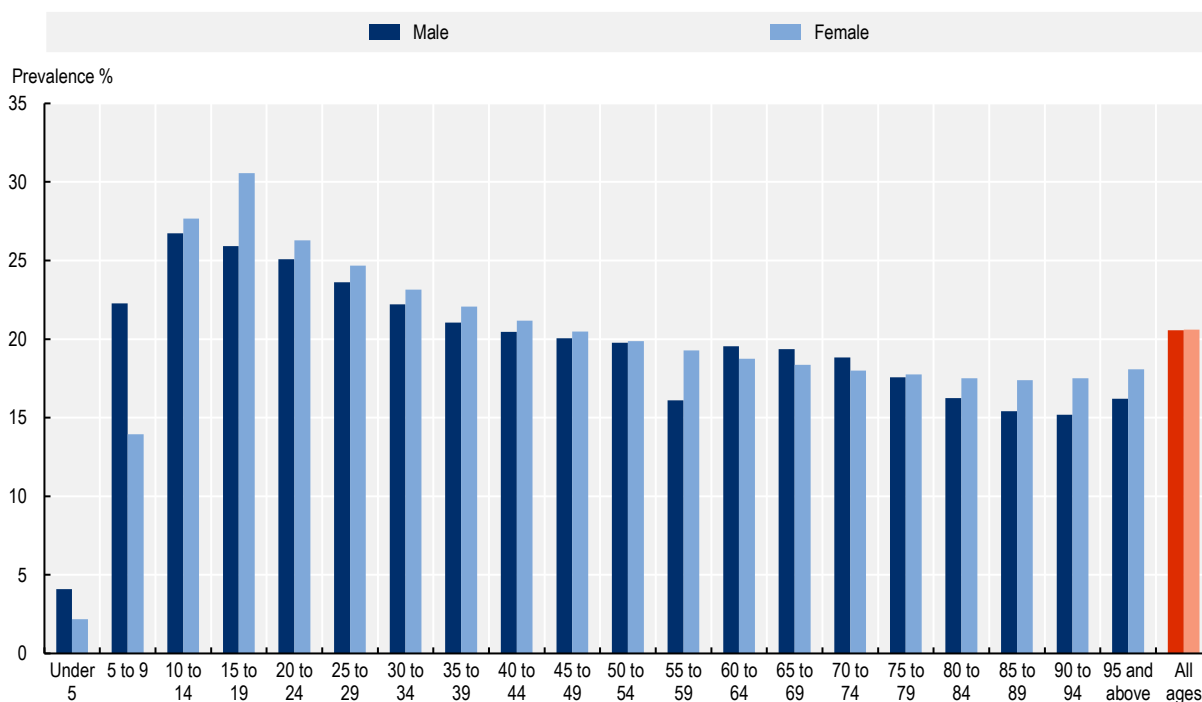
A range of socio-demographic factors are associated with elevated risk of mental ill health (Kirkbride et al., 2024<sup>[88]</sup>). While there is evidence of a broad range of factors, many of which can be cultural or regionally specific (such as culturally and linguistically diverse communities and native populations), a selection of commonly researched socio-demographic risk factors with a robust evidence base are discussed below. Understanding the factors that heighten risk of mental ill health throughout an individual’s life course is essential to implementing efficient and effective interventions for the right people at the right time. In particular, gender, age and socio-economic status have been shown to be strongly associated with mental health outcomes, as discussed below.

### ***Mental ill health is unequally distributed by gender***

It is well established that gender is a strong predictor of mental health, predicting not only prevalence but also the type and severity of the mental disorder suffered. As shown in Figure 2.5, women and girls experience higher rates of mental disorders than males across most age groups in EU countries, except children under 10 and adults aged 60-74. When looking at specific conditions, girls and women show higher rates of depression and anxiety than men and boys, while men experience higher rates of less prevalent disorders such alcohol use and substance use disorders (Kuehner, 2017<sup>[89]</sup>; Foster et al.,

2016<sup>[90]</sup>). The factors that drive these differences by gender are difficult to disentangle, although evidence overall suggests that both biological and social factors contribute to these disparities (Farhane-Medina et al., 2022<sup>[91]</sup>). Biological factors include genetics and hormones, encompassing hormonal changes with reproductive events such as menstruation, pregnancy and menopause, which increase the likelihood of depression and anxiety over a woman's life course (Halbreich and Kahn, 2001<sup>[92]</sup>; Soares and Zitek, 2008<sup>[93]</sup>; Bains and Abdijadid, 2024<sup>[94]</sup>).

**Figure 2.5. Prevalence of mental disorders by gender and age in EU countries, 2023**



Note: Anxiety disorders, bipolar disorders, depressive disorders, schizophrenia, substance use disorders and others (attention deficit and hyperactivity disorders, autism spectrum disorders, conduct disorders, eating disorders and other mental disorders) were included. It is likely that cumulative numbers are a slight overestimate, as individuals experiencing multiple disorders at once would be double counted in cumulative tallies.

Source: IHME (2026<sup>[7]</sup>), GBD Compare Data Visualization, <https://vizhub.healthdata.org/gbd-compare>.

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Social factors also probably play an important role in explaining the gender disparities in prevalence of mental disorders. Women experience disproportionate rates of sexual and domestic violence, which has been closely tied to adverse mental health outcomes (Oram, Khalifeh and Howard, 2017<sup>[95]</sup>). Moreover, socially constructed gender norms, roles and responsibilities create circumstances for women – far more frequently than men – in which they have little control over important decisions concerning their lives (WHO, 2002<sup>[96]</sup>). It is also suggested that interview techniques and self-reported instruments may not detect a large proportion of men who experience depressive symptoms (Addis, 2008<sup>[97]</sup>). Artefactual factors – such as women seeking help and reporting more detail about their depressive symptoms more often – may also contribute to the observed differences in mental ill health prevalence by gender (Kuehner, 2003<sup>[98]</sup>).

### ***Rates of mental ill health vary by age***

As shown in Figure 2.5, mental ill health is not distributed homogeneously across age groups. Prevalence of mental ill-health becomes measurable from around age 5, and rises steadily through childhood, reaching its highest levels in adolescence and early adulthood, when more than 26% of those aged 15-19 and 20-24 are living with a mental disorder. Prevalence then declines relatively consistently, up to age 95 and above, at which point prevalence of mental ill health appears to increase slightly – particularly for men. The fact that mental ill health is highest among adolescents and young adults is concerning, particularly considering the importance of this age group as a future predictor of mental health. Indeed, the life-course approach to mental health has been developing in recent years, and has demonstrated the unique importance of childhood and adolescence to mental health (Stelmach et al., 2022<sup>[99]</sup>; McDaid and Park, 2022<sup>[100]</sup>). This area of research emphasises that an individual’s mental health is shaped by experiences, exposures and influences across their entire lifespan, from before birth to old age, and across generations (Zhang et al., 2024<sup>[101]</sup>; Koenen et al., 2013<sup>[102]</sup>). Key life stages – such as childhood, adolescence, adulthood and later life – are considered critical windows during which positive or negative influences can have long-lasting effects. Indeed, 75% of adult mental disorders start before the age of 24 (Fusar-Poli, 2019<sup>[103]</sup>). When left untreated, early-onset mental disorders tend to persist into adulthood, contributing to the burden of many chronic mental disorders (Jones, 2013<sup>[104]</sup>; Kim-Cohen et al., 2003<sup>[105]</sup>). Promisingly however, early-onset cases of mental ill health can be very responsive to treatment, although they can often be more serious (Jones, 2013<sup>[104]</sup>). As such, adolescence and young adulthood is also a period when prevention or effective mental health interventions may yield substantial long-term benefits by reducing the risk of mental ill health that will endure (Fusar-Poli, 2019<sup>[103]</sup>).

In addition to the high prevalence of mental ill health among adolescents and young adults, the life-course approach to mental health highlights that accumulated adversities across the life course escalate risk of mental ill health. For example, transformative stages and/or events in life are associated with an elevated risk of new and reoccurring mental disorders – such as pregnancy and postpartum, job loss, extended period(s) of unemployment, divorce and family dissolution, death of a partner or other family member, economic hardship, migration, child or sexual abuse, and experiencing or observing domestic violence (Mindlis and Boffetta, 2017<sup>[106]</sup>; Lippard and Nemeroff, 2020<sup>[107]</sup>; Bhuller et al., 2024<sup>[108]</sup>; Grummitt et al., 2024<sup>[109]</sup>; Hald et al., 2020<sup>[110]</sup>; Munk-Olsen et al., 2006<sup>[111]</sup>; Virgolino et al., 2022<sup>[112]</sup>). A range of socio-economic risk factors – such as earning a low income or racial discrimination – further compound the risk of developing mental ill health (Kessler et al., 2005<sup>[113]</sup>; Houtepen et al., 2020<sup>[114]</sup>; McLaughlin et al., 2012<sup>[115]</sup>; Turner et al., 2019<sup>[116]</sup>; Merikukka et al., 2020<sup>[117]</sup>). Significantly, accumulation of multiple adverse events has not only an additive effect for risk of mental disorder onset but an interactive accumulation during the life course, in that each adverse event has a more significant negative effect when it occurs simultaneously with another (Mandemakers and Kalmijn, 2018<sup>[118]</sup>). As such, targeting at-risk age groups and people experiencing life transitions that put them at higher risk of mental ill health is increasingly understood to be to a more efficient and effective way to prevent and treat mental ill health (Khanh-Dao Le et al., 2021<sup>[119]</sup>).

### ***Mental ill health is inequitably distributed across socio-demographic groups***

As discussed, mental ill health is disproportionately experienced by gender and across the life course (Kirkbride et al., 2024<sup>[88]</sup>). While a broad range of factors elevate risk, two primary factors have been shown to be consistent predictors of mental ill health across countries and cultures: income and level of education. To estimate the extent to which inequalities exist across these socio-economic groups in the 27 EU countries, Iceland and Norway, an analysis was conducted using the Relative Index of Inequality (RII). This is a measure frequently used in epidemiological studies to assess socio-economic inequalities in health (Moreno-Betancur et al., 2015<sup>[120]</sup>), as described in Box 2.4. Owing to availability of data on income and level of education, this analysis was only able to be conducted for depressive symptoms, which is a

broader classification than major depressive disorders or depressive disorders. It refers to self-reported measures of depressive symptoms experienced in the prior two weeks, rather than reaching a clinical cutoff for depressive disorders (used for data analysed earlier in the chapter) (Eurostat, 2019<sub>[121]</sub>).

### Box 2.4. The Relative Index of Inequality

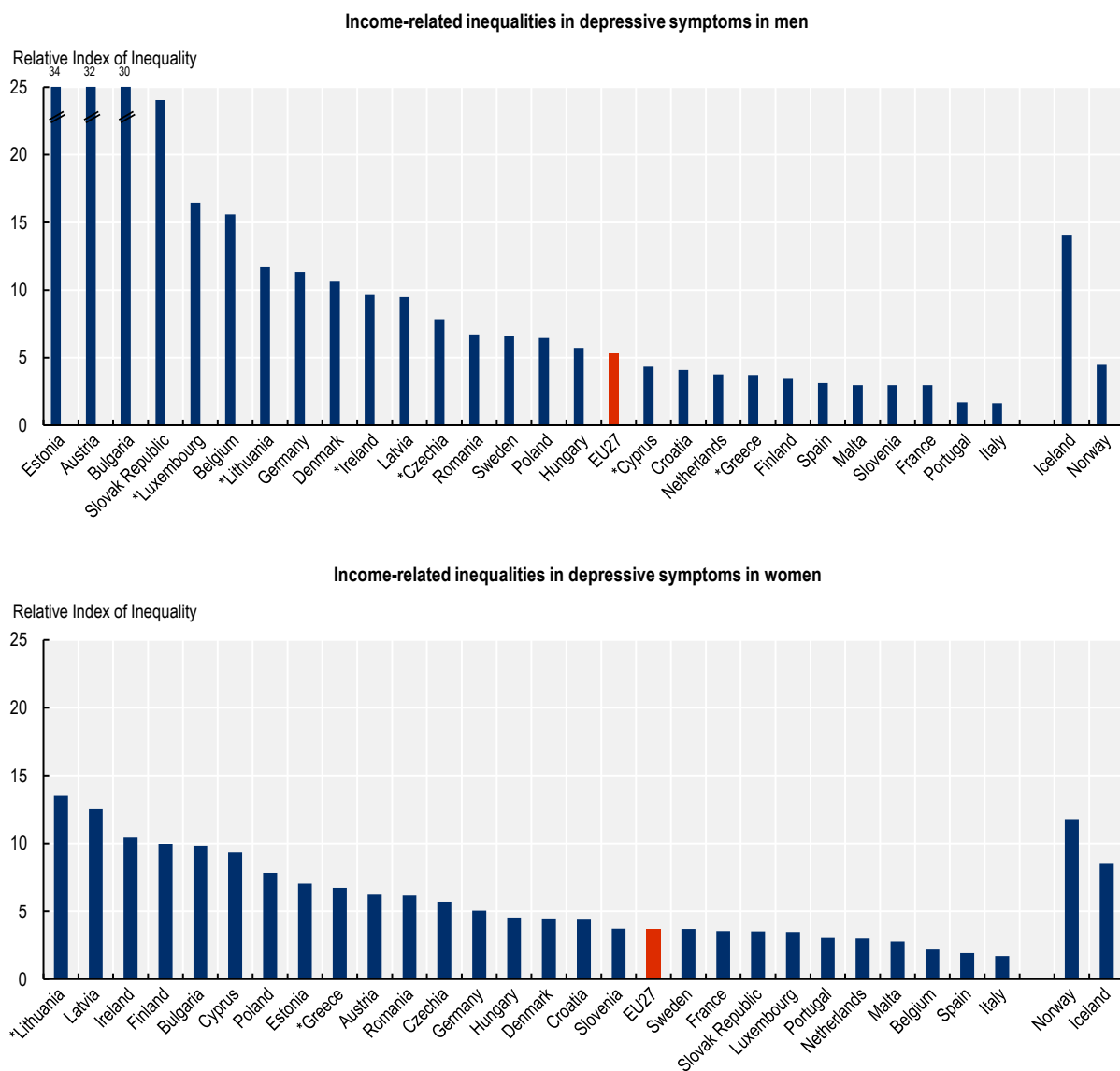
The RII is a commonly used measure of the extent to which an outcome, such as prevalence of a mental disorder, occurs as a function of socio-economic status (Sergeant and Firth, 2006<sub>[122]</sub>). The advantage of using RII is that it considers both population size and the comparative socio-economic status of various groups (Mackenbach and Kunst, 1997<sub>[123]</sub>). It aims to standardise the impact of the variation in socio-economic group size on the magnitude of health inequalities (Mackenbach et al., 2008<sub>[124]</sub>). It indicates the ratio between the rates of the lowest and the highest socio-economic groups (referring to education, occupation status or income). Typically it is conceptualised analogously to relative risk, represented as  $RII = h(1)/h(0)$ , where  $h(x)$  signifies the occurrence of health events, such as hazard rates or incidence rates, as a function of the socio-economic rank (Mackenbach et al., 2008<sub>[124]</sub>). The positions 0 and 1 represent the theoretical extremes of socio-economic advantage and disadvantage, respectively (Moreno-Betancur et al., 2015<sub>[120]</sub>). A higher score on the RII implies large health differences between the highest and the lowest socio-economic groups (Mackenbach and Kunst, 1997<sub>[123]</sub>). An RII value higher than 1 refers to higher prevalence of outcome of interest among those with a lower socio-economic status, while an RII lower than 1 indicates higher prevalence among those with higher socio-economic status (Hosseinpoor et al., 2012<sub>[125]</sub>). For example, an RII of 1.5 indicates that people in the lowest income quintile are 50% more likely to have the outcome of interest (e.g. depressive symptoms) than people in the highest income quintile.

### *Income is a strong predictor of mental health*

Income is consistently shown to be a very strong predictor of mental health. Individuals on lower incomes experience higher rates of mental ill health, including but not limited to major depression, anxiety and substance use disorders (Sareen et al., 2011<sub>[126]</sub>; Spivak et al., 2019<sub>[127]</sub>). These outcomes for people on lower incomes are argued to be driven by increased exposure to a range of additional hardships, such as housing and food insecurity, over-indebtedness, and an erosion of protective psychological factors (personal agency, self-esteem and hope) (Frankham, Richardson and Maguire, 2020<sub>[128]</sub>; Kimenez-Solomon et al., 2022<sub>[129]</sub>). Furthermore, low income earners may lack access to coping resources like social support networks that can help to buffer the effects of these stressors (Fryers et al., 2005<sub>[130]</sub>). This disparity may contribute to higher levels of social exclusion and feelings of marginalisation among people on lower incomes (Pickett and Wilkinson, 2010<sub>[131]</sub>). Importantly, the relationship between income and mental health is bi-directional, meaning that while low incomes lead to higher levels of mental ill health, higher levels of mental ill health also lead to lower incomes (Rauf, 2023<sub>[132]</sub>).

Analysis using the RII methodology reinforces previous evidence of a negative relationship between income and mental health outcomes, as shown in Figure 2.6. The analysis defines the lowest income group as the bottom 20% (quintile) of income earners, and the highest income group as the top 20% (quintile) of income earners in the 27 EU countries, Iceland and Norway. The analysis, divided by gender groups, reveals that men tend to experience greater levels of income-related disparities in depressive symptoms than women. Across these countries, the RII for males is around 5.3 and the RII for females is around 3.7, meaning that men in the lowest income quintile are more than five times more likely and women in the lowest quintile are nearly four times more likely to report depressive symptoms than those in the highest income quintile.

Figure 2.6. Income-related inequalities in depressive symptoms



Note: \* Prevalence of depressive symptoms for those with the highest income among those in the top quintile is assumed to be 1%.

Source: OECD analysis of Eurostat (2019<sub>[133]</sub>) data on current depressive symptoms by sex, age and income quintile (data refer to 2019).

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Income-related inequalities in depressive symptoms vary widely across countries. In ten countries, men in the lowest income quintile are more than ten times as likely to have chronic depression as those in the highest. The largest disparity is observed in Estonia, where the least wealthy men are almost 34 times more likely to experience depressive symptoms than their wealthiest counterparts. The smallest disparities are observed in Italy (RII = 1.6), where men with the lowest income levels are 60% more likely to have depressive symptoms than those with the highest (RII = 1.7). In five countries, women with the lowest incomes are ten times more likely to demonstrate depressive symptoms: Lithuania (RII = 13.5), Latvia (RII = 12.5), Norway (RII = 11.8), Ireland (RII = 10.4) and Finland (RII = 10.0). Among women residing in

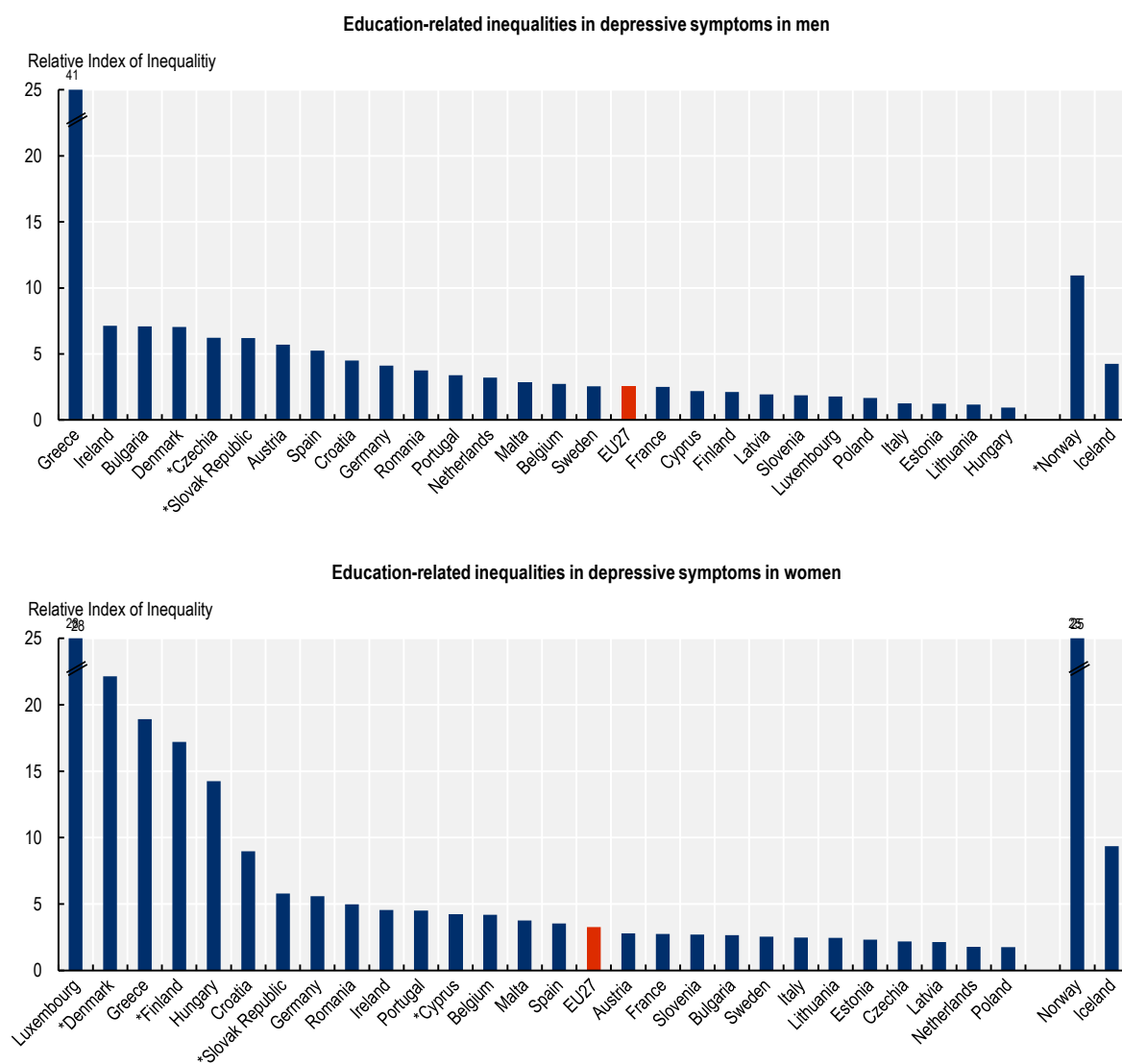
Italy (RII = 1.7), Spain (RII = 1.9) and Belgium (RII = 2.2), the levels of income-related inequalities in depressive symptoms are lowest. These findings align with previous studies, which reported that men suffer from higher levels of mental health disparities associated with income (Wildman, 2003<sup>[134]</sup>; Jacquet et al., 2018<sup>[135]</sup>).

*Level of educational attainment has an impact on mental health*

Like income, level of educational attainment is a reliable predictor of mental ill health (OECD, 2021<sup>[136]</sup>). Epidemiological studies consistently demonstrate that people with lower education levels experience higher prevalence of mental disorders (Dudal and Bracke, 2016<sup>[137]</sup>; Degerlund Maldi et al., 2019<sup>[138]</sup>). However, the reasons for these differences remain disputed. Some argue that higher educational attainment results in fewer chronic stressors, healthier lifestyles, more social support and better economic resources, and therefore is causally linked to lower levels of mental ill health (Ross and Wu, 1996<sup>[139]</sup>; Niemeyer et al., 2019<sup>[140]</sup>). Others suggest that people with higher education levels have better access to information about treatment options, and experience more effective symptom relief than those with lower education levels (Costa-Font and Gil, 2008<sup>[141]</sup>). Nevertheless, some research casts doubt over the causal impact of education on mental ill health, suggesting instead that education is a proxy for unobserved factors such as early-onset mental health problems, family characteristics, biologically based health conditions and genetics (Halpern-Manners et al., 2016<sup>[142]</sup>). There is also strong evidence of at least a bi-directional relationship between mental health and education, as evidence of mental ill health in school is associated with lower levels of educational attainment (Esch et al., 2014<sup>[143]</sup>).

The analysis undertaken on the 27 EU countries, Iceland and Norway using the RII method supports the premise that there is a negative relationship between education level and depressive symptoms. An RII greater than 1 indicates that depressive symptoms are more prevalent among those with the lowest levels of educational attainment. As shown in Figure 2.7, men in the lowest education quintile are 2.5 times more likely to have depressive symptoms than those in the highest. The largest inequalities among men were observed in Greece, where men with the lowest education levels were more than 41 times more likely to experience depressive symptoms than their most educated counterparts (RII = 41.1). In line with previous findings, women tend to experience greater levels of education-related disparities in depressive symptoms than men. In six countries, women with the lowest levels of education are more than 14 times more likely to demonstrate depressive symptoms. The largest education-related disparities in depressive symptoms among women were found in Luxembourg (RII = 27.5), Norway (RII = 25.3) and Denmark (RII = 22.1), while the smallest were found in the Netherlands (RII = 1.8) and Poland (RII = 1.8). On average, the least educated women in the studied countries were 3.3 times more likely to experience depressive symptoms than those with the highest education levels.

Figure 2.7. Education-related inequalities in depressive symptoms



Note: Refers to individuals aged 15-64. Population data from Eurostat disaggregated by educational attainment level, sex and age were used.  
 \* Prevalence of depressive symptoms for those with highest level of education among those in tertiary education is assumed to be 1%.  
 Source: OECD analysis of Eurostat (2019<sub>(133)</sub>) data on current depressive symptoms by sex, age and educational attainment level (data refer to 2019).

StatLink  <https://stat.link/ceyzsr>

## Trends and patterns can be seen in access to and unmet needs for mental health services

In recognition of the significant rates and inequalities in mental ill health, many countries have made attempts in recent years to increase access to mental health services, and to move the focus of services from hospitals into the community and other non-traditional mental healthcare settings. Despite this, a substantial proportion of individuals with mental ill health have unmet mental healthcare needs. This refers

to the gap between the services required to address one's mental health concerns and treatment coverage rates (the proportion of individuals who are able to access mental healthcare).

### **Several factors create barriers to mental healthcare access**

A variety of barriers contribute to unmet mental health needs, including financial, geographical and organisational barriers to mental healthcare (OECD, 2021<sup>[144]</sup>).

- In many regions, mental health services – particularly psychological therapies – may not be covered by health insurance or public health coverage, requiring individuals to pay out of pocket. This financial cost creates a significant barrier to accessibility, especially for those on low incomes (Mojtabai, Olfson and Mechanic, 2002<sup>[145]</sup>; Wang et al., 2007<sup>[146]</sup>).
- Geographical barriers also prevent access to mental healthcare, as individuals living in rural areas are less likely to receive mental health treatment than those who reside in urban areas (Wang et al., 2005<sup>[147]</sup>).
- Systemic issues like shortages of healthcare professionals also create organisational barriers to access and a scarcity of available services. A lack of trained mental health providers – including psychiatrists, psychologists, clinical psychologists and specialist nurses – can result in extensive waiting times for mental healthcare, which is associated with poorer mental health outcomes (Punton, Dodd and McNeill, 2022<sup>[148]</sup>; Boerema et al., 2017<sup>[149]</sup>; OECD, 2021<sup>[144]</sup>). Indeed, longer waits for psychiatric appointments can lead to increases in psychiatric hospitalisations, decompensation, impairment, disability and risk of suicide (Williams, Latta and Conversano, 2008<sup>[150]</sup>; Reichert and Jacobs, 2018<sup>[151]</sup>).
- Administrative requirements such as referrals from a GP are often needed to receive specialised mental healthcare. Insufficient referral information and inadequate co-ordination between GPs and mental health specialists also results in poor continuity of care and longer waiting times (Yang et al., 2022<sup>[152]</sup>; Hartveit et al., 2017<sup>[153]</sup>). In several OECD countries, a waiting-time target or guarantee has been set up in at least one area of mental healthcare, and most countries aim for patients to start treatment or make the first service contact within 1-3 months (OECD, 2021<sup>[144]</sup>).

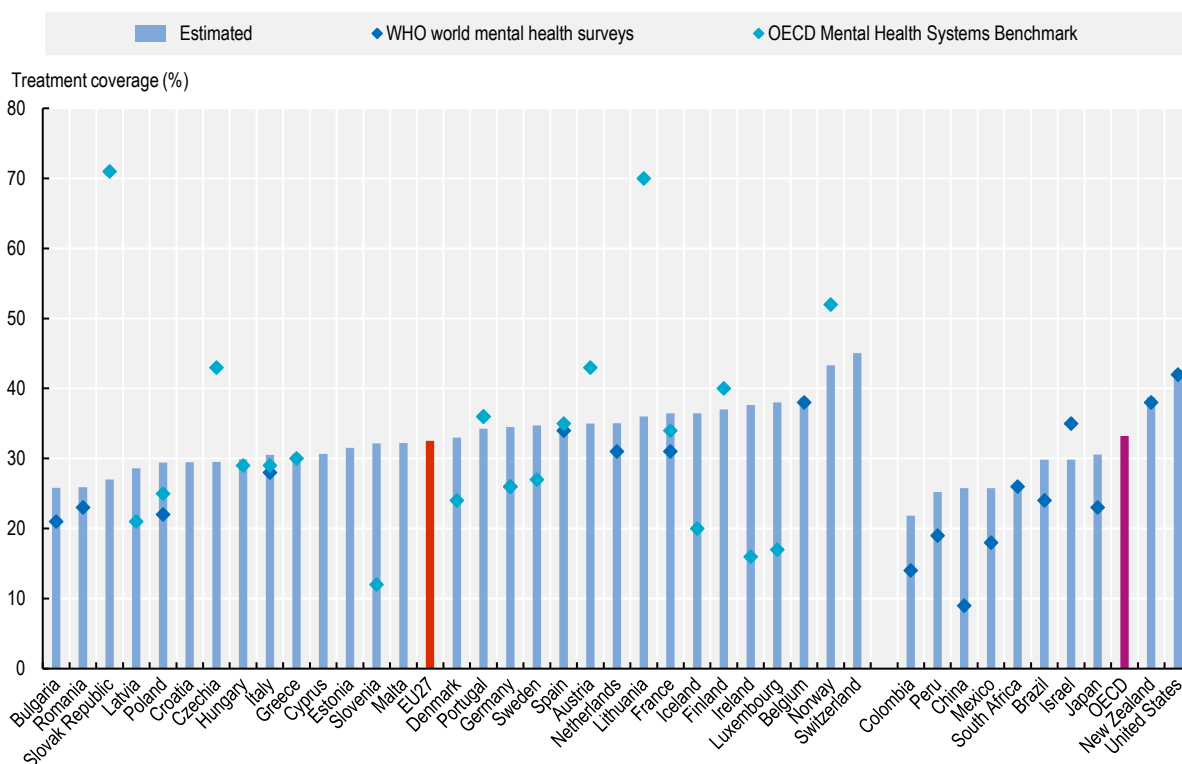
### **Only one-third of people requiring mental healthcare in EU countries are estimated to have access to treatment for their condition**

At present, understanding the extent of unmet needs for mental health is difficult because of a lack of data using consistent definitions. In the absence of an international standardised definition that provides a comparable measure of unmet mental healthcare needs across OECD countries and beyond, this publication estimates treatment coverage – referring to the proportion of people with mental disorders who are able to access mental health treatment. This estimation was based on existing research using OECD data reporting the share of people with unmet needs (OECD, 2021<sup>[144]</sup>) and treatment coverage estimates from the WHO World Mental Health survey. The survey asked respondents from several EU countries whether they had ever sought professional help for issues related to emotions, mental health, nerves or substance use, and, if they had, whether they had received such treatment within the 12 months preceding the interview (Evans-Lacko et al., 2018<sup>[154]</sup>). Based on that analysis, the calculation used in this publication as a proxy for treatment access is 100% minus the share of individuals identified as having unmet needs. For countries that were missing from this measure, a statistical regression analysis was conducted using both WHO measured data and OECD benchmarks to estimate the treatment access levels for the remaining EU countries.

Figure 2.8 represents the results of this analysis, showing that treatment access levels are estimated at 33% across EU countries. The highest rates are estimated to be in Norway and Switzerland (43% and 45%), while the lowest reported levels are in Bulgaria and Romania (26%). There are obviously limitations to this measure, such as the fact that people who had not sought treatment (for example, owing to barriers

such as financial burden) would not be captured. While this, among a range of other limitations, may reduce the accuracy of this measure, the analysis provides an interesting estimate of treatment access rates in the absence of a more comprehensive international measure of unmet healthcare needs.

**Figure 2.8. Treatment coverage for mental ill health across OECD and EU countries**



Note: Extrapolation for countries lacking data was performed using an ensemble model based on a lasso regressor, incorporating the following country-specific indicators: suicide rates, depression rates, world happiness index, number of mental health professionals, universal healthcare service coverage index and GDP. Extrapolated data should only be considered as a high-level indicator of the possible coverage of services for mental ill health.

Source: OECD Mental Health Systems Performance Benchmark survey (2021<sup>[144]</sup>), WHO World Mental Health survey (Evans-Lacko et al., 2018<sup>[154]</sup>).

StatLink  <https://stat.link/aqm5x6>

It is also worth noting that, with 67.5% of people across EU and OECD countries lacking treatment coverage for mental health conditions (Figure 2.8), unmet needs for mental healthcare appear substantial. Although the measure may not be fully comparable with the share of unmet needs for medical examinations and treatments, given that the numerators do not necessarily cover the same population of individuals who sought care, the significant contrast suggests that access challenges may be more pronounced for mental healthcare. Self-reported data from the 2024 EU-SILC survey indicate that 3.8% of people aged 16 and over in the EU reported an unmet need for a medical examination or treatment. Waiting lists were the most frequently cited reason, accounting for more than one-third of cases, followed by high costs, which represented around 26% (Eurostat, 2025<sup>[155]</sup>).

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## Notes

<sup>1</sup> The regional classification of European countries is based on the geographic classifications provided in EuroVoc, a multilingual thesaurus maintained by the Publications Office of the EU (2024<sup>[156]</sup>). The countries included in each European region are as follows: Central and Eastern Europe includes Bulgaria, Croatia, Czechia, Hungary, Poland, Romania, the Slovak Republic and Slovenia; Northern Europe includes Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden; Southern Europe includes Cyprus, Greece, Italy, Malta, Portugal and Spain; and Western Europe includes Austria, Belgium, France, Germany, Ireland, Luxembourg, the Netherlands and Switzerland.

# 3

## The significant health, social and economic costs of mental ill health

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This chapter provides an overview of the health and economic burden of mental ill health. Based on the results of the OECD Strategic Public Health Planning for Non-Communicable Diseases (SPHeP-NCDs) model, it presents the impact of mental ill health of three of the most prevalent mental disorders: major depressive disorders, generalised anxiety disorders and alcohol use disorders across EU countries. The analyses conducted using the OECD SPHeP-NCDs model gauge the impact of these conditions on health and economic outcomes in EU countries over the period 2025-2050, including effects on life expectancy, health expenditure and the labour market.

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## Key findings

- Mental ill health gives rise to significant health, social and economic costs. Major depressive disorders, generalised anxiety disorders and alcohol use disorders are among the most common mental health conditions. They account for the largest share of the burden on individuals and the economy, and are the primary focus of this chapter.
- Across EU countries, mental ill health is found to have a substantial impact on quality of life, reducing healthy life expectancy by an average of 2.5 years. Its impact on overall life expectancy is smaller – reducing it by an average of 0.25 years, or around 3 months. Nevertheless, this corresponds to approximately 28 000 premature deaths (among people aged under 75) each year, including deaths by suicide resulting from self-harm.
- At the current level of coverage, mental ill health is estimated to account for 6% of the aggregate annual health budget in EU countries. This corresponds to an average expenditure of EUR 76 billion annually from 2025 to 2050, which is comparable to Belgium's total annual healthcare budget.
- Treatment coverage for mental ill health is estimated to be low, at around 33% across EU countries. Closing this gap would require an increase in the budget devoted to mental health, which could amount to a 41% increase (about EUR 72 per capita per year) compared to current spending, if EU countries aimed to achieve full coverage.
- Beyond its costs to the healthcare system, mental ill health places a significant economic burden on the labour market due to the economic costs associated with absenteeism, presenteeism, unemployment and early retirement. These costs are equivalent to a loss of about 2.4 million full-time equivalent workers per year, which is similar to the Croatian working-age population.
- GDP in EU countries is projected to be 1.7% lower each year than it would be in the absence of mental ill health. This is equivalent to an annual loss of EUR 313 billion – approximately the same as the GDP of Czechia in 2023.

## The OECD Strategic Public Health Planning for Non-Communicable Diseases model estimates a substantial health and economic burden of mental ill health

As outlined in Chapter 2, prevalence of mental ill health is high across the population, with almost one in five people across EU and OECD countries experiencing a mental disorder in 2022. This high prevalence has significant negative impacts not only on health and quality of life but also on a country's broader economic prosperity. In order to model the health and economic impacts, the OECD SPHeP-NCDs microsimulation model has been adapted to simulate the emergence of mental ill health across the 27 EU Member States, Iceland, Norway and Switzerland over the period 2025-2050 (Box 3.1). The scope of this modelling includes three of the most prevalent conditions:

- major depressive disorders (including two levels of severity: mild and moderate, and severe)
- generalised anxiety disorders
- alcohol use disorders.

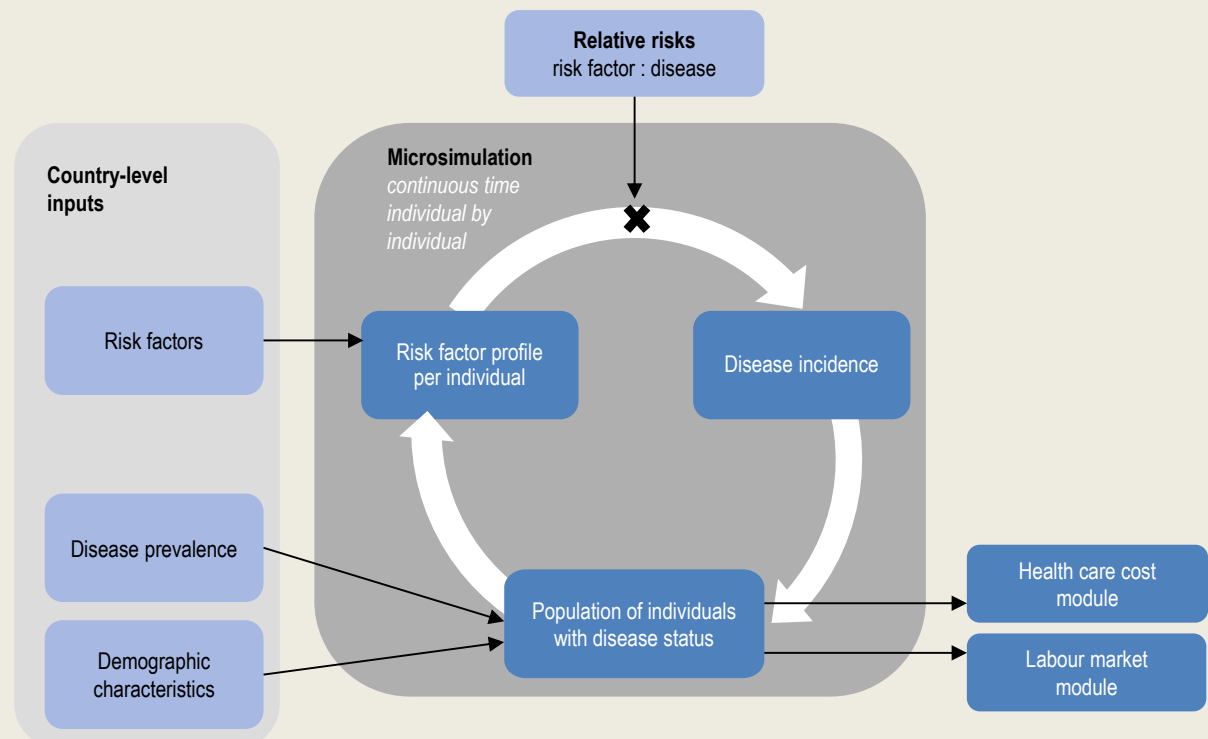
As discussed in Chapter 2, the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013<sup>[1]</sup>) and the International Classification of Diseases (WHO, 2026<sup>[2]</sup>) also include the following major categories of mental disorders: substance use disorders (excluding alcohol use disorders); bipolar and related disorders, and all other disorders. The decision to limit the scope of modelling the impacts of mental ill health to the three leading conditions (major depressive, generalised anxiety and alcohol use disorders) reflects the complexity and resources required to extend the analysis to additional diseases. Consequently, the modelling of economic and cost impacts focusses on these three most prominent conditions, which account for the majority of diagnosed mental disorders. These conditions are referred to collectively as “mental ill health” in this chapter, acknowledging that the findings underestimate the true impact of all mental health conditions. This underestimation is further reinforced by the fact that the analysis does not capture several significant indirect social costs – including, for example, lower educational attainment, heightened risks of poverty and social exclusion, and broader impacts on family well-being and intergenerational outcomes.

### Box 3.1. The OECD Strategic Public Health Planning for Non-Communicable Diseases model

The OECD SPHeP-NCDs model is an advanced systems modelling tool for public health policy and strategic planning. It is used to predict the health and economic outcomes of the population of a country or a region up to 2050. The model produces a comprehensive set of key behavioural and physiological risk factors and their associated non-communicable diseases, including mental ill health.

The model focussing on mental ill health currently covers 30 countries: the 27 EU Member States, Iceland, Norway and Switzerland. Results also include averages for the 27 EU countries. For each of the 30 countries, the model uses demographic and risk factor characteristics by age and gender-specific population groups from international databases (see Figure 3.1). These inputs are used to generate synthetic populations, in which each individual is assigned demographic characteristics and a risk factor profile. Based on these characteristics, an individual has a certain risk of developing a disease each year. Incidence and prevalence of diseases in a specific country's population were calibrated to match estimates from international datasets.

**Figure 3.1. Schematic overview of the modules in the OECD Strategic Public Health Planning for Non-Communicable Diseases model**



Note: This schematic is highly simplified and focusses on the disease component – it does not reflect some other components of the model (including births, immigration, emigration, deaths, remission and case-fatality rates).

Source: For more information on the OECD SPHeP-NCDs model, see the SPHeP-NCDs Technical Documentation, available at: <http://oecdpublichealthexplorer.org/ncd-doc>.

### Model outputs

For each year, a cross-sectional representation of the population can be obtained, to calculate health status indicators such as life expectancy, premature deaths (including as a result of self-harm), disease prevalence and DALYs using standard disability weights. Healthcare costs of disease treatment are estimated based on a per case annual cost, which is extrapolated from national health-related expenditure data. The additional costs of multimorbidity and end-of-life care are also calculated and applied.

The labour market module uses relative risks to relate disease status to the risk of absenteeism, presenteeism (where sick individuals, even if physically present at work, are not fully productive), early retirement and employment. These changes in employment and productivity are estimated in number of full-time equivalent workers and costed based on a human capital approach,<sup>1</sup> using national average wages. The output of the labour market module is also the main input for calculating the impact on GDP. Consistent with the approach used in the OECD's long-term economic forecasting mode (Guillemette and Turner, 2017<sup>[3]</sup>) and other established long-term models, such as the Long-Term Growth Model of the World Bank, a Cobb-Douglas production function is used (Loayza and Pennings, 2022<sup>[4]</sup>). In practical terms, the labour component of the working-age population (those aged 15-74) is modified based on the change of full-time equivalent workers.

### The mental health module

The SPHeP-NCDs model includes three major mental health conditions: major depressive disorders, generalised anxiety disorders and alcohol use disorders. Mental disorders are modelled via specific modules developed for each disease.

For major depressive and generalised anxiety disorders, an integrative approach is used, combining multiple longitudinal datasets to reconstruct individuals' mental health trajectories along a score curve that captures the range from no mental ill health to severe mental ill health. Each individual in the model is assigned with a PHQ-8 and a GAD-7 score (see Chapter 1, Box 1.2). Distribution of both scores is modelled using micro-level data with a zero-inflated beta regression using parameters of age, sex and country for PHQ-8 and age, sex and PHQ-8 score for GAD-7. The regression is performed in two steps: first, a logistic regression to predict the probability of zero and then, a beta regression to model the final score, taking into account the zero probability and scaling the score to between 0 and 1 to fit the distribution. Various models were tested to reproduce as closely as possible the observed PHQ-8 and GAD-7 score distributions, with the zero-inflated beta regression producing the best results.

Based on their score, individuals are more or less likely to develop major depressive and generalised anxiety disorders. Scores are recalculated on a bi-annual basis and following an episode of either disorder. For major depressive disorders, this link is based on a two-step method combining PHQ-8 screening and diagnostic criteria (Kroenke et al., 2009<sup>[5]</sup>). For generalised anxiety disorders, as no such empirical link was identified, a direct correspondence between the GAD-7 anxiety score and a diagnosis of generalised anxiety disorder was assumed.

The ninth question of the PHQ-9 score is modelled separately. Probability of having suicidal thoughts – identified via any “yes” response to question 9 on suicidal thoughts (from occasionally to almost every day) – is estimated based on micro-level data and modelled as a function of the PHQ-8 score. When question 9 is present, individuals are at higher risk of self-harm.

Incidence of alcohol use disorders is instead linked to the volume and pattern of alcohol consumption, based on relative risks. This model does not include other highly disabling conditions such as schizophrenia and bipolar disorder; nor does it account for upstream determinants of mental health such as well-being and resilience, which means it likely underestimates the true burden of mental ill-health.

For more information on the OECD SPHeP-NCDs model, see the SPHeP-NCDs Technical Documentation, available at: <http://oecdpublichealthexplorer.org/ncd-doc>.

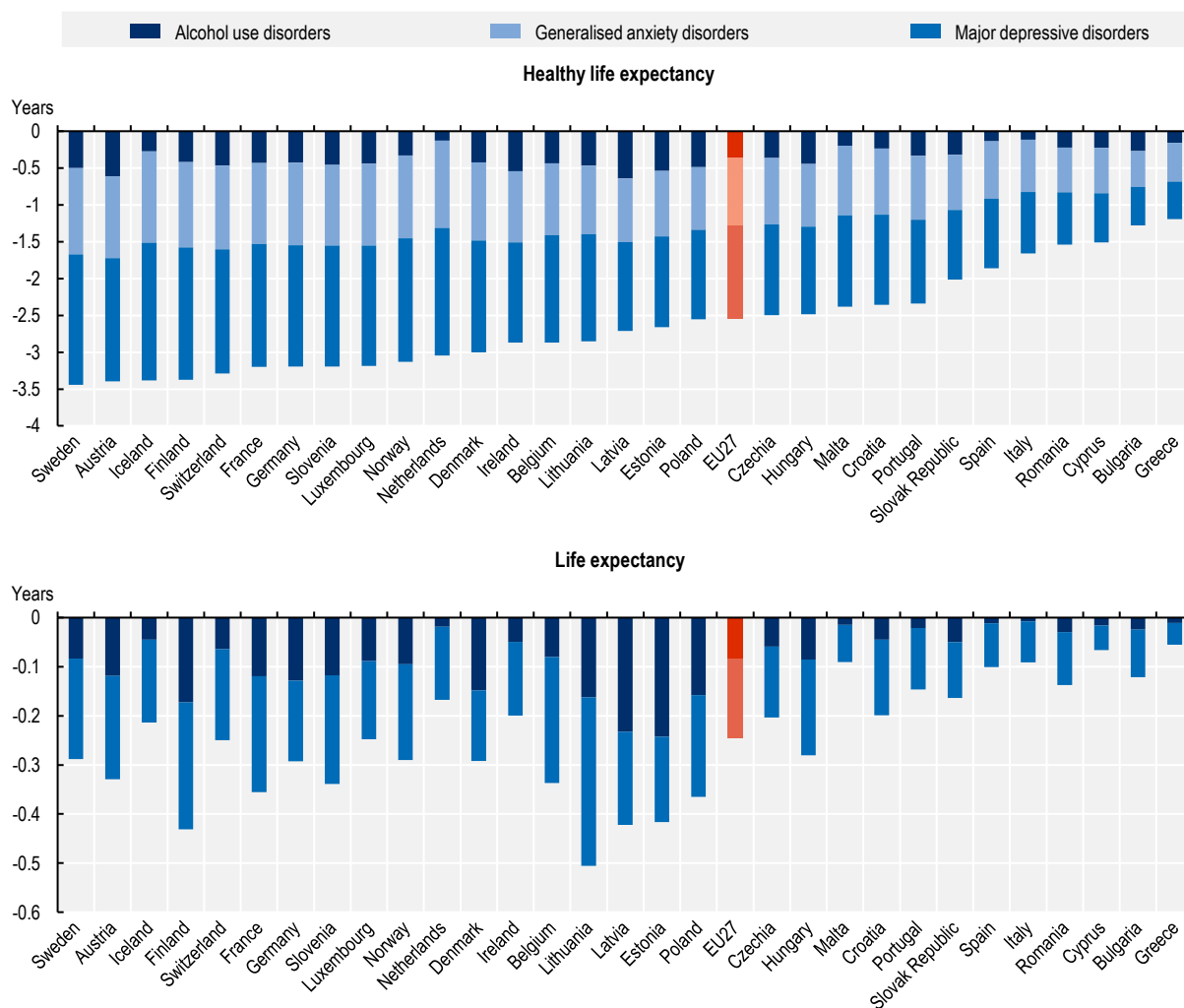
1. The human capital approach is based on assumptions simplifying the economic dynamics leading to economic losses – including, for example, assumptions about reserve labour force, friction costs and the impact on reserve wages.

## Mental ill health shortens healthy life expectancy by an average of 2.5 years and causes around 28 000 premature deaths annually across EU countries

Mental ill health is a major public health concern, with a significant negative impact on the quality of life of those affected (Figure 3.2). As mental disorders are chronic in nature, subject to continuous relapses and recurrent episodes over many years, it is perhaps unsurprising that there is a substantial negative impact of mental ill health on so-called healthy life expectancy, which can be considered a proxy for quality of life (Abdin et al., 2020<sup>[6]</sup>). Healthy life expectancy uses disease disability weights to calculate the number of years lived in good health. The OECD SPHeP-NCDs model finds that across EU countries, average healthy life expectancy will be reduced by 2.5 years between 2025 and 2050, compared to a scenario with

no mental ill health. All three conditions modelled affect healthy life expectancy, with major depressive disorders causing the greatest reduction (1.20 years), followed by generalised anxiety disorders (0.91 years) and alcohol use disorders (0.37 years). The smallest overall reductions in healthy life expectancy are projected in Greece and Bulgaria, at just under 1.2 years. In contrast, Sweden (3.37 years) and Austria (3.33 years) will see the largest reduction in healthy life years.

**Figure 3.2. Reduction in healthy life expectancy and life expectancy due to major depressive, generalised anxiety and alcohol use disorders, average 2025-2050**



Source: OECD analyses based on the OECD SPHeP-NCDs model.

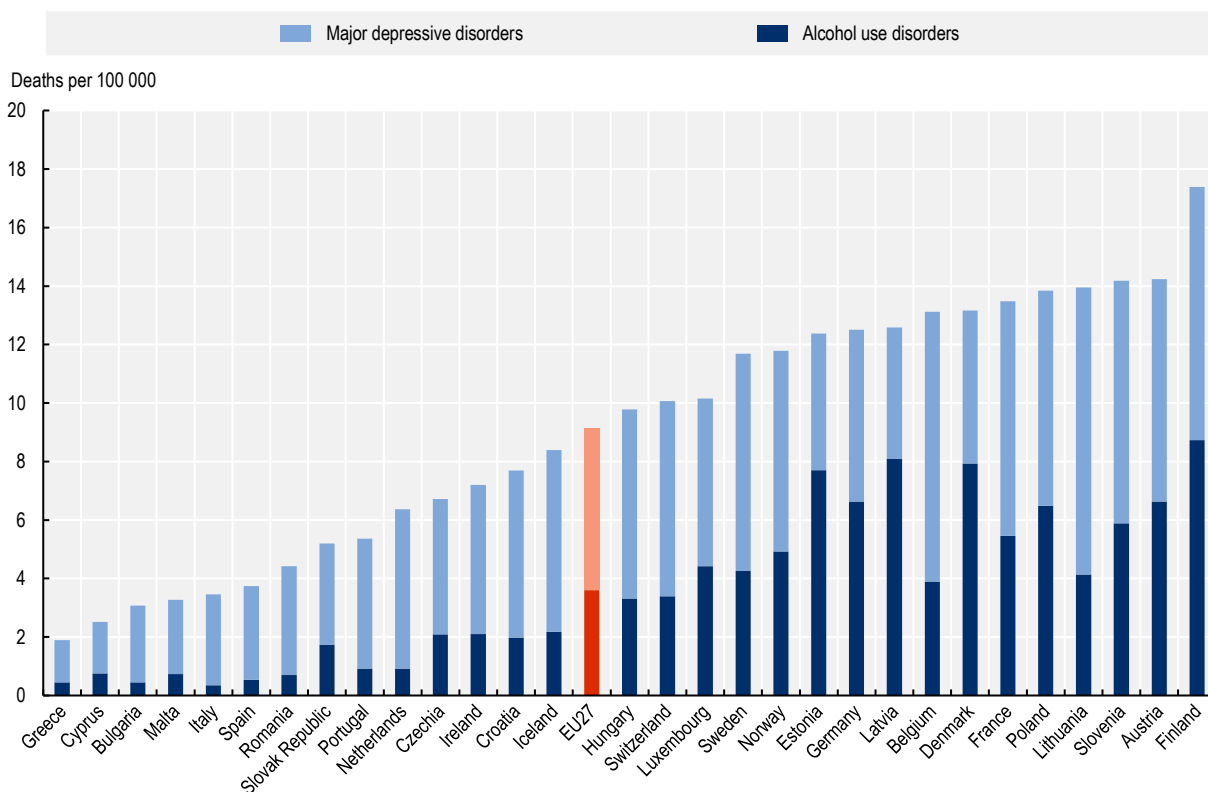
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Of the three mental disorders modelled in the OECD SPHeP-NCDs model, two (major depressive and alcohol use disorders) are associated with increased likelihood of death, including deaths by suicide as a result of self-harm (GBD 2019 Diseases and Injuries Collaborators, 2020<sup>[7]</sup>). Based on this evidence, the OECD SPHeP-NCDs model estimates that, during 2025-2050, life expectancy across EU countries will be 0.25 years (roughly 3 months) lower than it would be in the absence of these two conditions, with roughly two-thirds of this reduction attributable to major depressive disorders and one-third to alcohol use disorders


(Figure 3.2). Greece (0.05 years) and Cyprus (0.06 years) are projected to experience the smallest burden on life expectancy due to mental ill health, while Lithuania (0.50 years), Finland (0.43 years) and Latvia (0.41 years) will see the greatest impact. For context, life expectancy increased by an average of 0.18 years annually across OECD countries between 2010 and 2019 (OECD, 2023<sup>[8]</sup>). Thus, a 0.25-year lower life expectancy effectively offsets more than a year of progress in longevity gains.

The estimated 0.25-year lower life expectancy across EU countries also reflects a significant population-level impact. According to the OECD SPHeP-NCDs model, between 2025 and 2050, mental ill health will cause more than 709 300 premature deaths (deaths under the age of 75) or an average of 28 000 premature deaths per year, which is equivalent to 9 premature deaths per 100 000 population (Figure 3.3). These deaths are relatively evenly split between major depressive disorders (5.4 premature deaths per 100 000 people annually) and alcohol use disorders (4.6 per 100 000 people annually). The analyses also show great cross-country variability. The highest rates occur in Finland, Austria and Slovenia, each exceeding 14 premature deaths per 100 000 population annually (around 155% of the EU average), while Greece, Cyprus and Bulgaria show the lowest rates – all below 4 per 100 000 (less than 45% of the average).

**Figure 3.3. Number of deaths due to major depressive and alcohol use disorders (including deaths by suicide as a result of self-harm) in people aged under 75, per 100 000 population, per year**



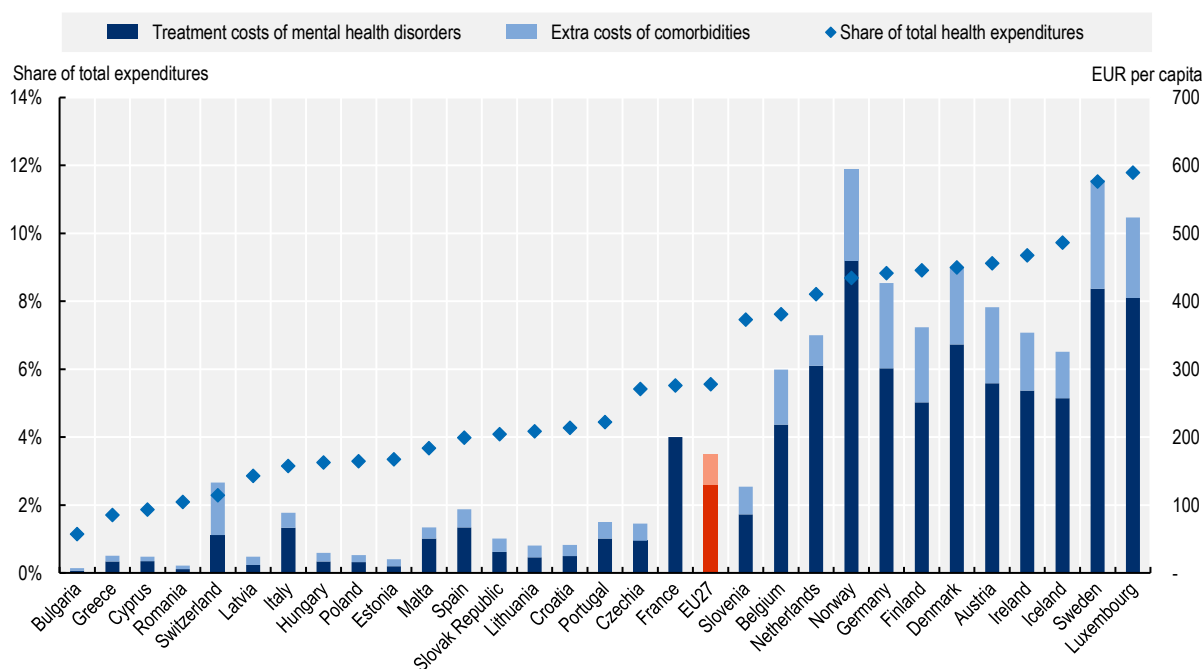
Source: OECD analyses based on the OECD SPHeP-NCDs model.

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## Mental ill health will account for 6% of total health expenditure in EU countries, assuming current levels of treatment coverage

In a business-as-usual scenario where major depressive, generalised anxiety and alcohol use disorders maintain current age-specific prevalence and treatment levels, mental ill health is estimated to cost EUR 76 billion per year in EU countries during 2025-2050. This is comparable to the annual healthcare budget of Belgium, and equivalent to about 6% of total EU healthcare spending (roughly EUR 175 per capita per year) (Figure 3.4). The estimate for EU countries is broadly in line with findings from other OECD contexts. For example, Milliken et al. (2024<sup>[9]</sup>) report costs of mental ill health in Canada amounting to approximately 6.4% of total health spending, while SAMHSA (2014<sup>[10]</sup>) estimates a similar burden for the United States at around 7%.

**Figure 3.4. Annual health expenditure due to major depressive, generalised anxiety and alcohol use disorders in EUR per capita and as a percentage of total health expenditure, average 2025-2050**



Source: OECD analyses based on the OECD SPHeP-NCDs model.

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Differences in overall healthcare budgets mean that the share of spending on mental ill health can vary significantly across countries. For nations with smaller budgets, even modest absolute costs can represent a large proportion of total expenditure. For example, Slovenia is projected to spend EUR 127 per person annually on mental ill health, which is below the EU average, but this would account for 7% of its healthcare budget – a higher proportion than the EU average. Conversely, Norway has the highest absolute cost among the 30 countries in the OECD SPHeP-NCDs model analysis (EUR 594 per capita), although this represents around 9% of its overall healthcare expenditure.

The total cost of mental ill health comprises both direct treatment expenses and additional costs arising from comorbidities (Box 3.2). Treating major depressive, generalised anxiety and alcohol use disorders accounts for the majority of healthcare costs, but a significant share of overall expenditure stems from the

extra resources required to manage other health conditions when a mental disorder is present (Cortaredona and Ventelou, 2017<sup>[11]</sup>). Model estimates indicate that of the EUR 175 per capita annual cost for mental ill health calculated by the OECD SPHeP-NCDs model, approximately 75% (EUR 131) is for treating mental disorders themselves, while the remaining 25% (EUR 44) reflects the added burden of comorbidities.

### Box 3.2. The additional cost of mental ill health as a comorbidity: Drivers and mechanisms

As shown in Figure 3.4, about 25% of total healthcare spending linked to mental ill health comes from the extra costs incurred when mental disorders occur alongside other chronic diseases as comorbidities. Research consistently shows that individuals with mental health conditions have higher healthcare expenditures than those without (Sartorius, 2018<sup>[12]</sup>). This is largely due to increased utilisation of outpatient services, emergency care and medications for comorbid conditions such as cardiovascular disease, diabetes and respiratory disorders (Simon et al., 2023<sup>[13]</sup>). Some studies focussing on people with severe mental ill health indicate that this group of patients incurs healthcare costs two to three times higher than those without such conditions (Figuroa et al., 2020<sup>[14]</sup>; Scott et al., 2016<sup>[15]</sup>).

Mental and physical health are strongly interconnected through a bi-directional relationship (Ogunmoroti et al., 2022<sup>[16]</sup>; Xiong and Qi, 2025<sup>[17]</sup>). Each can influence the other, creating a cycle that increases health risks and healthcare costs:

- Mental ill health raises the risk of chronic physical conditions through biological and behavioural mechanisms. Stress and perceived threat trigger physiological changes that exacerbate chronic disease risk (Kyrou and Tsigos, 2009<sup>[18]</sup>), while behavioural challenges – such as poor adherence to medication, lack of exercise and unhealthy diets – further compound these risks (Baldessarini, 2020<sup>[19]</sup>; Loprinzi et al., 2013<sup>[20]</sup>).
- Conversely, physical conditions such as cancer, autoimmune diseases and other chronic illnesses are also associated with mental ill health (Liao et al., 2022<sup>[21]</sup>). These conditions often lead to psychological distress, depression and anxiety, increasing the need for mental healthcare and, consequently, overall healthcare expenditure (Everard and Vuick, 2025<sup>[22]</sup>).

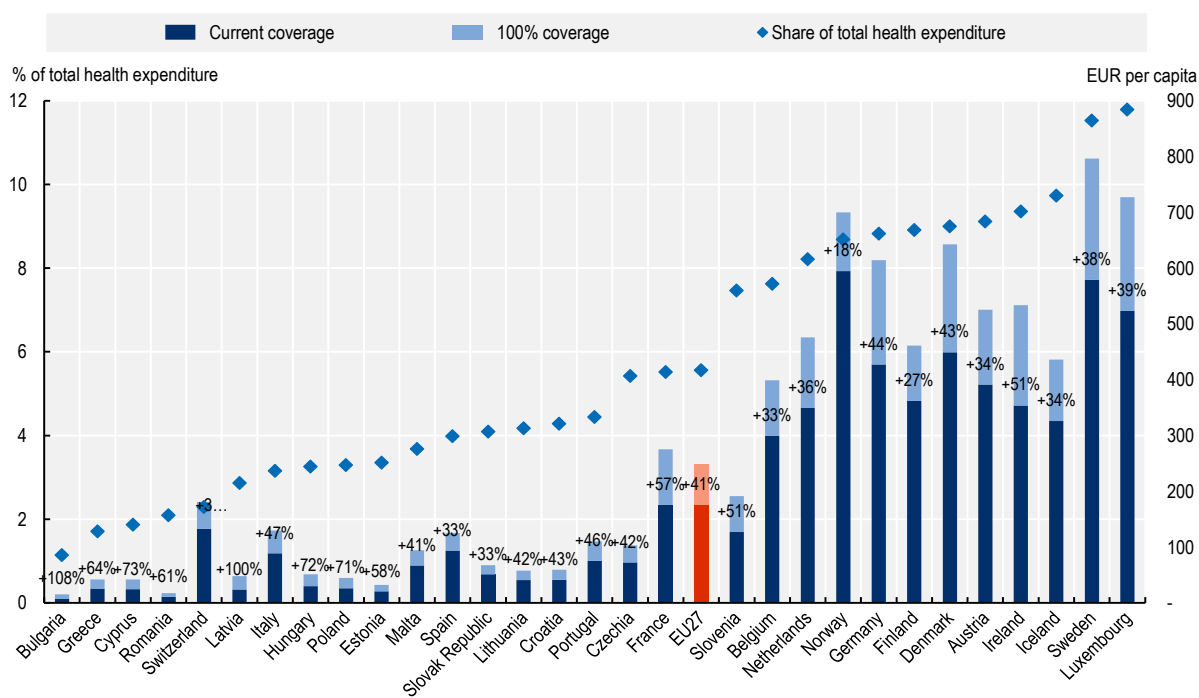
## Closing the treatment gap: Calculating the financial implications of extending coverage for mental ill health

As discussed in Chapter 2, coverage across the 30 countries in the OECD SPHeP-NCDs model analysis remains low, at just 33% on average. Limited coverage means that many individuals with mental ill health do not receive timely care, leading to worse health outcomes, higher long-term costs and increased pressure on other parts of the healthcare system due to the impact of mental ill health as a comorbidity. Improving coverage could reduce these burdens, but it has resource implications. To illustrate the potential financial impact, the OECD SPHeP-NCDs model was used to estimate costs under a hypothetical scenario of 100% treatment coverage. While achieving full coverage is unrealistic due to practical and logistical barriers, modelling this scenario provides valuable insight into the magnitude of the financing gap and an upper-bound estimation of the resources needed to close this gap.

Achieving full treatment coverage would significantly increase mental health expenditure, though less than might be expected given the scale of expansion. Reaching 100% treatment coverage for the considered conditions would require treating roughly three times as many people as today. Nevertheless, as shown in Figure 3.5, total spending on mental ill health would rise by only 41% on average across EU countries,

which is equal to an increase of EUR 72 per capita per year, bringing total expenditure to EUR 247 per person annually. This relatively moderate rise reflects the fact that current coverage already includes the most severe and costly cases, while the treatment gap consists mainly of mild to moderate conditions, which are less expensive to treat. Countries with the lowest current levels of coverage and spending, such as Bulgaria and Latvia, would experience the largest percentage increases, with mental health expenditure more than doubling under this scenario.

**Figure 3.5. Impact on mental-health-specific health expenditure, assuming a hypothetical scenario with 100% treatment coverage, per year, average over 2025-2050, including percentage change from current levels**



Note: HE is health expenditure. The light blue segment of each column represents the additional costs countries would incur if mental health service coverage were expanded to reach all individuals in need (100% coverage). This increase in healthcare spending is shown as a percentage relative to the current level of spending in the business-as-usual scenario. For example, achieving full coverage would require a 41% increase in mental health expenditure across EU countries. It is important to note that the share of total health expenditure shown refers to the current level of coverage.

Source: OECD analyses based on the OECD SPHeP-NCDs model.

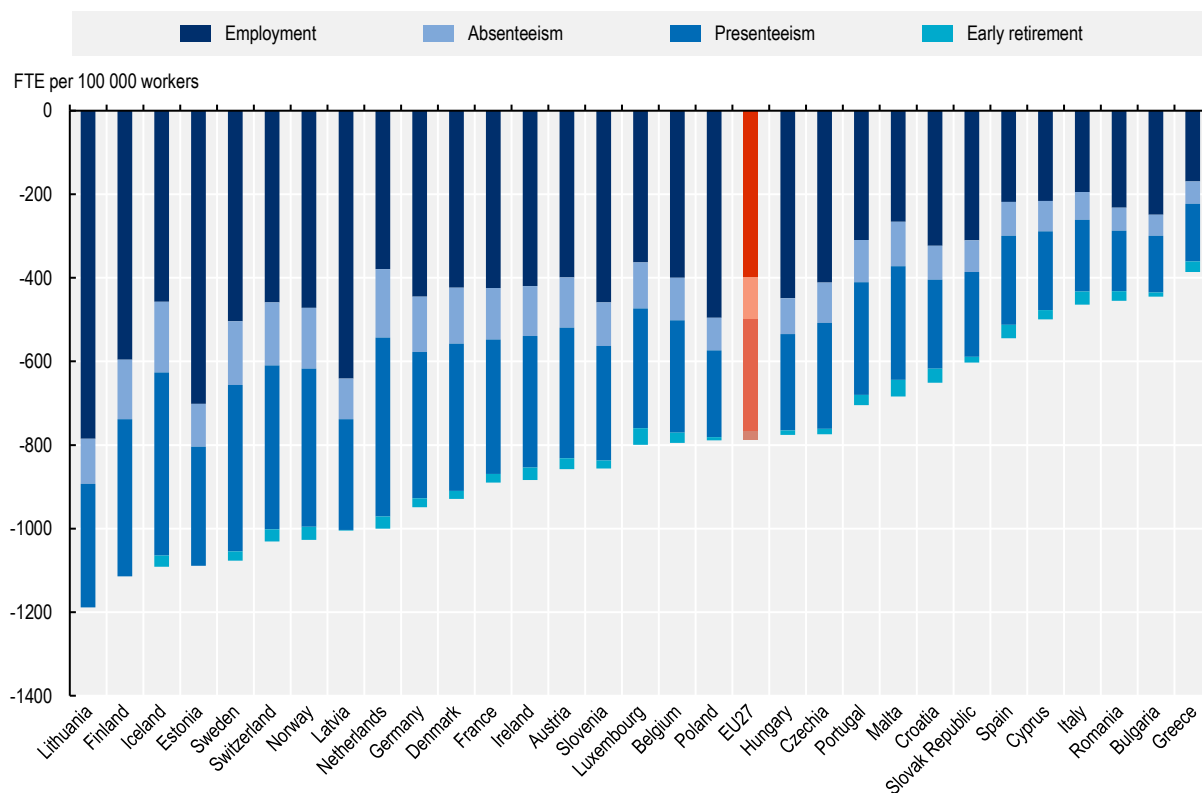
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### Mental ill health affects workforce productivity through increased absenteeism, presenteeism, unemployment and early retirement

In addition to the costs to life expectancy, healthy life expectancy and government healthcare expenditure, mental ill health causes broader economic costs through its detrimental impacts on workforce productivity (OECD, 2021<sub>[23]</sub>). People with mental disorders are less likely to be employed; if they have a job, they are more likely to work part time, to be absent from work or less productive than if they were in good health (also known as presenteeism), and to retire before the usual retirement age. In the case of absenteeism and presenteeism, the economic costs to the labour market are hidden, as they relate to wages paid to

employees without a corresponding level of output from their work. The cumulative detrimental impact of mental ill health due to major depressive, generalised anxiety and alcohol use disorders on these four factors and their consequent reduction in human capital has been calculated by the OECD SPHeP-NCDs model to represent almost 2.4 million workers per year, expressed in full-time equivalent workers, which is equivalent to the Croatian working-age population (Figure 3.6).

**Figure 3.6. Impact on the workforce through absenteeism, early retirement, employment and presenteeism, average over 2025-2050**



Note: FTE is full-time equivalent workers; the "employment" category combines both effects on unemployment and part-time working.  
Source: OECD analyses based on the OECD SPHeP-NCDs model.

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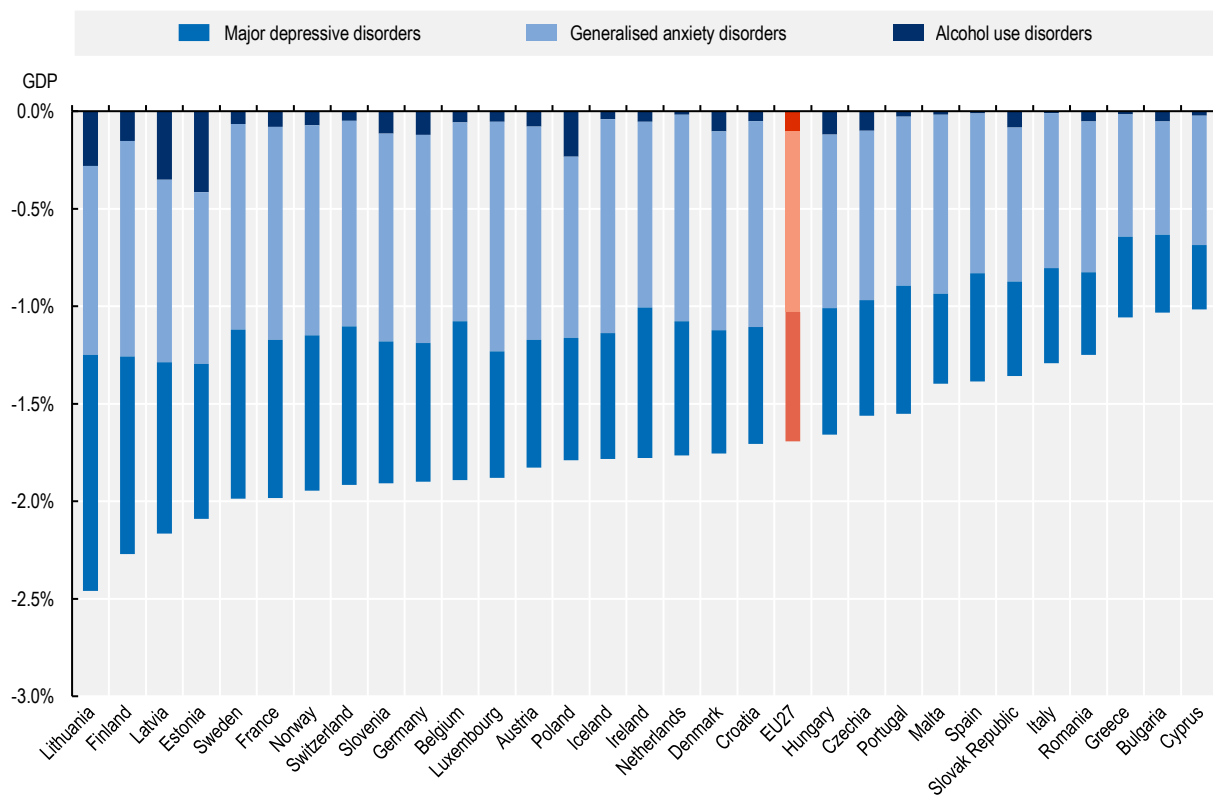
Examining the drivers of labour market costs by disease and by type of productivity loss reveals important patterns. Across countries, the largest share of lost productivity is due to reduced employment, which accounts for nearly half of the total impact (48%), followed by presenteeism (36%) and absenteeism (14%). Early retirement contributes only a small fraction (around 3%). When looking at disease-specific contributions, generalised anxiety disorders emerge as the primary driver, responsible for 56% of the total burden, followed by major depressive disorders at 39% and alcohol use disorders at just 5%. It is noteworthy that generalised anxiety disorders exert such a large impact despite having no effect on mortality; their influence on productivity stems entirely from symptoms that impair well-being and daily functioning.

## Significant economic losses result from mental ill health through reduced workforce productivity

To estimate the macroeconomic impact of mental ill health, outputs from the OECD SPHeP-NCDs model were integrated into the Long-Term Growth Model of the World Bank (Box 3.1). This approach allows for a comprehensive assessment of how health outcomes translate into economic performance over time. The analysis focussed on the combined effects of major depressive, generalised anxiety and alcohol use disorders on two critical dimensions that capture both the availability and effectiveness of human capital: life expectancy and workforce productivity. As previously discussed, mental ill health is projected to reduce life expectancy by an average of 0.25 years across EU countries and to cause labour market losses equivalent to 2.4 million full-time workers annually between 2025 and 2050. By linking these health and productivity impacts to long-term economic growth, the modelling provides valuable insights into the scale of GDP losses attributable to mental ill health.

On average, GDP across EU countries is projected to be 1.7% lower each year due to the impact of mental ill health compared to a scenario without these conditions (Figure 3.7). This translates into an annual loss of EUR 313 billion across EU countries, which is roughly equivalent to the entire GDP of Czechia in 2023 (Eurostat, 2026<sup>[24]</sup>). Most of this reduction is driven by generalised anxiety disorders (0.9% of GDP loss) and major depressive disorders (0.7%), while alcohol use disorders contribute around 0.1%. The greatest declines are expected in Lithuania, Finland, Latvia and Estonia, each facing reductions of more than 2%, whereas Bulgaria, Cyprus and Greece would experience the smallest impact, at about 1%.

Figure 3.7. Percentage difference in GDP due to mental ill health, average over 2025-2050



Source: OECD analyses based on the OECD SPHeP-NCDs model.

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This finding is consistent with earlier OECD research, which estimated that in 2015 reduced workforce productivity across the EU accounted for approximately 1.6% of GDP, out of a total mental health-related cost of around 4% (OECD/European Union, 2018<sup>[25]</sup>). This suggests that productivity losses represent a major component of the economic burden of mental ill health. Evidence from other OECD countries reinforces this pattern: studies in Australia (Beyond Blue and PwC, 2015<sup>[26]</sup>) and the United States (Abramson, Boerma and Tsyvinski, 2024<sup>[27]</sup>) report comparable impacts once methodological differences in study design and in the cost components considered are considered. Both these studies also identify reduced human capital and the resulting decline in productivity as crucial drivers of economic losses from mental ill health. However, the US study also highlights additional channels, including changes in consumption patterns and portfolio allocations, which would further amplify the detrimental economic impact of mental ill health.

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# **4**

## **Policies to prevent and treat mental ill health**

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This chapter examines the current state of mental health policy across 44 OECD and EU countries, with a focus on interventions designed to improve mental well-being. Particular attention is given to policies supported by a strong evidence base, including those implemented in primary healthcare, workplace and school settings. The analysis is summarised in a matrix of policy options outlining intervention mechanisms, delivery settings, objectives and modes of implementation. These interventions form the foundation for the cost-effectiveness analysis presented in Chapter 5.

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## Key findings

- International recognition of the growing burden of mental ill health has led to stronger policy action, with 42 out of 44 OECD and EU countries surveyed reporting that they have national strategies or action plans in place. A key reform trend is shifting management from hospitals to community-based interventions – initially in primary care, and increasingly in schools and workplaces – reflecting evidence that early, preventive approaches outside hospital settings can be effective and less expensive.
- National mental health strategies include a wide range of evidence-based policies, delivered through diverse mechanisms, settings and formats. To analyse this complexity, the chapter introduces a matrix of mental health policies, summarising how intervention options can be combined into comprehensive policies. The matrix focusses on interventions with a strong evidence base and frequent variation across countries, including mechanisms (e.g. psychological, pharmacological), delivery settings (e.g. PHC, workplace), intended outcomes (e.g. prevention, treatment) and modes of delivery (e.g. in-person, web-based).
- A range of evidence-based mechanisms are effective in preventing and treating mental ill health. Interventions can be grouped into five categories: i) mental health literacy and stigma reduction; ii) mindfulness and exercise-based interventions; iii) psychological interventions (excluding CBT); iv) CBT; and v) pharmacological therapies. While variations in delivery sector or mode can influence effectiveness, all five categories have a strong evidence base supporting their use for prevention and treatment.
- Countries are increasingly shifting the prevention and management of mental ill health towards community settings, including PHC, workplace and school settings. For nearly four out of five responding countries, policies to improve mental well-being are in development or have been implemented across these settings. This trend reflects a growing emphasis on early promotion and protection of mental health to prevent future ill health and reduce associated costs for individuals, health systems and economies. Intervention mechanisms, objectives and delivery modes vary by setting, with some approaches better suited to specific sectors.

## Mental health has increasingly become an international priority

Over the last decade, there has been increasing international recognition of the significant and growing burden that mental ill health imposes on society and the global economy, resulting in a range of international strategies and action plans to support the implementation of policies to improve mental well-being. In 2015, the OECD released the Council's Recommendation on Integrated Mental Health, Skills and Work Policy (OECD, 2015<sup>[1]</sup>), which provides a series of guidelines to address the impact of mental ill health on health, education, employment and social outcomes. Following the publication of the Recommendation, in 2021 the OECD assessed progress achieved in relevant policy areas including health, youth, workplace and welfare policies (OECD, 2021<sup>[2]</sup>). In the same year, the OECD Mental Health System Performance Benchmark was developed, providing a framework to support governments to better understand and improve mental health systems (OECD, 2021<sup>[3]</sup>).

Over the same period, the WHO released the Mental Health Action Plan 2013-2020, which highlights four primary objectives to guide international health systems and leaders to address mental ill health through policy (WHO, 2021<sup>[4]</sup>). In 2019, the Action Plan was extended to 2030, and updates to its implementation options and indicators were endorsed by the World Health Assembly in 2021. Under each primary objective are global targets that provide specific and quantifiable goals, with associated indicators for measuring progress towards these targets (Box 4.1).

### Box 4.1. WHO's Mental Health Action Plan 2013-2030: Objectives and global targets

The WHO's Mental Health Action Plan 2013-2030 sets out ambitious objectives to strengthen mental health systems worldwide. Table 4.1 outlines the global targets agreed in the Action Plan for each objective, along with the associated indicators against which progress is to be measured. Objectives 2 and 3 align particularly closely with objectives of the current publication, which seeks to provide governments with additional evidence on the interventions that are most cost-effective for promotion and protection of mental well-being – particularly in community settings such as school, workplace and PHC settings.

**Table 4.1. WHO's Mental Health Action Plan global targets, objectives and indicators**

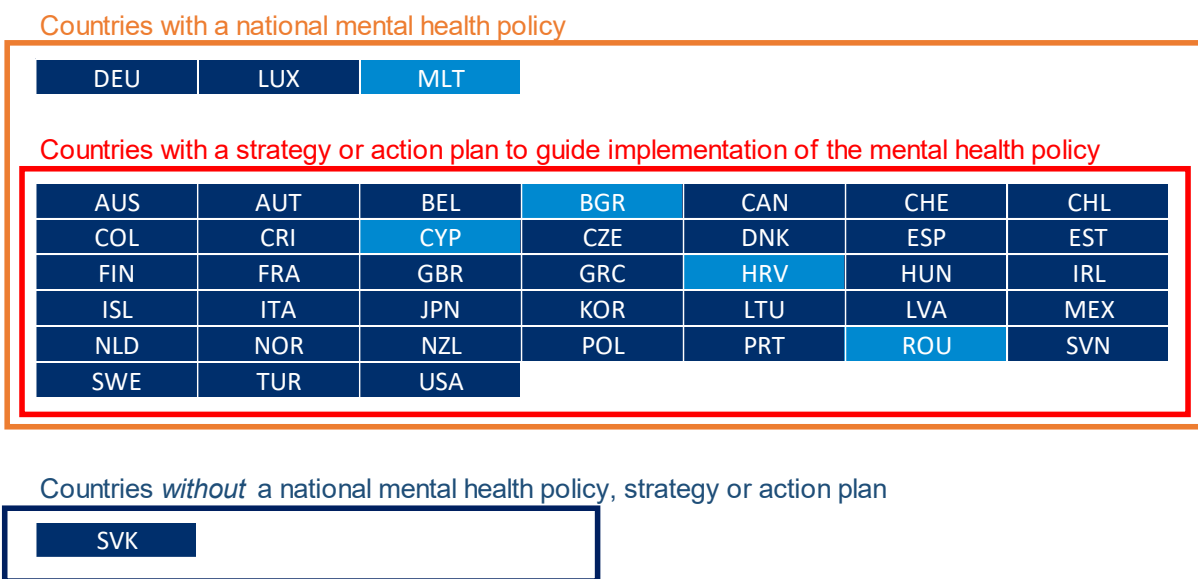
Global target number	Target	Indicator
<b>Objective 1. To strengthen effective leadership and governance for mental health</b>		
<b>Global target 1.1</b>	80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments, by 2030.	Existence of a national policy or plan for mental health that is being implemented and in line with international human rights instrument
<b>Global target 1.2</b>	80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments, by 2030.	Existence of a national law covering mental health that is being implemented and in line with international and regional human rights instruments
<b>Objective 2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings</b>		
<b>Global target 2.1</b>	Service coverage for mental health conditions will have increased at least by half, by 2030.	Proportion of people with psychosis who are using services over the past 12 months Proportion of people with depression who are using services over the past 12 months
<b>Global target 2.2</b>	80% of countries will have doubled number of community-based mental health facilities, by 2030.	Number of community-based mental health facilities
<b>Global target 2.3</b>	80% of countries will have integrated mental health into PHC, by 2030.	Existence of a system in place for integration of mental health into PHC
<b>Objective 3. To implement strategies for promotion and prevention in mental health</b>		
<b>Global target 3.1</b>	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes, by 2030.	Functioning programmes of multisectoral mental health promotion and prevention in existence
<b>Global target 3.2</b>	The rate of suicide will be reduced by one-third, by 2030.	Suicide mortality rate (per 100 000 population)
<b>Global target 3.3</b>	80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters, by 2030.	Existence of a system in place for mental health and psychosocial preparedness for emergencies/disasters
<b>Objective 4. To strengthen information systems, evidence and research for mental health</b>		
<b>Global target 4.1</b>	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every 2 years through their national health and social information systems, by 2030.	Core set of identified and agreed mental health indicators routinely collected and reported every two years
<b>Global target 4.2</b>	The output of global research on mental health doubles, by 2030.	Number of published articles on mental health research (defined as research articles published in the databases)

Source: WHO (2021<sup>[4]</sup>), *Comprehensive Mental Health Action Plan 2013-2030*, <https://iris.who.int/handle/10665/345301>.

The international commitment to stronger mental health policy was further strengthened in 2015 through the adoption of the Sustainable Development Goals (SDGs), which include targets specifically focussing on mental health (United Nations Department of Economic and Social Affairs, 2023<sup>[5]</sup>). These include SDG target 3.4 on “promoting mental health and well-being” through prevention and treatment policies and activities and SDG target 3.5 on “strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”.

In response to the growing international emphasis on preventing and treating mental ill health, governments across OECD and EU countries have increasingly strengthened their policy focus in this area. This has been reflected by the substantial number of countries that have developed and implemented national strategies and action plans and implemented a strategic approach to addressing mental ill health. In 2023, the OECD and the WHO Regional Office for Europe, with support from the European Commission’s Directorate-General for Health and Food Safety, carried out a survey on mental health system capacity across EU countries, Iceland and Norway (WHO Regional Office for Europe, 2024<sup>[6]</sup>). The OECD thereafter extended the survey to all OECD Member countries (referred to in this report as the WHO/OECD Mental Health Survey). According to the survey, 42 out of 44 (95%) national governments reported that they had a national mental health policy and/or a strategy or action plan in place to guide the implementation of a national mental health policy (Figure 4.1).

**Figure 4.1. Countries with a national mental health policy and/or strategy or action plan**



Note: OECD countries are dark blue; EU Member States that are not OECD countries are light blue.  
 Source: WHO/OECD Mental Health Survey.

## In recent decades, some OECD countries have introduced national programmes to expand community-based care

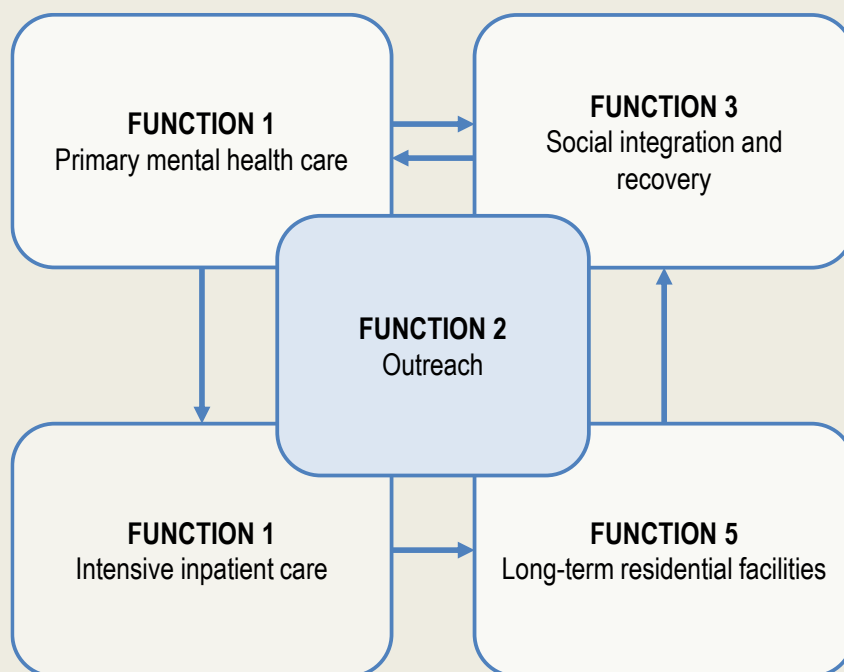
In recent decades, mental health reforms across OECD countries have increasingly focussed on delivering care outside hospital settings. Aligned with the overall focus of this publication, this chapter places particular emphasis on three key areas of non-hospital interventions: PHC-based, school-based and workplace-based initiatives. Together, these approaches aim to make mental health support more accessible within communities, better integrated into daily life and tailored to groups with specific needs. This focus reflects growing evidence that interventions delivered outside traditional clinical settings are both effective and cost-saving, as they help to prevent and detect mental ill health before it escalates into more serious conditions requiring treatment. Consequently, most interventions discussed in this chapter, and later modelled in Chapter 5, tend to be preventive, since treatment-oriented approaches are generally more appropriate for traditional clinical environments. Nonetheless, for certain interventions, the distinction between prevention and treatment can be less clear-cut, as some approaches may serve both purposes, depending on how and when they are applied.

Belgium is often mentioned among the countries that have implemented ambitious measures to reduce dependence on institutional care and to promote community-based, patient-centred approaches. Specifically, the Belgian reform is organised around local mental health networks that deliver five core functions, primarily in community-based settings (Box 4.2). These functions encompass services such as primary care and social support, ensuring that care is accessible beyond traditional hospital environments. This national experience, together with interventions implemented by other countries, represents an emerging best practice that offers valuable lessons for shaping future health system reforms across OECD countries (OECD, 2025<sup>[7]</sup>).

### Box 4.2. The reform of the national mental health system in Belgium: Focus on strengthening primary healthcare service delivery

Since 2010, Belgium has implemented a nationwide reform of its mental health networks, aimed at expanding patient-centred, community-based mental health services and reducing reliance on psychiatric institutionalisation. This multisectoral approach introduced a broad range of services, including outreach and prevention, inpatient and outpatient care, primary care, day programmes, and vocational, housing and social support (Borgermans et al., 2018<sup>[8]</sup>). These reforms align with the WHO Mental Health Action Plan 2013-2030, which calls for a shift from institutional care toward PHC and other community-based settings. The Belgian model is built on decentralised leadership and delivers both acute and chronic mental healthcare through collaborative networks. Each network operates within a defined geographical area, develops its own governance mechanisms and provides five core functions through multisectoral partnerships (Figure 4.2).

Figure 4.2. Core functions of multisectoral mental health networks in Belgium



Source: Adapted from Borgermans et al. (2018<sup>[8]</sup>), Multisectoral mental health networks in Belgium: An example of successful mental health reform through service delivery redesign: good practice brief, <https://iris.who.int/handle/10665/345626>.

To support this new model, funding was reallocated from institutional care to create mobile treatment teams (Function 2). Composed of hospital-based staff working in the community, these teams were cost-neutral for hospitals in the short term and free for patients. Evidence from over 13 000 patients followed in 2016 shows that these teams helped to prevent long-term hospitalisation. By 2017, their implementation had reduced the number of long-term psychiatric beds by 1 230. However, this represents only a modest change: Belgium had 152 psychiatric beds per 100 000 inhabitants in 2008, and this dropped by just over 1% to 150 beds per 100 000 by 2015 (European Commission, 2018<sup>[9]</sup>; WHO Regional Office for Europe, 2005<sup>[10]</sup>). More recent reviews suggest that the impact on outcomes for severely mentally ill patients has been limited, with reforms linked to slight improvements in continuity of care but not to broader clinical outcomes (Lorant et al., 2019<sup>[11]</sup>).

Another key aspect of the reform is its emphasis on strengthening primary mental healthcare (Function 1). The reform created co-ordinated regional and local networks of mental health professionals and introduced reimbursement for both low-threshold and specialised psychological care. Over 30 multidisciplinary professional networks have been established nationwide, providing prompt and free-of-charge access to psychologists for both children and adults. The new scheme covers up to eight low-threshold sessions and 20 specialised sessions per patient per year. OECD analyses have documented the reform's positive impact on mental health outcomes (OECD, 2025<sup>[71]</sup>): among individuals who accessed psychological care through the networks, prevalence of mental disorders decreased by an average of 10% within six months of enrolment. The reform has also reduced financial barriers to care: nearly 40% of users reported that they had previously forgone psychological support when it was not reimbursed, suggesting that these individuals would probably have gone without treatment in the absence of the new scheme.

### A mental health intervention matrix has been developed, covering mechanism, place, objective and delivery mode

OECD and EU countries have introduced a diverse set of mental health interventions, which vary widely in both design and implementation. The remainder of this chapter highlights best practices and policies featured in these national strategies, with a focus on interventions delivered in primary and frontline healthcare, schools and workplaces. The analysis prioritises policies that are evidence-based, are widely adopted across countries, and stand out for their innovation and/or cost-effectiveness.

The design and implementation of mental health interventions vary across multiple dimensions. This chapter examines selected interventions by grouping them according to four key characteristics:

- **Intervention mechanism** refers to how the intervention influences mental health, such as through psychosocial support, pharmacological treatment, or education and awareness strategies.
- **Place of delivery** is the setting in which the intervention is provided. As noted earlier, this chapter focusses on delivery in primary or frontline healthcare, school and workplace settings.
- **Objective** relates to whether the intervention primarily aims to prevent mental ill health or to treat it. While many interventions have traditionally been used for treatment, they are increasingly adapted for early-stage prevention.
- **Delivery mode** is the way the intervention reaches recipients – whether face-to-face with a provider, via web-based platforms, over the telephone or through other channels.

These factors are not mutually exclusive and can be combined in numerous ways. For example, a psychosocial intervention might be delivered across multiple settings such as PHC, school or workplace settings using different modes (in-person, online or by phone) and targeting various objectives, from promotion and prevention to treatment.

Table 4.2 illustrates how these characteristics can be combined to form individual mental health interventions or policies. The matrix summarises common combinations of policy elements, many of which are frequently applied in research and practice. In Chapter 5 of this publication, a selection of these widely implemented and well-studied combinations is modelled using the OECD SPHeP-NCDs framework. Although other interventions exist – including parenting programmes and suicide prevention programmes, some of which are examined in the publication on best practices in public health for mental health promotion and prevention (OECD, 2025<sup>[71]</sup>) – the interventions presented in Table 4.2 reflect the most prevalent approaches identified in the literature and policy documents.

**Table 4.2. Matrix of mental health interventions**

Intervention mechanism	Place of delivery			Objective		Delivery mode		
	PHC	Workplace	School	Prevention	Treatment	In-person	Phone-based	Web-based
Mental health literacy and stigma reduction	✓	✓	✓	✓		✓	✓	✓
Mindfulness	✓	✓	✓	✓	✓	✓	✓	✓
Psychological interventions (excluding CBT)	✓	✓	✓	✓	✓	✓	✓	✓
CBT	✓	✓	✓	✓	✓	✓	✓	✓
Pharmacological therapies	✓				✓	✓ *	*	*

Note: \* Prescription of pharmacological therapies depends on the regulatory guidelines of different jurisdictions.

### ***Interventions influence mental health through several mechanisms***

Mental health interventions rely on diverse mechanisms to promote well-being and improve outcomes, reflecting the complexity of mental health needs and the variety of approaches available to address them. Interventions to improve mental well-being can employ a variety of mechanisms – psychological, biological, social or interpersonal – each differing in terms of goals, effectiveness, cost and suitable settings. The following section does not aim to be exhaustive; rather, it highlights the main types of interventions widely used in national health strategies and supported by strong evidence, including systematic reviews.

#### *Mental health literacy and stigma-reduction interventions*

Mental health literacy initiatives and stigma-reduction programmes are effective in both promoting well-being and encouraging help-seeking for mental ill health (Moreira, 2018<sup>[12]</sup>). With relatively low implementation costs, these interventions offer significant potential as cost-effective strategies for mental health promotion and prevention (Yeo et al., 2024<sup>[13]</sup>).

Health literacy plays a critical role in enabling individuals to make informed decisions about their health. It refers to the social and cognitive skills that determine a person's motivation and ability to access, understand and apply information to maintain good health (Nutbeam and Kickbusch, 1998<sup>[14]</sup>). Interventions to improve health literacy typically target three levels: seeking healthcare, preventing disease and promoting overall well-being. By strengthening these skills, such interventions directly influence an individual's capacity and willingness to act on health information, ultimately improving health outcomes. This link between health literacy and better health outcomes also applies to mental health. People with mental ill health often have lower health literacy than the general population, with some studies reporting inadequate health literacy rates of nearly 50% (Degan et al., 2021<sup>[15]</sup>). Evidence also shows that these individuals are less likely to seek timely treatment for conditions such as depression or anxiety (Wells et al., 1994<sup>[16]</sup>).

As with low mental health literacy, stigma surrounding mental health and its treatments remains a major barrier to help-seeking (Schomerus et al., 2018<sup>[17]</sup>). Stigma-reduction interventions aim to eliminate feelings of embarrassment or shame associated with mental ill health, thereby promoting well-being and

encouraging help-seeking behaviours (Bonabi et al., 2016<sup>[18]</sup>). Additionally, improving mental health literacy among key groups, such as police officers and emergency department staff, not only helps to reduce stigma but also equips them with the knowledge to understand and respond appropriately to individuals in need of support.

These interventions are generally implemented as awareness-raising activities, structured training sessions or media campaigns. Such approaches aim to inform individuals about mental health, challenge misconceptions and normalise help-seeking behaviours. Awareness campaigns can reach large audiences to reduce stigma, while targeted training equips specific groups such as educators, employers and first responders with practical knowledge and skills to identify and respond to mental health needs. These activities are particularly effective because they are scalable, adaptable to different contexts and relatively inexpensive compared to clinical interventions.

Mental health literacy and stigma-reduction interventions are widely recognised for increasing awareness, and evidence suggests that they also promote help-seeking behaviours (Kutcher, Wei and Coniglio, 2016<sup>[19]</sup>; Cook et al., 2014<sup>[20]</sup>; Xu et al., 2018<sup>[21]</sup>). A recent meta-analysis found that health literacy interventions were associated with a significant reduction in depression and anxiety scores (Magallón-Botaya et al., 2023<sup>[22]</sup>), although their long-term effectiveness remains uncertain – particularly regarding their impact on stigma and social distance (Freĳian et al., 2021<sup>[23]</sup>). These positive effects hold across variations in delivery setting, objective and mode of implementation. For instance, both mental health literacy and stigma-reduction interventions have proved effective in PHC, school and workplace settings (Sampaio, Goncalves and Sequeira, 2022<sup>[24]</sup>; Bonabi et al., 2016<sup>[18]</sup>; Lam et al., 2022<sup>[25]</sup>). Norway, for example, successfully piloted a school-based mental health literacy programme (Box 4.3). Evidence also supports diverse delivery modes, including traditional media and online platforms (Brijnath et al., 2016<sup>[26]</sup>). Importantly, the way these interventions are designed and implemented can significantly influence their effectiveness, underscoring the need to align strategies with emerging evidence on what works best (Brijnath et al., 2016<sup>[26]</sup>; McCulloch and Scrivano, 2023<sup>[27]</sup>).

#### Box 4.3. Universal, school-based mental health literacy programme in Norway

In Trondheim, Norway, school health services implemented “MEST” – short for the Norwegian word for coping – as a mental health literacy intervention in upper secondary schools, supported by the Norwegian Directorate of Health (Bjornsen et al., 2017<sup>[28]</sup>). The programme offers voluntary participation in open school seminars, classroom sessions and small group discussions focussed on improving students’ mental health literacy and providing practical resources for well-being. Topics include sleep hygiene, stress management, relaxation techniques, body image, self-esteem and emotional regulation.

The effectiveness of MEST was evaluated through a randomised controlled trial of 357 students in 2017. Results showed that students who participated in MEST improved their mental health literacy by 2.1% compared to non-participants, as measured by the 10-item Mental Health Promoting Knowledge scale (Bjornsen et al., 2017<sup>[28]</sup>). Girls who participated in the programme reported higher mental well-being scores on the Short Warwick-Edinburgh Mental Well-being Scale, but no statistically significant effect was observed among boys. These findings suggest that mental health literacy programmes like MEST can effectively increase knowledge and, in some cases, improve well-being, although impacts may vary across demographic groups.

Similar school-based interventions in Germany, Australia and Wales have reported comparable benefits, including improved mental health literacy and, in some cases, greater intention to seek help for mental ill health (Kirchhoff et al., 2023<sup>[29]</sup>; Simkiss et al., 2023<sup>[30]</sup>; Hart et al., 2018<sup>[31]</sup>).

### *Mindfulness-based interventions*

Mindfulness-based interventions have grown significantly in prevalence over the past decade, supported by a growing evidence base demonstrating their role in both preventing and treating mental ill health (Galante et al., 2023<sup>[32]</sup>). Originating from Buddhist traditions, mindfulness is commonly defined as “the awareness that emerges through paying attention on purpose, in the present moment and non-judgementally to the unfolding of experience moment by moment” (Baer et al., 2019<sup>[33]</sup>; Kabat-Zinn, 2013<sup>[34]</sup>). These practices encourage individuals to observe thoughts, feelings, physical sensations and behavioural urges, emphasising that how people respond to distress – rather than the distress itself – often determines the extent to which it can be relieved or transformed (Crane et al., 2016<sup>[35]</sup>).

Mindfulness-based interventions typically include three core components:

- **Mindfulness meditation training** builds familiarity with the mind and body, teaching that attention can be regulated and optimised through practice.
- **Mindful activities** typically involve formal practices such as body scans, mindful movement and sitting meditation. These aim to support “decentring” or “re-perceiving”, helping individuals recognise that thoughts are not always accurate reflections of reality.
- **Collective and individual inquiry using participatory learning** encourages recognition of direct experiences – thoughts, emotions and sensations – and patterns of reactivity, creating opportunities to develop new, healthier response patterns.

Mindfulness-based interventions have surged in popularity over recent decades, becoming one of the most widely used approaches for mental health promotion (Burke et al., 2017<sup>[36]</sup>). An estimated 20% of Australians, 15% of British adults and 5% of adults in the United States have practised mindfulness at some point in their lives (Samele, 2016<sup>[37]</sup>; Simonsson, Fisher and Martin, 2021<sup>[38]</sup>; Dib et al., 2021<sup>[39]</sup>).

The rise in popularity of mindfulness-based interventions has been accompanied by a growing body of evidence demonstrating their effectiveness in preventing and treating mental ill health across diverse settings. A systematic review and meta-analysis found that psychological distress, including anxiety and depression, was reduced by a small to moderate degree (5.4%) within one to six months following a mindfulness-based intervention (Galante et al., 2023<sup>[32]</sup>). Workplace-based mindfulness programmes have shown effect sizes ranging from small to large for outcomes such as mental distress, although evidence on long-term impacts remains inconclusive (Vonderlin et al., 2020<sup>[40]</sup>). Similarly, a meta-analysis of school-based interventions reported reductions in anxiety, while highlighting the need for more robust research to guide policy (Phan et al., 2022<sup>[41]</sup>). Overall, targeted mindfulness interventions appear more effective in preventing depression and anxiety than universal approaches (Galante et al., 2023<sup>[32]</sup>).

Mindfulness-based interventions have also demonstrated strong effectiveness as treatments for mental health conditions, including depression, anxiety and substance use disorders (Galante et al., 2021<sup>[42]</sup>; Korecki et al., 2020<sup>[43]</sup>). In fact, some studies show that these interventions perform comparably to CBT and other standard evidence-based treatments for conditions such as major depressive, generalised anxiety, alcohol use and substance use disorders (Hofmann and Gomez, 2017<sup>[44]</sup>; Korecki et al., 2020<sup>[43]</sup>). These benefits extend to web-based mindfulness programmes, which have been found effective in reducing symptoms of depression and anxiety (Sevilla-Llewellyn-Jones et al., 2018<sup>[45]</sup>). Overall, evidence supports the efficacy of mindfulness-based interventions for both prevention and treatment of mental ill health. Given that they achieve similar outcomes to care-as-usual treatments while requiring fewer resources, they hold promise for cost-effectiveness and even cost savings compared to interventions such as CBT (Zhang et al., 2022<sup>[46]</sup>). Box 4.4 illustrates an example where mindfulness training delivered in group sessions achieved comparable results to treatment as usual, while significantly reducing resource requirements by enabling participants to continue practising skills individually.

#### Box 4.4. Mindfulness-based group therapy delivered in primary healthcare settings in Sweden

In Skåne County, Sweden, a group-based mindfulness programme delivered in PHC settings proved effective for managing depression and anxiety, offering a lower-cost and less resource-intensive alternative to traditional treatment options (Sundquist et al., 2018<sup>[47]</sup>).

The eight-week mindfulness group therapy programme was introduced for PHC patients seeking treatment for depression, anxiety, stress or adjustment disorders. The initiative aimed to address the challenge that conventional treatments for these conditions are often resource-intensive, costly and difficult to access. Patients were recruited from 16 PHC centres, where two instructors at each site were trained to deliver mindfulness group therapy adapted from mindfulness-based stress reduction and mindfulness-based cognitive therapy techniques. The programme consisted of weekly two-hour in-person group sessions with an average of eight participants. Sessions included structured and guided mindfulness exercises, complemented by take-home resources such as a CD, training manual and diary to support an additional 20 minutes of daily mindfulness practice at home.

The intervention was evaluated through a randomised controlled trial of 215 participants, assessing its impact on mental health symptoms both eight weeks after completion and at a one-year follow-up. Results showed statistically significant improvements in depression, anxiety and adjustment disorders at both time points. Specifically, symptoms of depression and anxiety decreased from a baseline score of 2.34 to 2.15 – an approximate 8% reduction – on the Hopkins Symptoms Checklist. These effects were comparable to treatment as usual. Overall, the findings suggest that mindfulness-based group therapy can deliver long-term improvements in depression and anxiety while offering a lower-cost, less resource-intensive alternative to traditional treatments in PHC settings.

#### *Psychological interventions (excluding cognitive behavioural therapy)*

While definitions of psychological interventions vary, they are generally understood as treatments grounded in psychological theory, designed to improve functioning and delivered within a structured therapeutic relationship (Prothero et al., 2018<sup>[48]</sup>). In line with the WHO's *Psychological Interventions Implementation Manual*, this publication uses the term to refer specifically to evidence-based interventions that follow standardised, manualised protocols (WHO, 2024<sup>[49]</sup>). Psychological or psychosocial approaches that are not evidence-based or that lack a structured manual are not included within this definition.

Psychological interventions cover a wide spectrum of evidence-based approaches, including behavioural, cognitive, humanistic, systemic, motivational, disease-focussed, social and environmental methods (National Collaborating Centre for Mental Health (UK), 2011<sup>[50]</sup>). Each approach is shaped by its underlying theoretical model and applies distinct techniques to improve mental health outcomes. Prominent examples include CBT, psychodynamic therapy, and eye movement desensitisation and reprocessing, among many others (Lovelock et al., 2018<sup>[51]</sup>).

CBT is considered separately from other psychosocial interventions due to the substantial body of evidence specific to CBT – particularly studies indicating that it may be more effective in treating a wide range of mental health conditions compared to other psychological interventions (Cuijpers et al., 2023<sup>[52]</sup>). This distinction enables a focussed discussion and comparative analysis of evidence and policies that use CBT-based interventions relative to other psychosocial approaches.

Psychosocial interventions have traditionally been delivered in frontline settings by mental health professionals (WHO, 2024<sup>[49]</sup>). However, strong evidence demonstrates their successful implementation across diverse community settings, using various delivery modes and targeting different outcomes. These interventions have proved effective in preventing and treating mental ill health in PHC settings, as well as

in workplaces and schools (Linde et al., 2015<sup>[53]</sup>; Llistosella et al., 2023<sup>[54]</sup>; Carolan, Harris and Cavanagh, 2017<sup>[55]</sup>). Moreover, they have been adapted to address the needs of high-risk populations, such as refugees (Box 4.5).

#### Box 4.5. Self-Help Plus: A psychological intervention for Syrian refugees in Türkiye

In 2020, Türkiye was the world's leading refugee-hosting country, sheltering over 3.6 million Syrian refugees alone (United Nations High Commissioner for Refugees, 2020<sup>[56]</sup>). Refugee populations face heightened risks of mental ill health due to exposure to traumatic experiences, as well as increased vulnerability to discrimination, economic hardship and social isolation (Hou et al., 2020<sup>[57]</sup>; Acarturk et al., 2021<sup>[58]</sup>). To address these risks, a preventive psychological intervention known as “Self-Help Plus” was implemented and evaluated among Syrian refugees in Türkiye (Acarturk et al., 2022<sup>[59]</sup>).

The intervention, developed by the WHO and based on acceptance and commitment therapy principles, consists of a prerecorded audio course delivered in group settings by trained facilitators, complemented by an illustrated self-help book adapted to the target cultural context. The programme is structured into five sessions of two hours each, covering information and practical exercises for stress management. In Türkiye, the intervention was implemented among Syrian refugees experiencing psychological distress. Local non-governmental organisations working with refugee communities identified and recruited participants.

The programme was evaluated through a two-arm, assessor-masked randomised controlled trial. In the treatment group, 322 participants received the Self-Help Plus Programme combined with enhanced care as usual, while the control group of 620 received enhanced care as usual only. Six months after completion, participants in the Self-Help Plus group were significantly less likely to meet diagnostic criteria for a mental disorder, including major depressive and anxiety disorders. Specifically, 40.7% of the control group met these criteria compared to 21.7% of Self-Help Plus participants. Although prevalence remained high, these findings indicate that preventive psychological interventions requiring relatively few resources can effectively reduce mental health risks among refugees. Self-Help Plus can therefore be considered a promising approach to preventing mental ill health in refugee populations.

Digital delivery models are increasingly recognised as a viable alternative to traditional in-person approaches for psychological interventions. Evidence indicates that psychological interventions delivered via telephone or web-based platforms can be as effective as those provided face to face (Castro et al., 2020<sup>[60]</sup>; Cowpertwait and Clarke, 2013<sup>[61]</sup>). These delivery modes became particularly widespread during the COVID-19 pandemic, offering flexibility by removing the need for geographical proximity and reducing the costs and resources typically associated with psychosocial interventions, which are often time- and resource-intensive (Witteveen et al., 2022<sup>[62]</sup>).

Leveraging frontline actors, such as teachers and social workers, to deliver psychosocial interventions has also proved effective and appropriate across diverse contexts (Arnold et al., 2022<sup>[63]</sup>). Psychological interventions are beneficial for both prevention and treatment of mental ill health, with emerging evidence suggesting that preventive approaches may be more cost-effective than care as usual (Moreno-Perel et al., 2017<sup>[64]</sup>; Conejo-Ceron et al., 2021<sup>[65]</sup>). Over the past two decades, research on psychological interventions has expanded substantially, creating new opportunities to implement approaches that are more cost-effective and accessible.

### *Cognitive behavioural therapy*

CBT is a psychological intervention widely recognised for its effectiveness in preventing and treating a range of mental health conditions, including depression, generalised anxiety disorder, panic disorder and post-traumatic stress disorder (Butler et al., 2006<sup>[66]</sup>). CBT has a strong evidence base and is often considered the current “gold standard” in psychological treatment (David, Critsea and Hofmann, 2018<sup>[67]</sup>; Fordham et al., 2021<sup>[68]</sup>). It is the most extensively researched psychological therapy for depression and is recommended as a first-line intervention in most treatment guidelines (Cuijpers et al., 2023<sup>[52]</sup>). CBT encompasses a set of targeted strategies designed to modify thinking and behavioural patterns that contribute to negative emotions and maladaptive behaviours (David, Critsea and Hofmann, 2018<sup>[67]</sup>; Gaudiano, 2008<sup>[69]</sup>). Examples include:

- **Problem-solving therapy** is a cognitive behavioural approach based on the premise that symptoms often stem from ineffective coping strategies. It helps individuals understand the role of emotions and develop more adaptive strategies (Nezu, Nezu and D’Zurilla, 2012<sup>[70]</sup>).
- **Dialectic behaviour therapy** was originally developed for individuals at high risk of suicide. This talking therapy aims to help patients “build a life worth living” by developing new skills and coping strategies to replace maladaptive behaviours (Chapman, 2006<sup>[71]</sup>).
- **Meta-cognitive therapy** is based on the principle that psychological disorders can result from perseverative thinking patterns, known as cognitive attentional dysfunction, including worry, rumination and threat monitoring. Treatment focusses on identifying and modifying these patterns through dialogue and behavioural experiments (Normann and Morina, 2018<sup>[72]</sup>).

Evidence suggests that CBT may be slightly more effective than other psychological therapies, although some argue that this difference is small or reflects the substantially larger evidence base for CBT compared to alternative approaches (Leichsenring and Steinert, 2017<sup>[73]</sup>; Cuijpers et al., 2023<sup>[52]</sup>). CBT also appears to have a similar short-term effect size to pharmacotherapy but demonstrates greater effectiveness at six- to twelve-month follow-ups (Cuijpers et al., 2023<sup>[52]</sup>). Like other psychological therapies, CBT is effective across a wide range of settings and delivery modes, including PHC, school and workplace settings (Linde et al., 2015<sup>[74]</sup>). Its efficacy is maintained whether delivered face to face, by telephone or online, and whether aimed at prevention or treatment of mental ill health (Box 4.6).

#### Box 4.6. The cognitive behavioural therapy-based online INTERACT Programme in primary healthcare in the United Kingdom

CBT has long been a cornerstone of mental health treatment in PHC settings in the United Kingdom, supported by substantial investment from the National Health Service in recent years (NHS England, 2019<sup>[75]</sup>). Major reforms have expanded access to talking therapies under the Five Year Forward View for Mental Health (NHS England, 2016<sup>[76]</sup>) and the NHS Mental Health Implementation Plan (NHS England, 2019<sup>[75]</sup>). Since 2016, the number of adults accessing talking therapies on the National Health Service has increased by 11% (NHS England, 2024<sup>[77]</sup>).

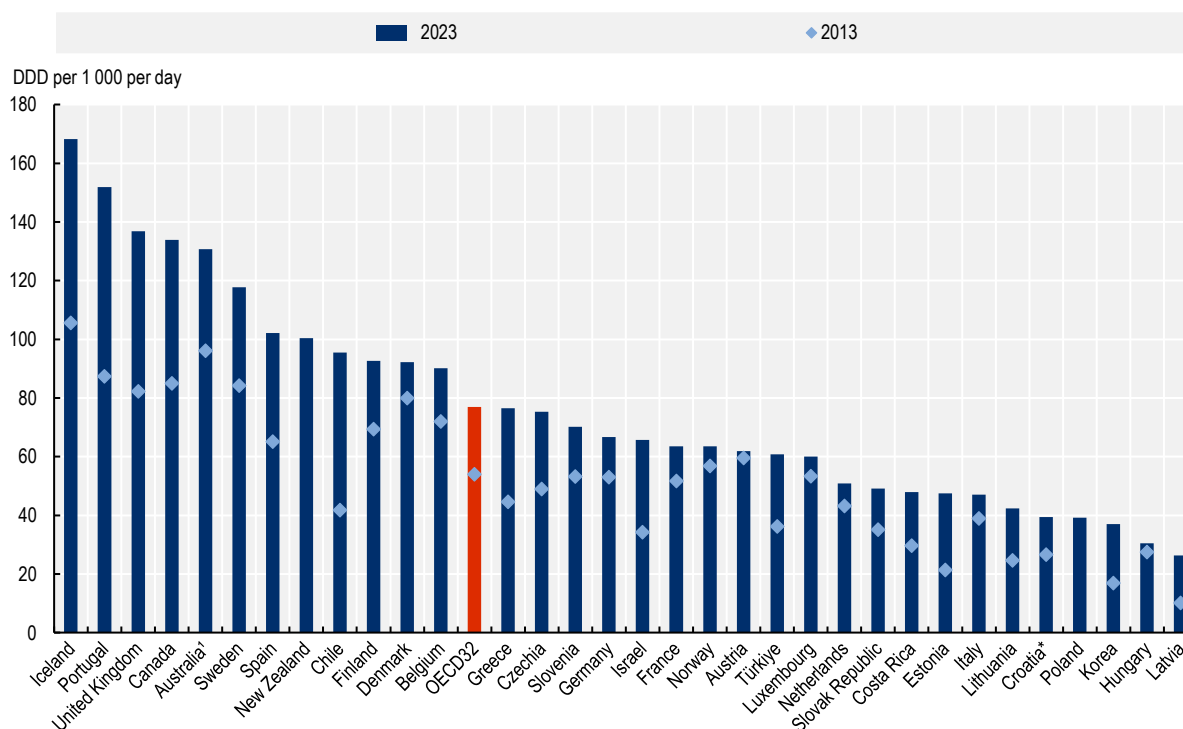
In line with efforts to improve accessibility, the National Institute for Health and Care Research has funded the INTERACT Programme through its Programme Grants for Applied Research (Tallon et al., 2023<sup>[78]</sup>). This eight-year initiative is testing a new CBT delivery model that integrates online CBT materials with high-intensity, therapist-led sessions delivered remotely and in real time. The approach aims to reduce costs and improve access for individuals with depression, including those facing barriers related to geography, work or caregiving responsibilities. Patients are recruited from PHC settings across the United Kingdom. The intervention begins with an in-person session, followed by real-time CBT delivered via instant messaging at scheduled appointments (Wiles, 2023<sup>[79]</sup>). Participants also receive supplementary materials and access to online tools and devices. The INTERACT Programme is ongoing and is being evaluated for both clinical efficacy and cost-effectiveness.

#### *Pharmaceutical interventions*

Pharmacological interventions remain a long-standing and essential component of mental health treatment. These include antidepressants for depressive disorders, diazepam for generalised anxiety disorder and methadone or buprenorphine for substance use disorders (WHO, 2009<sup>[80]</sup>). By design, pharmacological treatments are primarily suited to managing mental ill health rather than promoting mental well-being or preventing disorders. Their delivery is most appropriate in PHC or other clinical settings, given the need for prescription by a qualified health professional (Lam et al., 2022<sup>[81]</sup>). In recent years, prescribing practices have also increasingly incorporated telehealth and web-based channels, a trend accelerated by the COVID-19 pandemic. While these modalities have improved access and proved effective, they may also exacerbate inequalities across demographic groups (Link et al., 2023<sup>[82]</sup>; McBain et al., 2023<sup>[83]</sup>).

Despite growing research and utilisation of non-pharmaceutical treatments over the past decade, pharmacological interventions remain among the most widely used approaches for mental ill health (Chen, Lee and Wang, 2023<sup>[84]</sup>). Antidepressants are the most frequently prescribed treatment for major depressive disorder (OECD, 2023<sup>[85]</sup>). Consumption of this category of medicines increased by over 40% in OECD countries between 2013 and 2023, and more than doubled in Chile, Estonia, Korea and Latvia (Figure 4.3). However, available data do not clarify whether this increase reflects changes in prescribing practices (such as longer treatment courses or higher dosages), a higher rate of individual prescriptions or both (Cipriana et al., 2018<sup>[86]</sup>; Chen et al., 2022<sup>[87]</sup>).

Figure 4.3. Antidepressant consumption by OECD countries in 2021



Note: DDD is defined daily dose.

Source: OECD (2023<sup>[85]</sup>), *Health at a Glance 2023: OECD Indicators*, <https://doi.org/10.1787/7a7afb35-en>.

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Identifying the most appropriate treatment for each patient is critical to achieving optimal outcomes, including for pharmacological approaches (Ray et al., 2018<sup>[88]</sup>). Pharmacological treatments are effective for a wide range of mental health conditions and, in some contexts, represent the most suitable and effective option. For example, in the treatment of substance use disorders, pharmacological treatment plays a critical role in managing acute withdrawal, reducing cravings and urges to use illicit substances, and preventing relapse. In many cases, these treatments are recommended as first-line therapy (Maqbool et al., 2019<sup>[89]</sup>). Conversely, evidence suggests that for certain conditions, such as mild to moderate major depressive disorders, psychological interventions can be equally or more effective than pharmacological treatment (Chen et al., 2019<sup>[90]</sup>; Gartlehner et al., 2017<sup>[91]</sup>; Borwin et al., 2015<sup>[92]</sup>). Finally, in some cases, treatments combining pharmacotherapy and psychotherapy such as CBT offer the greatest benefits (Cuijpers, 2017<sup>[93]</sup>).

The effectiveness of mental health interventions varies according to multiple factors, including the condition being treated, severity, type of intervention, population characteristics and treatment duration, among others (Cheng et al., 2020<sup>[94]</sup>). This is especially important for pharmaceutical treatments, which may be associated with a range of side effects (Bousman et al., 2017<sup>[95]</sup>). Evidence shows that individuals who receive their preferred treatment, whether pharmacotherapy or psychotherapy, are twice as likely to complete therapy compared to those who do not, making treatment preference an important moderator of intervention effectiveness (Swift et al., 2021<sup>[96]</sup>).

## ***Place of delivery is a vital factor in mental health interventions***

The place of delivery is a critical element of any mental health intervention or policy. The setting influences not only the efficacy of an intervention but also its accessibility, uptake, coverage and adherence. National mental health strategies and action plans across OECD and EU countries emphasise the importance of implementing mental health promotion and protection measures beyond traditional health system settings – particularly in workplaces and schools, as highlighted in previous OECD work (OECD, 2021<sup>[2]</sup>).

As discussed in the remainder of this section, the WHO/OECD Mental Health Survey found that nearly four in five OECD and EU countries have been making progress on policies improving mental well-being across PHC, workplace and school settings. These efforts are essential to improving mental health early in the life course, and to ensuring timely identification and treatment of mental ill health. However, effective mental health strategies require a comprehensive, cross-sectoral approach that extends beyond schools and workplaces to include social services, long-term care, frontline actors such as paramedics and fire services, and employment and unemployment services (Box 4.7) (OECD, 2021<sup>[3]</sup>; OECD, 2022<sup>[97]</sup>; OECD, 2023<sup>[98]</sup>).

### **Box 4.7. The need for cross-sectoral collaboration in social services to create effective mental health policy**

Beyond implementation in PHC, school and workplace settings, mental health policy plays a critical role in social services, including social protection systems and employment services. For example, between one-third and one-half of all unemployment benefit recipients experience mental health conditions, with risks increasing during prolonged periods of social assistance (OECD, 2021<sup>[2]</sup>). This underscores the strong link between joblessness and mental health, a relationship well documented over the past decade (Paul and Moser, 2009<sup>[99]</sup>). Yet mild to moderate mental health issues among benefit recipients remain insufficiently acknowledged and rarely integrated into policy in most OECD countries (OECD, 2021<sup>[2]</sup>). Similarly, social protection systems, such as cash transfer programmes, offer valuable opportunities to deliver mental health promotion and protection interventions (Bauer et al., 2021<sup>[100]</sup>). However, implementation of such programmes remains limited across OECD countries, highlighting an important opportunity to test and evaluate policies within social services, such as employment and social protection, to strengthen the evidence base on effective approaches for preventing, identifying and treating mental ill health in these settings.

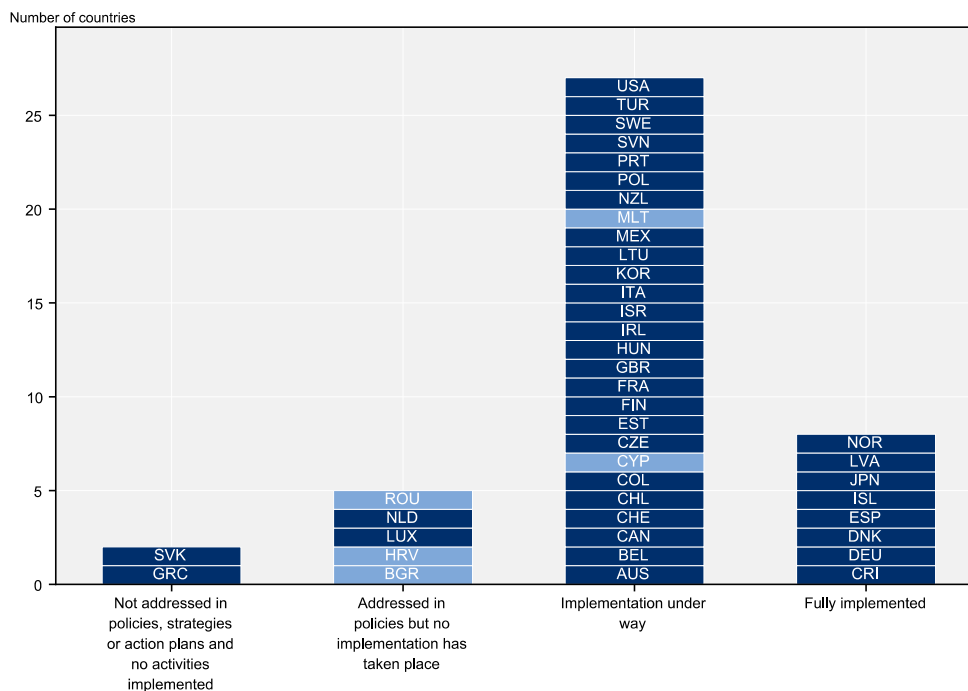
### *Primary healthcare settings*

PHC is the front line of health services and a key entry point for mental healthcare. Strengthening mental health provision in PHC is essential to improving access, reducing treatment-related stigma and preventing the chronicity of mental illness (Wakida et al., 2018<sup>[101]</sup>). In 2004, WHO formally adopted the Alma-Ata model of PHC, designed to deliver comprehensive, universal, equitable and affordable health services (WHO, 2019<sup>[102]</sup>). Under this model, countries are encouraged to adapt mental health services to promote self-care, build informal community care, develop community-based mental health services and integrate mental healthcare into general hospitals (WHO, 2009<sup>[103]</sup>). These recommendations, along with guidance from WHO, OECD and other organisations, have driven significant progress in integrating mental health interventions into national PHC systems (OECD, 2021<sup>[3]</sup>).

The vast majority of OECD and EU countries surveyed by the WHO/OECD Mental Health Survey have been making progress on implementing mental ill health interventions in PHC settings (Figure 4.4). However, progress remains uneven: only 8 of the 42 countries have fully implemented a policy and another

27 countries are still in the implementation process. This reflects both the complexity of adapting mental health services within PHC and the need for sustained investment and capacity-building. Encouragingly, there is emerging global evidence and a growing consensus on the specific operational principles required to scale these services successfully, shifting the focus from whether integration is possible to how it can be achieved systematically (Box 4.8). A robust and expanding evidence base also demonstrates the cost-effectiveness of mental health policies and interventions delivered through PHC (Gilbody, Bower and Whitty, 2007<sup>[104]</sup>).

**Figure 4.4. Interventions for mental ill health in primary healthcare across OECD countries**



Notes: OECD countries are dark blue; EU Member States that are not OECD countries are light blue.  
 Source: WHO/OECD Mental Health Survey.

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### Box 4.8. Operationalising an effective scale-up of mental health services in primary care settings: Principles for success

Despite PHC's potential to deliver accessible, person-centred mental health support, many systems continue to underutilise it for several reasons – including, for example, insufficient political commitment, fragmented services and inadequate financing.

A recent report by the WHO Regional Office for Europe identifies four mutually reinforcing strategies for scaled-up integration: enhancing mental health competencies of primary care workers through education and training; integrating dedicated mental health professionals into primary care teams; strengthening linkages between primary care and specialist mental health services; and fostering multisectoral collaboration to address social determinants of mental health (WHO Regional Office for Europe, 2025<sup>[105]</sup>). To realise these gains, policy levers must transition from isolated clinical adjustments to comprehensive structural reforms. This necessitates a formal commitment at the highest levels of government to ensure that mental health is prioritised within national health plans and legislative frameworks, underpinned by redistribution of human resources and sustainable financing mechanisms.

Successful implementation further requires a “matched” or “stepped” care model that aligns service intensity with patient needs, supported by a robust enabling environment. This environment must include continuous supervision, digital and physical infrastructure upgrades, and improved data collection to ensure policy coherence. By addressing these systemic foundations, health systems can reduce stigma and close the treatment gap through a holistic, people-centred approach. Based on the main messages of the report, some strategic dimensions for action and operational priorities for achieving this transition can be identified (Table 4.3).

**Table 4.3. Key enablers and implementation pitfalls to scale up effective mental health services in primary care**

	Enablers	Pitfalls
Governance and policy	Using clear legislation, stakeholder engagement and co-ordinated policy frameworks to mandate integration	Avoiding misaligned strategies or isolated pilot projects that lack long-term systemic support
Financing and resources	Ensuring sufficient financial and human resources, including infrastructure upgrades, for primary care	Avoiding introducing financing changes without aligning provider roles, incentives and service models
Workforce capacity	Prioritising continuous education, supervision and mentoring for primary care workers	Avoiding expanding roles without providing adequate time, training or resources
Service model and clinical delivery	Ensuring that patients receive effective intervention, with clear pathways for escalation to specialists	Avoiding overemphasis on diagnosis and medication and not ignoring physical – mental comorbidities
Digital and information systems	Using new technologies such as teleconsultations and e-screening to strengthen co-ordination and reach underserved populations	Avoiding weak information systems that inhibit continuity of care, monitoring and accountability
Multisectoral and community	Partnering with other sectors such as education, housing and employment to address the social determinants of mental health	Avoiding pursuing reforms that ignore persistent stigma among providers and communities, as it undermines service uptake

Source: WHO Regional Office for Europe (2025<sup>[105]</sup>), *Scaling Up Mental Health Services Within the PHC Approach: Lessons from the WHO European Region*, <https://iris.who.int/handle/10665/381029>.

PHC is the main setting for treating most mental disorders, rather than specialist services (Jetty et al., 2021<sup>[106]</sup>). Patients also tend to prefer receiving care in PHC settings (Dunn et al., 2021<sup>[107]</sup>). This preference reflects a combination of factors, including system dynamics, resource availability and patient characteristics, but evidence points to several key drivers: the flexibility and familiarity of PHC, lower costs, reduced stigma, greater comfort and faster access to care. For these reasons, PHC is widely regarded as

a critical setting to reduce the burden of mental disorders by promoting awareness, enabling early detection and ensuring rapid access to appropriate treatment. This approach has become increasingly important as health systems face growing demand for mental health services (Fleury et al., 2012<sup>[108]</sup>; Cummings et al., 2023<sup>[109]</sup>).

Within PHC settings, CBT and other psychosocial interventions are effective in reducing symptoms of depression, anxiety and alcohol use disorder (Butler et al., 2006<sup>[66]</sup>). Research also indicates that many patients prefer psychosocial treatments over pharmacological options, which, while effective, can be associated with side effects not present in psychosocial approaches (McHugh et al., 2013<sup>[110]</sup>; WHO, 2009<sup>[103]</sup>). However, implementation of CBT and similar interventions in PHC remains limited due to resource constraints, lack of training and time pressures among frontline workers, as these interventions are often resource-intensive (Weisberg et al., 2013<sup>[111]</sup>). Digital delivery models offer a promising solution: when provided online or via telehealth platforms, these interventions demonstrate comparable effectiveness to face-to-face methods and can significantly reduce costs (Catarino et al., 2023<sup>[112]</sup>; Hoifodt et al., 2011<sup>[113]</sup>).

In addition to treatment-focussed interventions, several mental health promotion and prevention strategies have proved effective in PHC settings. Mental health literacy programmes, for example, have been shown to improve outcomes, including reducing symptoms of depression and anxiety (Magallón-Botaya et al., 2023<sup>[22]</sup>). Similarly, mindfulness-based and exercise-based interventions have demonstrated positive impacts when delivered in PHC contexts (Zemberi, Ismail and Abdullah, 2020<sup>[114]</sup>; Tomlinson-Perez et al., 2022<sup>[115]</sup>; Demarzo et al., 2015<sup>[116]</sup>). Some experts advocate for greater use of exercise prescriptions, both as a preventive measure and as part of treatment for individuals living with mental illness (Reinhart, Keller and James, 2017<sup>[117]</sup>; Ashdown-Franks et al., 2020<sup>[118]</sup>). These approaches not only improve health outcomes for individuals but also help to reduce pressure on overstretched mental health services. Canada is among the countries that have tested models using single-session interventions to improve timely access to mental healthcare within PHC settings (Box 4.9).

#### **Box 4.9. A “single-session” intervention service delivery model in a primary healthcare setting in Canada**

In Canada, demand for mental healthcare significantly exceeds the availability of services, a challenge further intensified by the COVID-19 pandemic, which drove a sharp increase in service needs (Statistics Canada, 2018<sup>[119]</sup>; Marshall, Miller and Moritz, 2023<sup>[120]</sup>). Even before the pandemic, access was constrained: a 2020 study reported that, between 2014 and 2016, the median waiting time from physician referral to a first specialist appointment was 88 days, with one-quarter of patients waiting more than 233 days (Liddy et al., 2020<sup>[121]</sup>). These delays are likely to have worsened in recent years, as 76% of PHC clinicians report seeing more patients with medical and emotional needs (Wong, 2020<sup>[122]</sup>). Extended waiting times are associated with poorer treatment outcomes and higher costs of care (Adu et al., 2024<sup>[123]</sup>; van Dijk et al., 2023<sup>[124]</sup>; Catarino et al., 2023<sup>[112]</sup>).

To address long waiting times for mental health services, a study in Quebec, Canada, examined the impact of a single-session intervention delivered in a university family medicine group setting (Perreault, Breton and Berbiche, 2023<sup>[125]</sup>). The approach aimed to improve timely access to psychological care by offering a single 60-minute session with a psychologist in a PHC context. A single-session intervention was offered to patients deemed appropriate by a healthcare professional, excluding those in crisis (for example, experiencing suicidal or homicidal ideation). Unlike traditional models that automatically schedule 8-12 sessions, a single-session intervention treats the initial session as a complete intervention, with no planned follow-up. The goal is for patients to leave with a clear problem-solving plan and confidence in their ability to manage challenges, while knowing that they can return if

needed. This model seeks to address psychosocial issues promptly, recognising that delays in care often lead to further deterioration in mental health. Evidence suggests that single-session interventions can achieve outcomes only slightly less effective than multi-session interventions, while requiring substantially fewer resources and less time (Weisz et al., 2017<sub>[126]</sub>).

The introduction of the single-session intervention produced notable results. Of the participants, 69 (91%) received an appointment within seven working days and the number of patients accessing psychological consultations was approximately seven times higher than under the traditional multi-session model (Perreault, Breton and Berbiche, 2023<sub>[125]</sub>). Measures of patient-perceived problem intensity and psychological distress showed statistically significant reductions immediately after the session. On a scale of 1 to 10, perceived problem intensity fell from an average of 7.8 before the session to 6.8 after. Psychological distress scores, measured using the Kessler Psychological Distress Scale, decreased from 13.6 to 8.8, with scores above 16 indicating severe mental disorder. These improvements were maintained at six- to eight-week follow-up, although the study used a pre-post design without a control group. Overall satisfaction was high (92.9%) and 51% of participants reported that one session was sufficient to address their concerns. These findings suggest that single-session interventions can provide timely access to psychological support, help to prevent deterioration in mental health and offer a cost-effective option for integration into PHC models without adding pressure to already overstretched health systems.

### *School settings*

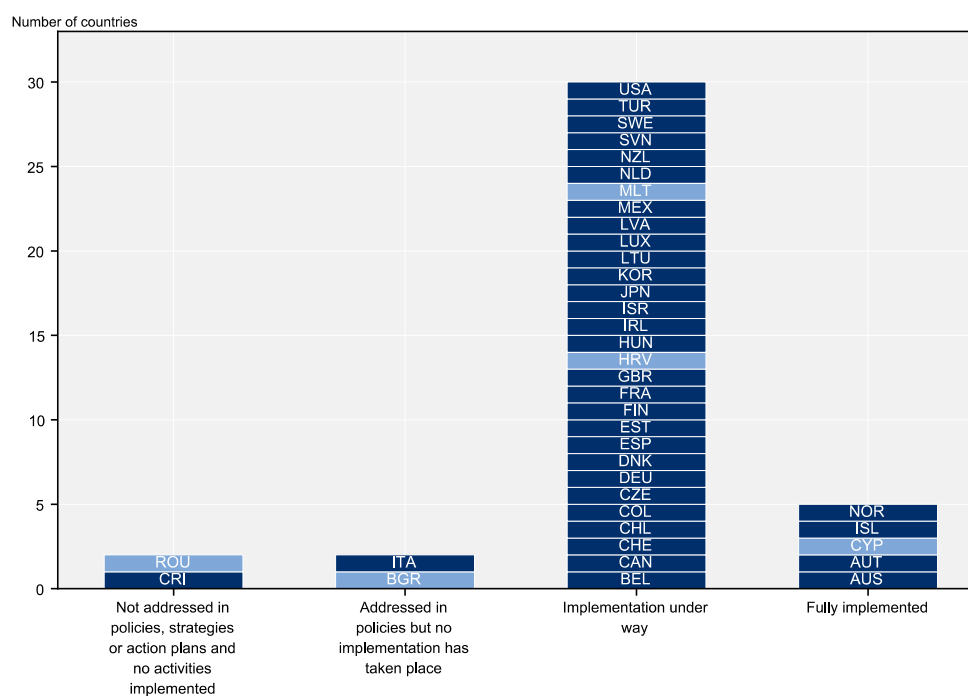
Childhood and adolescence are pivotal stages for shaping life-long mental health. Evidence shows that mental health during these periods strongly predicts outcomes later in life (Mulraney et al., 2021<sub>[127]</sub>; Schlack et al., 2021<sub>[128]</sub>). Even small increases in symptoms during adolescence are associated with a higher risk of mental health conditions in adulthood (Solmi et al., 2022<sub>[129]</sub>). For example, a longitudinal study in New Zealand found that individuals with subthreshold depressive symptoms or major depression at age 17-18 were 2.4 times more likely to experience mental health problems at age 25 compared to those who were asymptomatic (Fergusson et al., 2005<sub>[130]</sub>). These findings underline the importance of early intervention: effective mental health strategies targeting children and adolescents can deliver long-term benefits that persist throughout the life course (McDaid, Hewlett and Park, 2017<sub>[131]</sub>).

Schools provide an important opportunity to deliver mental health interventions in a familiar environment for students. As adolescents spend a significant proportion of their time in school, this setting is particularly well suited for interventions aimed at preventing and treating mental ill health (Eccles and Roeser, 2011<sub>[132]</sub>). School-based programmes can also help to overcome common barriers to accessing care, such as cost, location and time constraints (Werner-Seidler et al., 2017<sub>[133]</sub>).

A growing body of systematic reviews and meta-analyses confirms that school-based mental health interventions can improve mental well-being and support prevention and treatment of mental ill health. However, while effects are statistically significant, they are often modest in size. For example, a recent meta-analysis of more than 45 000 participants found that school-based interventions led to average improvements of 1.23% for depression and 1.05% for anxiety, across both universal and targeted trials (Werner-Seidler et al., 2017<sub>[133]</sub>). Despite these relatively small effect sizes, such interventions could represent a valuable public health opportunity. Even minor improvements in mental health during childhood and adolescence can translate into substantial reductions in health and economic costs over the life course.

Most OECD and EU countries are moving towards wider adoption of school-based mental health interventions. In 2023, 30 out of 36 countries reported that they were in the process of implementing such programmes, while an additional five had already achieved full implementation (Figure 4.5). This trend reflects growing recognition of schools as a key setting for promoting mental health and improving access to early support.

Figure 4.5. Policies and programmes to prevent and treat mental ill health in school-based settings



Notes: OECD countries are dark blue; EU Member States that are not OECD countries are light blue.

Source: WHO/OECD Mental Health Survey.

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Evidence shows that a variety of interventions can be effective in school and educational settings, including psychosocial education and skill-building programmes, mindfulness practices, exercise-based activities, mental health literacy initiatives, and stigma-reduction strategies (Werner-Seidler et al., 2017<sup>[133]</sup>; Das et al., 2016<sup>[134]</sup>; Strøm et al., 2014<sup>[135]</sup>). Among these, CBT-based interventions demonstrate the strongest evidence for preventing depression and anxiety in young people (Hetrick, Cox and Merry, 2015<sup>[136]</sup>).

Both preventive and treatment-focused interventions can be delivered in school settings, and there are indications that universal prevention programmes may be more commonly implemented than targeted or selective approaches (Horowitz et al., 2007<sup>[137]</sup>). Universal interventions are generally easier to implement, require fewer resources and carry less risk of stigmatising students compared to targeted programmes (Offord et al., 1998<sup>[138]</sup>). However, evidence suggests that targeted interventions tend to achieve larger effect sizes (Calear and Christensen, 2010<sup>[139]</sup>). Delivery mode also matters: interventions can be provided face to face, online or through blended approaches, with implications not only for effectiveness but also for implementation costs and cost-effectiveness (Clarke, Kuosmanen and Barry, 2015<sup>[140]</sup>). While delivery modes are found to affect intervention efficacy, they also have substantial implications for implementation costs and therefore for relative cost-effectiveness. Similarly, the choice of provider influences outcomes. Programmes delivered by medical professionals typically show greater impact than those implemented by teachers or school staff, although they are more resource-intensive (Werner-Seidler et al., 2017<sup>[133]</sup>; Stallard et al., 2014<sup>[141]</sup>). Box 4.10 illustrates a successful example from Australia, where an intervention combined online materials with classroom learning to improve mental health literacy and teach strategies for identifying and managing symptoms of mental ill health.

#### Box 4.10. Universal school-based cognitive behavioural skills mental health intervention in Australia

Australia has implemented a universal, school-based intervention that provides evidence of a scalable prevention strategy targeting youth depression, anxiety and substance use (Birrell et al., 2018<sup>[142]</sup>). Known as the Climate Schools Combined Programme, the intervention applies cognitive behavioural principles to help students identify and manage problematic mental health symptoms. It is built on a social influence approach, presenting information in an engaging and age-appropriate format for adolescents aged 13-14. Delivery combines online learning with classroom activities to reinforce key messages. The Programme consists of 12 lessons of 40 minutes each, including a 20-minute online cartoon component followed by a 20-minute teacher-led activity. Teachers are supported by a hard-copy manual that provides implementation guidelines, links to the education syllabus and lesson summaries.

The Climate Schools Combined intervention was rolled out in 88 schools across Australia starting in 2014, reaching more than 6 300 students aged 13-14 (grades 8 and 9). A randomised controlled trial found that, compared to the control group, students who participated in the Programme demonstrated greater knowledge of alcohol, cannabis and mental health (Teeson et al., 2020<sup>[143]</sup>). The Programme also reduced the growth in the odds of any drinking and heavy episodic drinking, and lowered symptoms of anxiety over a 30-month period. After 30 months, the likelihood of being diagnosed with generalised anxiety disorder was 11.4% among students in the intervention group, compared to 15.4% in the control group. Similarly, the odds of developing depression were 15.2% for those receiving the intervention versus 19.6% for controls. These findings are promising and support the case for scaling up school-based interventions that combine evidence-based techniques with engaging, age-appropriate content.

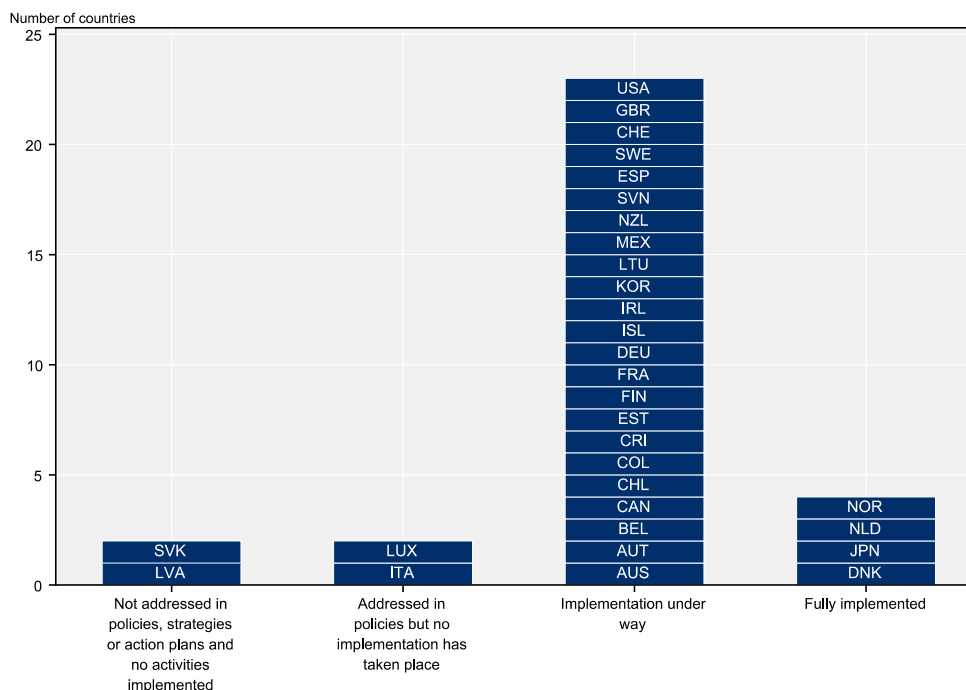
#### *Workplace settings*

With nearly 60% of the global population engaged in work and around 15% of working-age adults living with a mental disorder at any given time, the workplace represents a critical setting for promoting mental health and providing support for mental ill health (WHO and ILO, 2022<sup>[144]</sup>; OECD, 2021<sup>[3]</sup>). As with schools, workplaces are environments where individuals spend a substantial portion of their time, making them well suited for interventions that protect mental health and help to identify those at risk (Rugulies et al., 2023<sup>[145]</sup>).

The economic impact of mental ill health is particularly pronounced among working populations, driven by costs associated with absenteeism, presenteeism and lost productivity (OECD, 2022<sup>[97]</sup>). Consequently, effective workplace mental health interventions have the potential to be not only cost-effective but also cost-saving, given the substantial economic returns that can result from improving mental health among the working-age population (de Oliveira et al., 2020<sup>[146]</sup>). Investments in health and well-being initiatives that boost productivity and reduce absenteeism can generate significant benefits for both employers and governments (OECD, 2022<sup>[97]</sup>). Reflecting this potential, intergovernmental organisations have published guidelines to support wider uptake and implementation of workplace-based mental health interventions (WHO, 2022<sup>[147]</sup>; WHO and ILO, 2022<sup>[144]</sup>; OECD, 2021<sup>[3]</sup>).

While the majority of OECD countries (27 out of 38) have introduced some form of workplace mental health intervention (Figure 4.6), these measures remain relatively underutilised overall, despite evidence pointing to their potential effectiveness and cost-efficiency (OECD, 2021<sup>[2]</sup>). It is important to note, however, that these figures probably underestimate the full scope of activity, as many initiatives implemented by private companies and employers may not be captured by government reporting, and therefore remain unrecorded.

**Figure 4.6. Policies and programmes to prevent and treat mental ill health in workplace-based settings**



Notes: In contrast to the rest of questions collected by the WHO/OECD Mental Health Survey from 2023, only OECD countries were included in this question. As such, non-OECD EU countries are not captured in the analysis for workplace-based interventions.

Source: WHO/OECD Mental Health Survey.

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Recommendations from the OECD, WHO, International Labour Organization and others highlight a wide range of evidence-based options for implementing workplace mental health interventions. While this breadth offers flexibility, it also makes it difficult to isolate the impact of individual intervention components, given the diversity of elements and outcomes assessed in the literature (Hesketh et al., 2020<sup>[148]</sup>). Nonetheless, several approaches have demonstrated clear benefits for health and economic outcomes, particularly when implemented at scale (Rugulies et al., 2023<sup>[145]</sup>). Specifically:

- Physical activity and exercise-based programmes, such as supervised training sessions or aerobic classes delivered once or more per week, are effective in reducing symptoms of depression and anxiety (Chu et al., 2014<sup>[149]</sup>; Christensen et al., 2016<sup>[150]</sup>).
- Mindfulness and meditation interventions can improve mental health, although their impact on depression remains inconclusive (Lomas et al., 2018<sup>[151]</sup>).
- Psychosocial interventions, including CBT, have proved effective in reducing symptoms of depression and anxiety, with no significant differences between delivery modes such as web-based, telephone or face-to-face formats (de Oliveira et al., 2020<sup>[146]</sup>; Carolan, Harris and Cavanagh, 2017<sup>[55]</sup>).
- Stigma-reduction interventions show more limited evidence: while they appear to improve mental health knowledge in the workplace, it remains unclear whether these improvements lead to greater help-seeking or better mental health outcomes (Hanisch et al., 2016<sup>[152]</sup>).

Box 4.11 provides an example of a successful mental health literacy and stigma-reduction intervention trialled in the workplace.

#### **Box 4.11. International workplace mental health promotion through literacy and stigma-reduction initiatives in small and medium-sized enterprises**

As part of the Horizon 2020 Project funded by the European Commission, an online workplace mental health literacy and stigma-reduction intervention was piloted across nine economies: Albania, Australia, Finland, Germany, Hungary, Ireland, Kosovo, the Netherlands and Spain.

The initiative, known as the Mental Health Promotion and Intervention in Occupational Settings Programme, aims to improve mental well-being and reduce depression, anxiety and suicidal behaviour. Delivered through a hub online platform, the Programme provides psychoeducational materials, videos, audio clips and interactive exercises. It targets small (10-50 employees) and medium-sized (50-250 employees) enterprises and offers multilevel interventions: at the individual level (e.g. coping strategies), group level (e.g. peer support and de-stigmatisation), supervisor level (to encourage help-seeking and address psychosocial risks) and organisational level (to promote positive work environments) (Arensman et al., 2022<sup>[153]</sup>).

A pilot study involving 25 organisations included 346 participants at baseline and 96 at six-month follow-up (Tsantila et al., 2023<sup>[154]</sup>). Results showed significant improvements in mental well-being, reductions in anxiety symptoms, and decreases in personal stigmatising attitudes toward depression and anxiety among participants receiving the intervention.

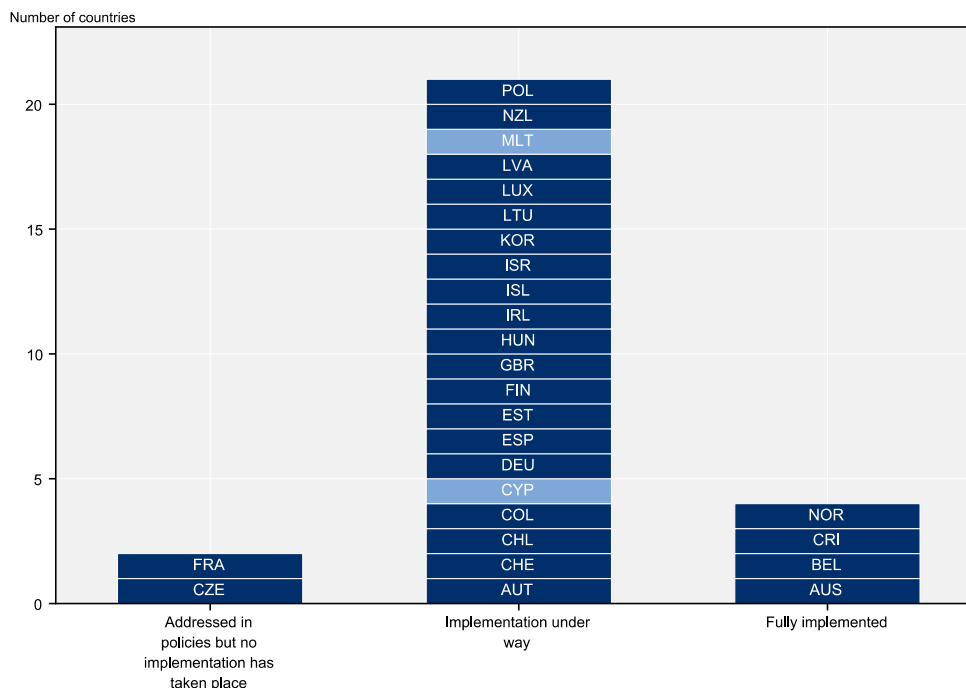
In addition to interventions targeting individual workers, workplaces offer an important opportunity to implement organisation-level measures that address risk factors with the potential to have a negative effect on employees' mental health (Cohen, 2017<sup>[155]</sup>). Such interventions can reduce psychosocial risks, including unsafe working environments, excessive working hours and insufficient financial or social protections (Rugulies, 2019<sup>[156]</sup>). These risks may have intensified in recent years as labour markets undergo rapid transformation – driven by technological change such as teleworking, automation and artificial intelligence – which was further accelerated by the COVID-19 pandemic (ILO, 2020<sup>[157]</sup>). While individual-level interventions have been studied more extensively, there is evidence that organisation-level approaches, such as increasing flexibility or promoting employee participation, can have positive mental health effects (Harvey et al., 2014<sup>[158]</sup>). Some countries have also introduced formal protections for workers' mental well-being. For example, France (2016), Spain (2017) and Ontario, Canada (2022) have enacted legislation granting employees the “right to disconnect” from work-related communications outside working hours and during holidays (Lerouge and Pons, 2022<sup>[159]</sup>; Fricke, 2023<sup>[160]</sup>).

#### ***The intervention delivery mode plays a key role***

Over the past decade, the growing availability and adoption of internet-enabled technologies has created significant opportunities to improve healthcare accessibility, responsiveness and efficiency, while reducing costs and environmental impact. Widespread use of personal computers, tablets, smartphones and other connected devices has driven rapid growth in the delivery of health services through phone-based and web-based platforms, including mental healthcare. This trend accelerated sharply during the COVID-19 pandemic, as digital solutions facilitated continuity of care while minimising physical contact and reducing transmission risks (Jayawardana and Gannon, 2020<sup>[161]</sup>). Alongside this expansion, research has shown that telehealth approaches can be as effective as traditional face-to-face delivery models.

In 2023, more than half (58%) of OECD and EU countries reported having fully or partially implemented policies and programmes to support the integration of digital technologies into mental healthcare delivery (Figure 4.7).

**Figure 4.7. Countries that have policies and programmes to enable integration of digital technologies and tools into mental healthcare delivery**



Notes: OECD countries are dark blue; EU Member States that are not OECD countries are light blue.

Source: WHO/OECD Mental Health Survey.

StatLink  <https://stat.link/6qz5ih>

Digital technologies and telehealth have the potential to reduce the costs associated with traditional models of care significantly. Interventions well suited to online or telephone delivery, such as psychotherapy and mindfulness-based programmes, can be provided at lower cost through web-based platforms, given their reduced time and resource requirements (Kählke et al., 2022<sub>[162]</sub>). These technologies have also enabled new approaches to mental health promotion and treatment, including self-guided mobile applications, which have grown increasingly popular in recent years (Chandrashekar, 2018<sub>[163]</sub>). With strong evidence and considerable potential for cost-effectiveness, these delivery models offer an important opportunity to expand mental health prevention and care across diverse settings, supporting early intervention and ongoing management throughout the life course.

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# **5** The cost-effectiveness of a suite of mental health policy options

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This chapter presents the results of modelling implementation of selected mental health policy interventions across three settings: primary healthcare, schools and workplaces. The analysis examines not only the health impacts of these interventions but also their broader economic implications, including changes in health expenditure, labour-market outcomes and GDP. Results are reported for the 27 EU Member States, Iceland, Norway and Switzerland.

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## Key findings

- Evidence from systematic reviews and meta-analyses shows that interventions delivered in PHC, workplace and school settings can effectively mitigate mental ill health, although the quality and consistency of implementation vary – particularly in non-clinical environments.
- The OECD microsimulation model evaluated the impact of six scalable interventions. In PHC settings, these include a web-based programme for adults with mild to moderate depression or anxiety; group psychotherapy delivered by trained nurses for adults with mild to moderate depression; and combined psychotherapy and medication for severe depression cases not responding to treatment. Workplace interventions comprise an online programme for employees with mild to moderate depression or anxiety; and a universal programme based on CBT. Finally, in schools, the intervention comprises a universal resilience-focussed CBT programme.
- If implemented in 2025 and sustained through to 2050, these interventions are projected to yield larger gains in quality of life, measured in DALYs, than in life expectancy. The most effective intervention – combined psychotherapy and pharmacotherapy delivered in PHC settings – is associated with approximately 27 additional DALYs per 100 000 population, on average across countries. At a population level, this would create a total of 107 292 additional DALYs per year across EU countries over the modelled period.
- Scaling up interventions is projected to reduce healthcare expenditure by between EUR 0.1 and EUR 10.4 per capita per year, with the most effective options generating total savings of around EUR 3.2 billion across EU countries over 2025-2050. However, these savings remain modest relative to the current cost of mental ill health: even the most impactful intervention only lowers mental-health-specific healthcare spending by 4.2%.
- Interventions also enhance workforce productivity, thereby supporting economic growth. The most impactful option modelled – combined psychotherapy and pharmacotherapy in PHC settings – is estimated to be equivalent to adding 16 893 full-time equivalent workers per year across EU countries. The associated gains in human capital are projected to raise economic output by around 0.013%, corresponding to approximately EUR 2.6 billion across EU countries.
- Most interventions provide good value for money, meeting the EUR 50 000 per DALY cost-effectiveness threshold and, in some cases, even generating net savings. They also yield positive returns on investment, with economic gains usually exceeding the resources required for implementation. Interventions targeting the current workforce and delivered at relatively low cost, such as web-based programmes, tend to perform particularly well. Interventions delivered in PHC settings also show strong results.
- Improving population mental health requires the assessed interventions to be accompanied by complementary measures. First, strengthening intervention design and implementation by adhering to best-practice models can enhance effectiveness. Second, more ambitious coverage targets are needed to maximise benefits, although scaling up will require significant upfront investment and increased workforce capacity. Finally, it is crucial to tackle underlying and persistent drivers of mental distress, such as economic insecurity and labour-market instability.

## Investments in evidence-based interventions to promote mental health contribute positively to population health and the economy

Mental ill health – including major depressive, generalised anxiety and alcohol use disorders – has both substantial impacts on health and quality of life and broader social and economic consequences. Chapter 3 showed that mental ill health is projected to reduce healthy life years by an average of 2.5 years across EU countries and to account for around 6% of health spending between 2025 and 2050. Effective interventions that reduce the prevalence, severity or duration of mental ill health can therefore not only alleviate suffering and improve well-being but also help to mitigate these associated economic impacts.

This chapter analyses the cost-effectiveness of a range of mental health interventions to support governments in selecting policies that deliver strong health and economic returns. A wide spectrum of policy options has been shown to be effective in promoting good mental health and in preventing and treating mental ill health, as outlined in Chapter 4 and in a recent OECD report on mental health promotion and prevention (OECD, 2025<sup>[1]</sup>). This chapter seeks to provide a better understanding of the cost-effectiveness of a range of mental health interventions, including the impacts not only on health and quality of life but also on the broader economy. This is particularly important due to the broad range of policy options and levers that governments can consider when evaluating which policy approach to implement, such as intended outcomes (prevention or treatment), sector of implementation and target populations, among others. To provide governments with the data needed to identify which policy intervention, or combination of interventions, represents good value for money, a suite of common and evidence-based interventions were modelled using the OECD SPHeP-NCDs model (for more information, see Chapter 3).

This chapter presents the modelled health and economic impacts of scaling up each selected intervention, assuming national-level implementation. The analysis quantifies the outcomes of intervention scenarios relative to a business-as-usual baseline. Results are generated for the 27 EU Member States (for which averages are also reported) and for Iceland, Norway and Switzerland over the period 2025-2050, based on implementation beginning in 2025. To be included in the model, interventions were required to meet a set of criteria and parameter specifications ensuring their suitability for integration into the OECD SPHeP-NCDs model, as summarised in Box 5.1.

### Box 5.1. Calculating the value for money of mental health interventions using the OECD Strategic Public Health Planning for Non-Communicable Diseases model

The effectiveness of any policy intervention depends on a range of factors, some of which are context-specific. For example, the value for money of a policy is influenced not only by its intrinsic efficacy but also by local conditions such as the cost of treating related diseases and complications, demographic structures, epidemiological patterns, and the costs associated with implementation. Within the OECD SPHeP-NCDs model, policies are assessed using four key parameters:

- The parameter of effectiveness at the individual level captures the extent to which mental health outcomes change following exposure to the intervention. Wherever possible, estimates are drawn from peer-reviewed meta-analyses, preferably based on randomised controlled trials.
- Intervention effects may be time-limited or time-dependent, typically increasing initially before stabilising or diminishing. The parameter of time to maximum effect and evolution of effectiveness over time describes how effectiveness changes over the duration of exposure.
- The parameter of intervention coverage includes defining the eligible population and the share of individuals exposed to the intervention. Some policies target specific groups (such as particular age cohorts or those with defined risk factors), and in many cases only a proportion of eligible individuals participate or receive the intervention.
- The final parameter is implementation costs. Public health actions may incur costs related to planning, administration, monitoring, evaluation and provision of materials or equipment (such as brochures and stand-up desks). Costs are estimated using the WHO-CHOICE methodology (Bertram et al., 2021<sup>[2]</sup>), adjusted for cross-country price differentials using purchasing power parity calculations and exchange rates. All costs are reported in 2019 EUR.

To assess the population-level impact and benefit-cost performance of mental health policies, interventions are compared with a business-as-usual baseline in which no new measures are implemented, and preventive and health services continue at current, country-specific levels. The difference between the business-as-usual and policy scenarios represents the impact of the intervention. This comparison encompasses all relevant dimensions, including health outcomes, healthcare expenditure, labour-market productivity and other economic effects, thereby providing the basis for a comprehensive return-on-investment analysis.

In considering the findings of this analysis, it should be noted that the model includes only a subset of mental disorders, albeit the most prevalent ones (see Box 3.1 for additional information), and does not account for upstream determinants of mental health such as well-being and resilience. This means that the analysis is likely to underestimate the true impact of interventions, and is not designed to assess the effects of upstream efforts such as investments in positive health promotion and resilience-building.

Note: For more information on the OECD SPHeP-NCDs model, please see the SPHeP-NCDs Technical Documentation, available at: <http://oecdpublichealthexplorer.org/ncd-doc>.

## Six interventions to improve mental health, and prevent and treat mental ill health were identified and modelled

The analysis in this chapter examines six interventions selected on the basis of robust evidence demonstrating their effectiveness in improving mental health and/or treating mental ill health, as well as availability of data suitable for integration into the OECD SPHeP-NCDs model (Barry et al., 2024<sup>[3]</sup>). These interventions are summarised in Table 5.1, and brief descriptions are provided below. The selected interventions correspond to the three priority settings identified in Chapter 4: PHC, schools and workplaces. The detailed model specifications and key assumptions underpinning each intervention are presented in the following section.

**Table 5.1. Interventions modelled in the analysis, including actions in primary healthcare, workplace and school settings**

	PHC			Workplace		School
Intervention	Web-based intervention	Psychotherapy treatment by clinicians	Combined psychotherapy and pharmacotherapy intervention by clinicians	Web-based intervention via mobile app	CBT intervention	Resilience-focussed CBT intervention
Targeted disorders	Mild and moderate MDD and GAD	Mild and moderate MDD	Severe MDD	Mild and moderate MDD and GAD	MDD	MDD and GAD
Target population	Adults aged 15+	Adults aged 15+	Adults aged 15+	Adults employed within large companies	Adults employed within large companies	Students aged 8-18
Target group	Individuals with PHQ-8 score between 5 and 15 (for MDD) and/or GAD-7 score between 5 and 15 (for GAD)	Individuals diagnosed with MDD and with PHQ-8 score lower than 15	Individuals diagnosed with MDD and with PHQ-8 score equal to or higher than 15	Individuals with PHQ-8 score between 5 and 15 (for MDD) and/or GAD-7 score between 5 and 15 (for GAD)	Universal intervention	Universal intervention
Target coverage	10% of primary care physicians participating (~1.12% of eligible)	All the individuals already in treatment and an additional 5% among those untreated	All the individuals already in treatment	68% of large companies offering the intervention, and 14% of those eligible participating	68% of large companies offering the intervention and 14% of those eligible participating	75% of schools offering the intervention and 90% of students participating
Effectiveness (absolute delta score)	-1.03 for PHQ-8; -1.58 for GAD-7	-1.81 (treated) and -3.58 (untreated) for PHQ-8	-2.88 for PHQ-8	-1.28 for PHQ-8; -1.68 for GAD-7	-0.49 for PHQ-8	-0.41 for PHQ-8; -1.12 for GAD-7
Effectiveness timeframe	Effective at 6 months and no longer effective after 12 months	Effective at 6 months and no more effective after 12 months	Effective at 6 months and maintained over 27 months; no more effective after 3 years	Effective at 6 months and no more effective after 12 months	Effective at 6 months and no more effective after 12 months	Effective at 6 months and no more effective after 12 months
Programme cost in EUR per capita (country range)	0.203 (0.025-1.174)	1.229 (0.163-2.911)	2.016 (0.339-4.556)	0.329 (0.069-0.775)	3.131 (1.26-6.545)	1.301 (0.536-3.284)

Note: MDD is major depressive disorders; GAD is generalised anxiety disorders.

Source: Deady et al. (2017<sup>[4]</sup>); Santoft et al. (2019<sup>[5]</sup>); Stratton et al. (2017<sup>[6]</sup>); Tan et al. (2014<sup>[7]</sup>); Dray et al. (2017<sup>[8]</sup>).

### **Three interventions in primary healthcare settings were selected**

#### *Web-based intervention to prevent major depressive and generalised anxiety disorders*

Over the past decade, the rapid diffusion of internet-enabled tools has created new opportunities to enhance accessibility, responsiveness and efficiency across health systems, while also reducing costs and associated carbon emissions (Ebert et al., 2015<sup>[9]</sup>; Purohit, Smith and Hibble, 2021<sup>[10]</sup>). Evidence shows that web-based psychological interventions delivered in PHC settings can effectively prevent depression and anxiety, highlighting the value of digital channels for delivering accessible mental health support at scale and at a relatively low cost. To assess their cost-effectiveness, the modelling draws on a meta-analysis indicating that eHealth interventions lead to a 0.493-point reduction in depressive symptoms on the PHQ-8 scale and a 1.023-point reduction in anxiety on the GAD-7 scale (see Box 1.2) (Deady et al., 2017<sup>[4]</sup>). These interventions are primarily based on CBT delivered through technology platforms, with a smaller share reflecting alternative modalities such as acceptance and commitment therapy. Given their preventive focus, the modelling assumes that GPs deliver these interventions to patients aged 15 and over who have mild or moderate symptoms of depression or anxiety (PHQ-8 and/or GAD-7 scores between 5 and 15). In line with previous OECD analyses (OECD, 2025<sup>[11]</sup>), it is assumed that 10% of GPs participate and that only 14% of eligible patients complete the programme, reflecting high dropout rates of around 86%. This results in an overall coverage rate of 1.12% of the eligible population, given that approximately 80% of individuals visit a GP at least once per year.

#### *Face-to-face psychological treatment for mild and moderate major depressive disorders*

CBT is a psychological treatment that has proved effective for a wide range of mental health conditions, including depression, generalised anxiety disorders, panic disorder and post-traumatic stress disorder (Butler et al., 2006<sup>[11]</sup>). CBT encompasses targeted therapeutic strategies aimed at modifying thought and behaviour patterns that contribute to negative emotions and maladaptive behaviours (David, Critsea and Hofmann, 2018<sup>[12]</sup>; Gaudiano, 2008<sup>[13]</sup>). A recent systematic review and meta-analysis shows that CBT delivered by clinicians in PHC settings is an effective treatment for depression (Santoft et al., 2019<sup>[5]</sup>). It also shows that group-based CBT sessions are generally more effective than other treatment modalities for mild and moderate depression, yielding an average 3.59-point reduction on the PHQ-8 scale compared to waiting list controls, and a 1.81-point reduction compared to a care-as-usual scenario among patients already receiving treatment. Drawing on this evidence, the modelling assumes that psychotherapy interventions target individuals aged 15 and over diagnosed with mild to moderate major depressive disorders, defined as a PHQ-8 score between 5 and 15. To align the intervention with best practice and current evidence, it is assumed that GPs refer eligible patients to group CBT consisting of 12 sessions, each involving around ten participants and led by two trained nurses; the intervention aims both to treat those currently receiving care and to increase overall treatment coverage by 5%.

#### *Combined psychotherapy and pharmacotherapy for severe major depressive disorders*

Severe depression is often resistant to treatment, and evidence indicates that combining psychotherapy with pharmacotherapy can more effectively reduce symptoms and support recovery (Santoft et al., 2019<sup>[5]</sup>). To assess the impact of scaling up this approach, combined therapy was modelled for the treatment of severe major depressive disorders. Drawing on findings from a previous meta-analysis, the intervention targets individuals aged 15 and over who are already receiving treatment for severe major depressive disorders, defined as a PHQ-8 score above 15. This research showed that combined treatment is associated with an average 2.88-point reduction in PHQ-8 scores compared with a care-as-usual scenario. Under the modelled scenario, targeted patients are referred by their GP to receive 12 sessions of individual CBT delivered by a trained therapist, alongside appropriate pharmacotherapy. Pharmacotherapy alone is treated as the care-as-usual baseline; it is therefore not included in the implementation costs of the combined intervention.

## **Two workplace-based interventions were selected**

### *Web-based intervention to prevent major depressive and generalised anxiety disorders*

Workplace-based interventions can be effective not only when delivered in person but also when provided through digital channels such as mobile applications or web-based platforms. These approaches offer several advantages over face-to-face programmes, including lower delivery costs and improved discretion for employees, which may help to reduce perceived stigma. Evidence from a meta-analysis suggests that web-based workplace interventions may help to prevent major depressive and generalised anxiety disorders, yielding average reductions of 0.41 points on the PHQ-8 scale and 1.12 points on the GAD-7 scale (Stratton et al., 2017<sup>[6]</sup>). However, the robustness of this evidence remains limited due to the small number of high-quality studies available. In line with existing research, the intervention is modelled as a targeted programme offered to employees of large companies who, following screening, are identified as being at risk of developing a mental illness – defined in the model as a PHQ-8 score between 5 and 15 and/or a GAD-7 score between 5 and 15 (National Mental Health Commission, 2021<sup>[14]</sup>). It is assumed that the intervention is delivered via a mobile application offering a combination of CBT-based tools, mindfulness modules and/or stress-management exercises. Drawing on OECD analysis of the 2020 Workforce Disclosure Initiative (OECD, 2022<sup>[15]</sup>) the model assumes that 68% of large companies offer such a mental health programme. Consistent with assumptions applied to web-based interventions in PHC settings, only 14% of eligible employees are expected to participate.

### *Cognitive behavioural therapy delivered as an intervention to prevent major depressive disorders*

Workplaces present a valuable opportunity to improve and support mental health, including through evidence-based interventions such as CBT, which have been shown to reduce the severity of conditions like major depressive disorders. A systematic review and meta-analysis found that workplace-based CBT interventions reduce depressive symptoms by an average of 0.49 points on the PHQ-8 scale (Tan et al., 2014<sup>[7]</sup>). The studies included in the review used different approaches to engage employees: in one pilot, human resources staff promoted the programme to all employees on an optional basis, resulting in a participation rate of around 3%; in another case, a company targeted lower- and middle-level managers, and 72% agreed to participate. These findings highlight the importance for enterprises of assessing which strategies are most effective in increasing participation. Based on the review evidence, the workplace CBT intervention was modelled as a universal intervention offered to all employees aged 18 and over in large companies, regardless of their initial level of depressive symptoms. Following OECD analysis of the 2020 Workforce Disclosure Initiative (OECD, 2022<sup>[15]</sup>), the model assumes that 68% of large companies will offer such programmes and that 14% of employees will enrol. Consistent with the design used in the study by Ahola and colleagues (2012<sup>[16]</sup>), the intervention assumes that each company designates two staff members (human resources or occupational health and safety) to attend four full-day training workshops (32 hours in total) with a psychologist to prepare them to deliver the programme. The intervention itself consists of four half-day group sessions, each involving 5-20 employees, conducted during working hours by the two trained facilitators from the organisation.

## **One school-based intervention was selected**

### *Psychological resilience-based intervention to prevent major depressive and generalised anxiety disorders*

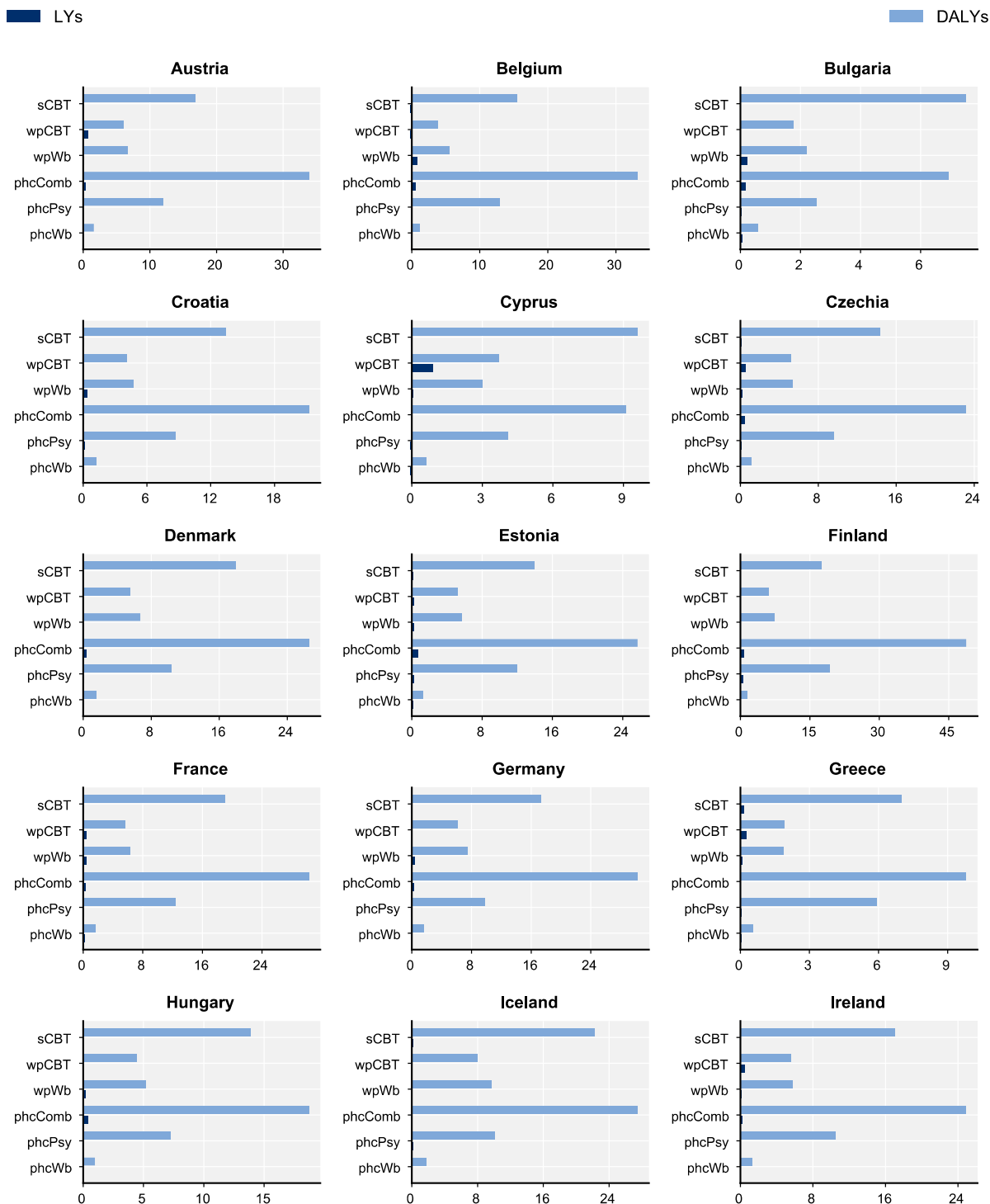
Resilience-based interventions are psychological therapies designed to strengthen protective factors that support mental health and well-being, and to prevent the onset of conditions such as major depressive and generalised anxiety disorders. A recent systematic review of universal resilience-focussed interventions

found that these programmes can produce short-term reductions in depressive and anxiety symptoms among children and adolescents, particularly when they incorporate CBT components (Dray et al., 2017<sup>[8]</sup>). These interventions were associated with a 0.41-point reduction on the PHQ-8 scale and a 1.12-point reduction on the GAD-7 scale. In line with the criteria applied in the systematic review, the modelled intervention is structured as a universal, school-based programme delivered to all students, regardless of their initial symptom levels, with the aim of preventing the development of major depressive and generalised anxiety disorders. The model assumes that 75% of schools implement the intervention and that student attendance averages around 90%. As the literature suggests that the effects diminish after one year, the model further assumes that schools repeat the intervention annually to maintain its impact over time.

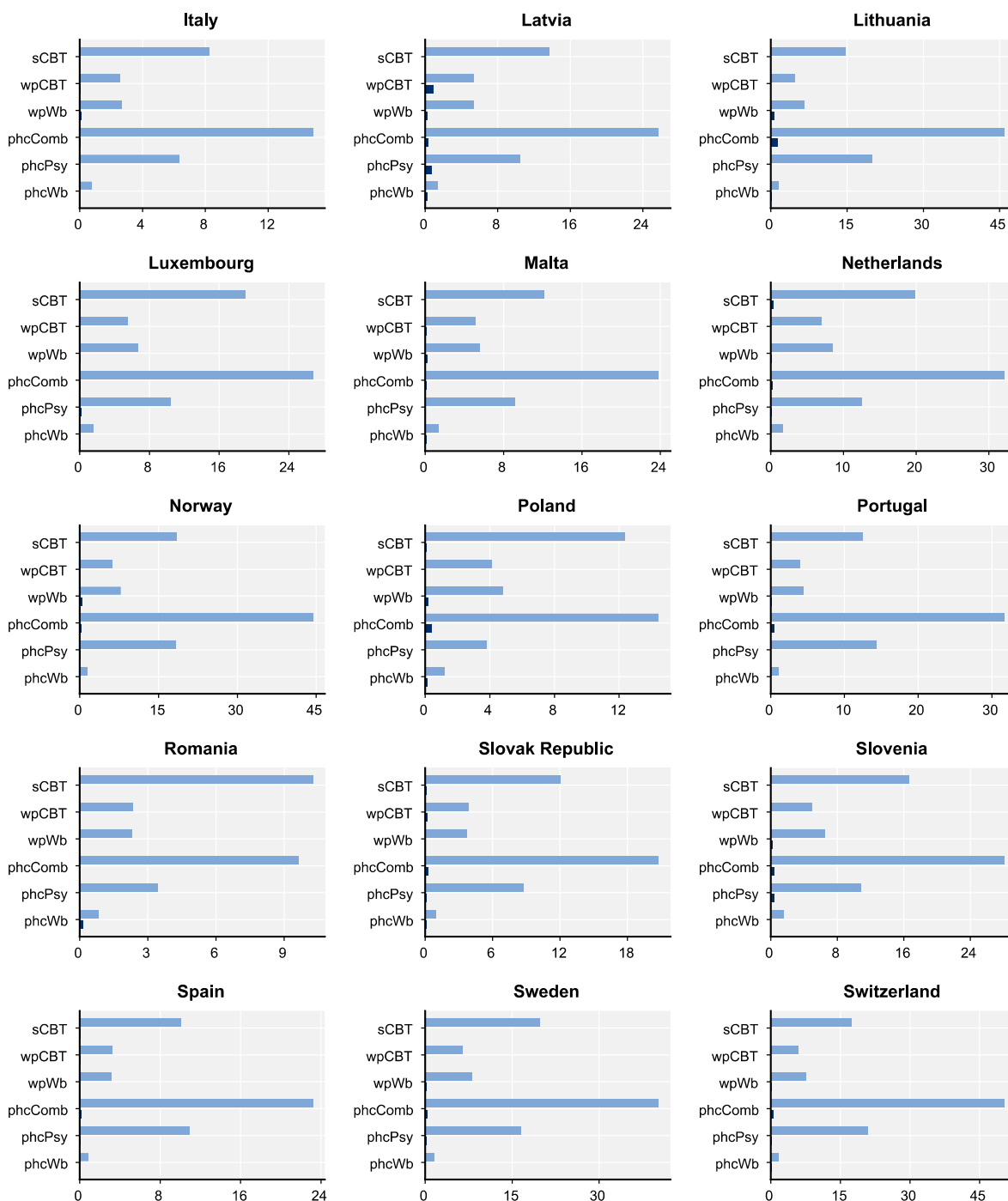
### Scaling up the six interventions to increase population coverage enhances people's lives

Modelling of the six interventions indicates that all generate positive impacts on population health. Improvements are observed primarily in quality of life, measured in DALYs, with comparatively smaller gains in life expectancy (Figure 5.1). This pattern is consistent with that discussed in Chapter 3, as mental ill health affects quality of life more substantially than it reduces life expectancy, measured in life years. The results further suggest that interventions delivered in PHC settings have the largest effects, relative to workplace- and school-based approaches. Combined psychotherapy and pharmacotherapy delivered by clinicians emerges as the most effective intervention modelled: scaling it across EU countries is estimated to produce an average gain of 27 DALYs per 100 000 population every year, which is equivalent to 27 additional people per 100 000 living one additional year in a perfect state of health. Across EU countries, this corresponds to 107 292 additional DALYs per year during 2025-2050.


Figure 5.1. Population effect of interventions on health, life years and disability-adjusted life years gained per 100 000 population annually, 2025-2050



■ LYs ■ DALYs



Note: LY is life year; phcWb is PHC web-based; phcPsy is PHC psychotherapy; phcComb is PHC combined psychotherapy and pharmacotherapy; wpWb is workplace web-based; wpCBT is workplace CBT; sCBT is school CBT.  
 Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

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The second most effective intervention is resilience-focussed CBT delivered in school settings, which yields an average gain of 15 DALYs per 100 000 population per year, or a total of 62 163 DALYs across EU countries during 2025-2050. Psychotherapy treatment delivered in PHC settings also generates substantial benefits, with an average gain of 11 DALYs per 100 000 population per year, amounting to 41 656 DALYs across EU countries. Workplace-based interventions, while still beneficial, produce relatively smaller improvements in quality of life: web-based programmes increase DALYs by 6 per 100 000 population per year (23 010 DALYs across EU countries), and universal workplace CBT leads to a gain of 5 DALYs per 100 000 population per year (19 990 DALYs across EU countries).

It is important to recognise that the overall impact of a mental health intervention depends not only on the mechanism and setting in which it is delivered but also on several additional factors related to its design and implementation. Three main elements help to explain the observed patterns:

- The most influential factor is how **effective the intervention is for each person** who receives it. Interventions that produce substantial and sustained reductions in symptoms of depression or anxiety have a larger aggregate impact. For example, psychotherapy combined with pharmacotherapy in PHC settings yields an effect on targeted individuals that is nearly seven times greater than that of school-based CBT.
- The next factor is the **number of people reached**. Universal interventions typically influence more people, and therefore have the potential for a larger population-level effect. For instance, CBT programmes in schools can reach all students aged 8-18, which is a large cohort. However, because these programmes are delivered to everyone, many participants may have limited need and may thus derive smaller individual benefits.
- The third factor is the **type and severity of mental health needs addressed**. Targeted interventions focussing on individuals with more severe mental health problems – such as combined psychotherapy and pharmacotherapy in PHC settings – reach fewer people overall, but concentrate resources on those with the greatest level of need. This targeted approach can generate a stronger overall impact despite the smaller population reached.

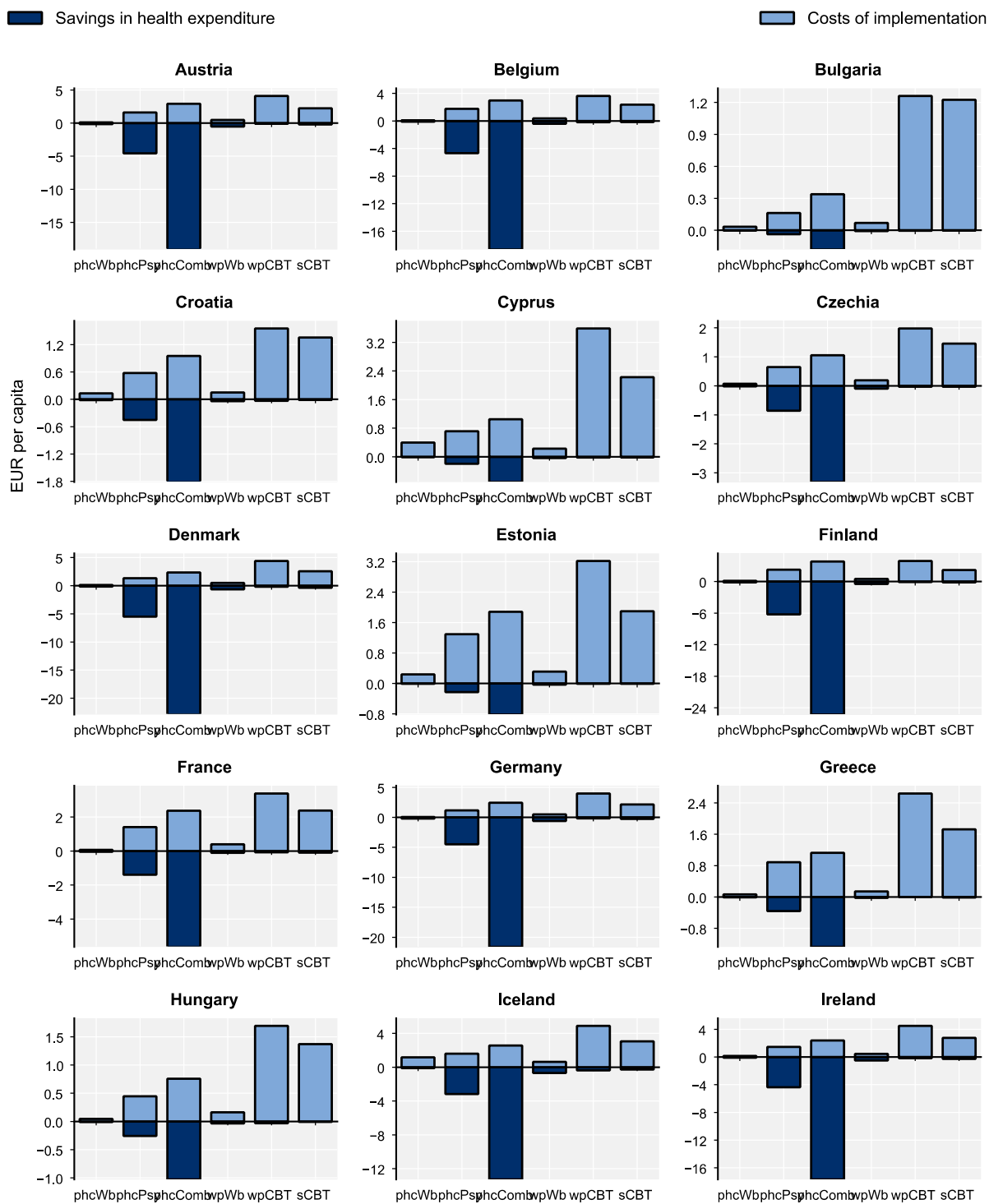
In general, findings from the model suggest that, when scaled up, the most effective interventions fall into two broad categories: highly effective, targeted treatments for individuals with significant mental health needs, and broader, lower-intensity programmes that reach large segments of the population.

Compared with the scale of the overall burden, the estimated impacts of the modelled interventions remain relatively modest. Across EU countries, and at the assumed levels of implementation, the interventions reduce the projected burden of mental disorders by up to around 1%, with the largest effects observed for combined psychotherapy and pharmacotherapy delivered in PHC settings. Expanding population coverage beyond modelled levels would generate further health gains; however, the coverage assumptions used in the analysis reflect what is considered realistic under real-world conditions. Scaling up these programmes may be constrained by factors such as shortages of trained professionals, resource pressures within PHC and educational settings, and challenges in maintaining sustained engagement among target populations.

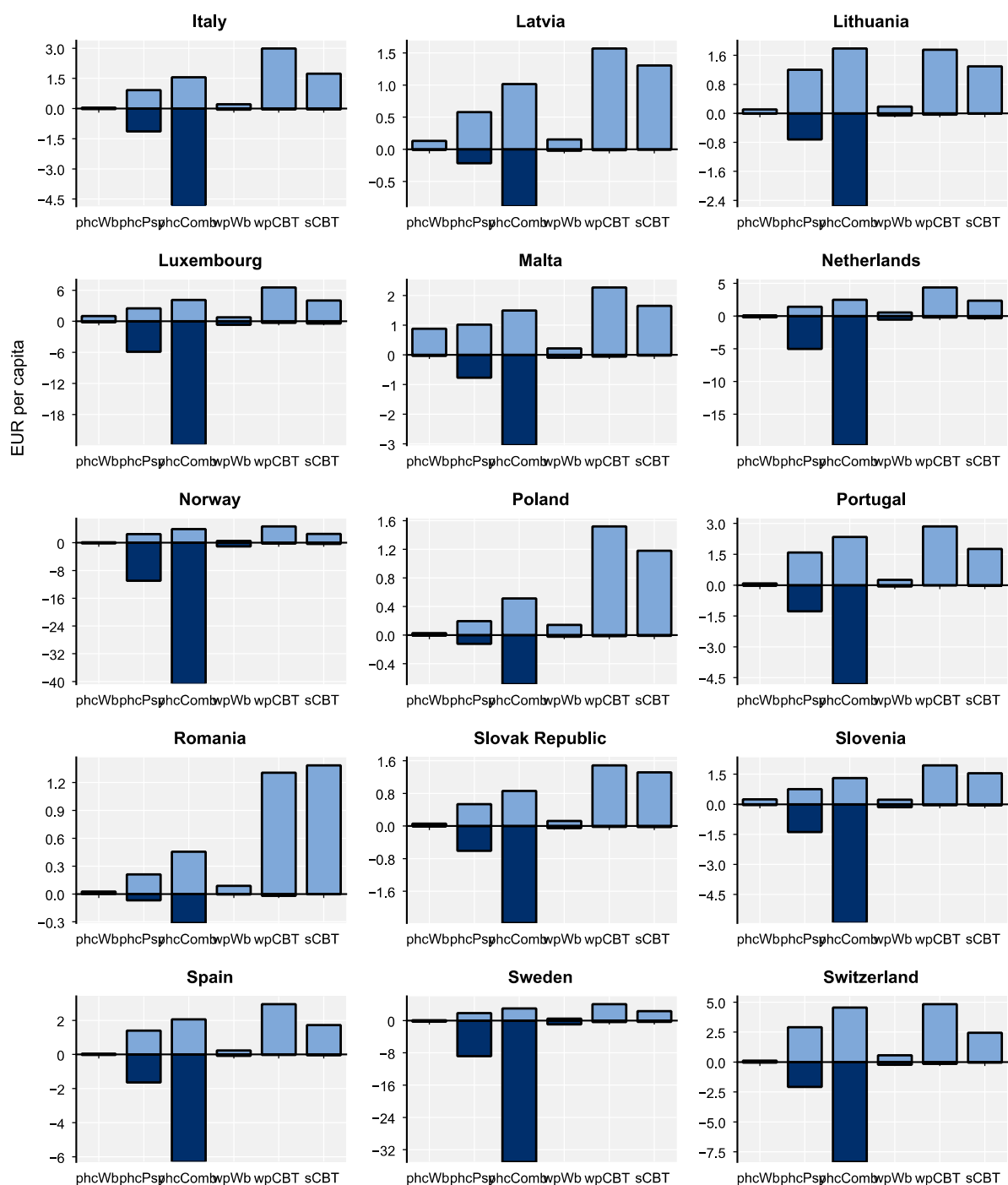
### ***Mental health interventions can reduce healthcare costs, but their impact is relatively small compared to the overall scale of the burden***

Modelling the scale-up of mental health interventions across EU countries shows that doing so would generate an overall reduction in healthcare expenditure (Figure 5.2). These savings arise from lower spending on other forms of treatment and from reductions in the healthcare costs associated with mental ill health as a comorbidity. The estimates do not, however, include the direct costs of scaling up the interventions themselves. The interventions that generate the largest reductions in healthcare expenditure are the same as those that deliver the greatest health gains. In both cases, combined psychotherapy and pharmacotherapy delivered in PHC settings has the largest impact, reducing healthcare expenditure by an estimated EUR 10.4 per capita per year, or around EUR 3.2 billion across EU countries over 2025-2050.

Figure 5.2. Costs of interventions and their impact on health expenditure, annually, 2025-2050



■ Savings in health expenditure      ■ Costs of implementation



Note: phcWb is PHC web-based; phcPsy is PHC psychotherapy; phcComb is PHC combined psychotherapy and pharmacotherapy; wpWb is workplace web-based; wpCBT is workplace CBT; sCBT is school CBT.  
 Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

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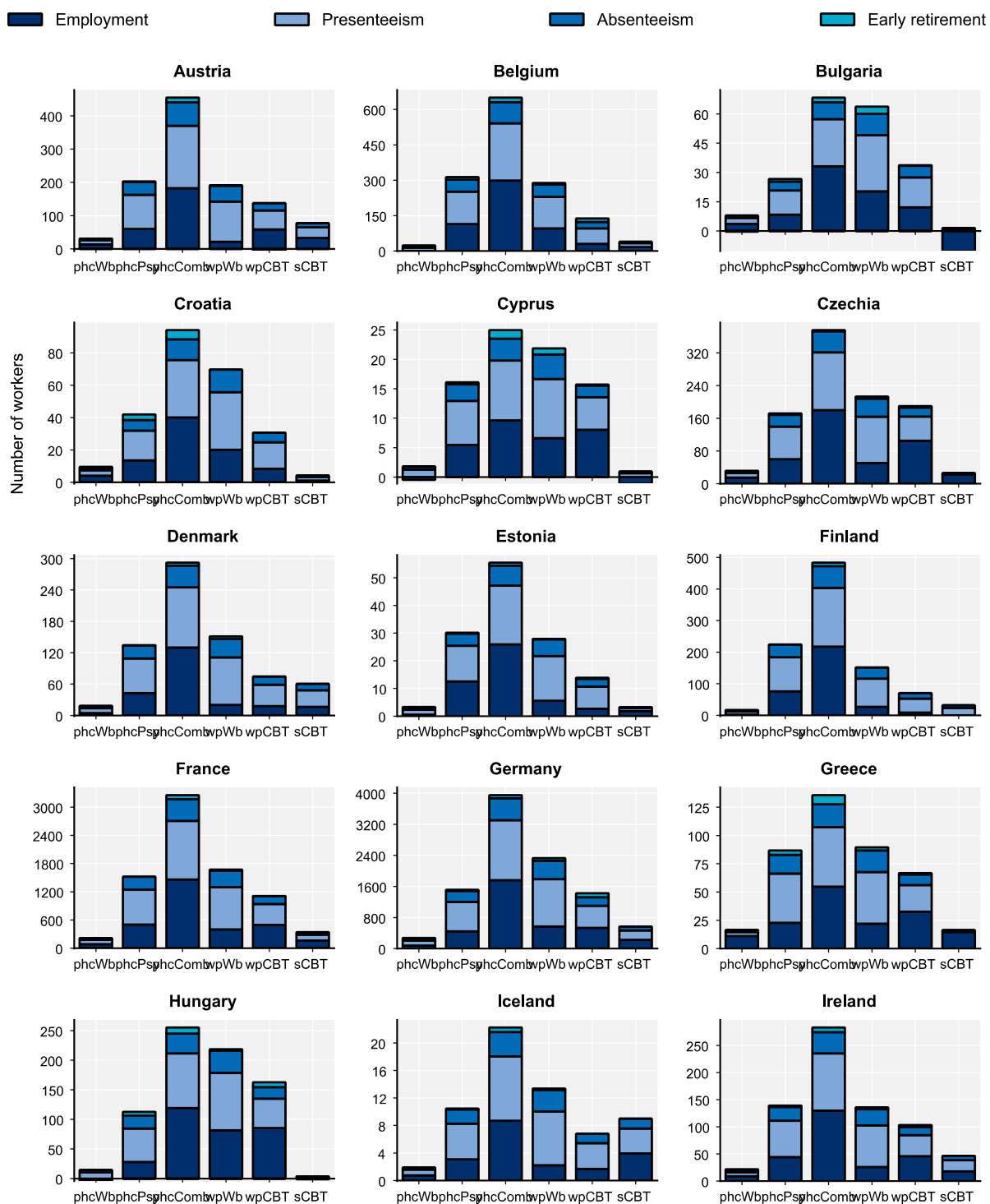
By contrast, the smallest reductions are associated with web-based interventions delivered in workplace settings, which are estimated to generate savings of EUR 0.1 per capita per year – equivalent to EUR 79 million across EU countries between 2025 and 2050. For most other interventions, reductions range between EUR 0.1 and EUR 0.3 per capita per year, with the exception of psychotherapy delivered in PHC settings, which is estimated to reduce spending by EUR 2.6 per capita per year. In total, this corresponds to savings of between EUR 24 million and EUR 738 million across EU countries during 2025-2050. Significant variation is also observed across countries, reflecting differences in baseline health expenditure and in the magnitude of potential savings, as illustrated in Figure 5.2.

It is important to note that, as with the modelled effects on population health, the overall impact of the interventions on healthcare expenditure remains small relative to the total cost of mental ill health. Even the intervention generating the largest reduction in healthcare spending lowers mental health-related expenditure by only 4.2%. This underscores that, while the modelled interventions can make a meaningful contribution to reducing the burden of mental ill health, they are unlikely on their own to reduce the overall healthcare costs associated with these conditions substantially.

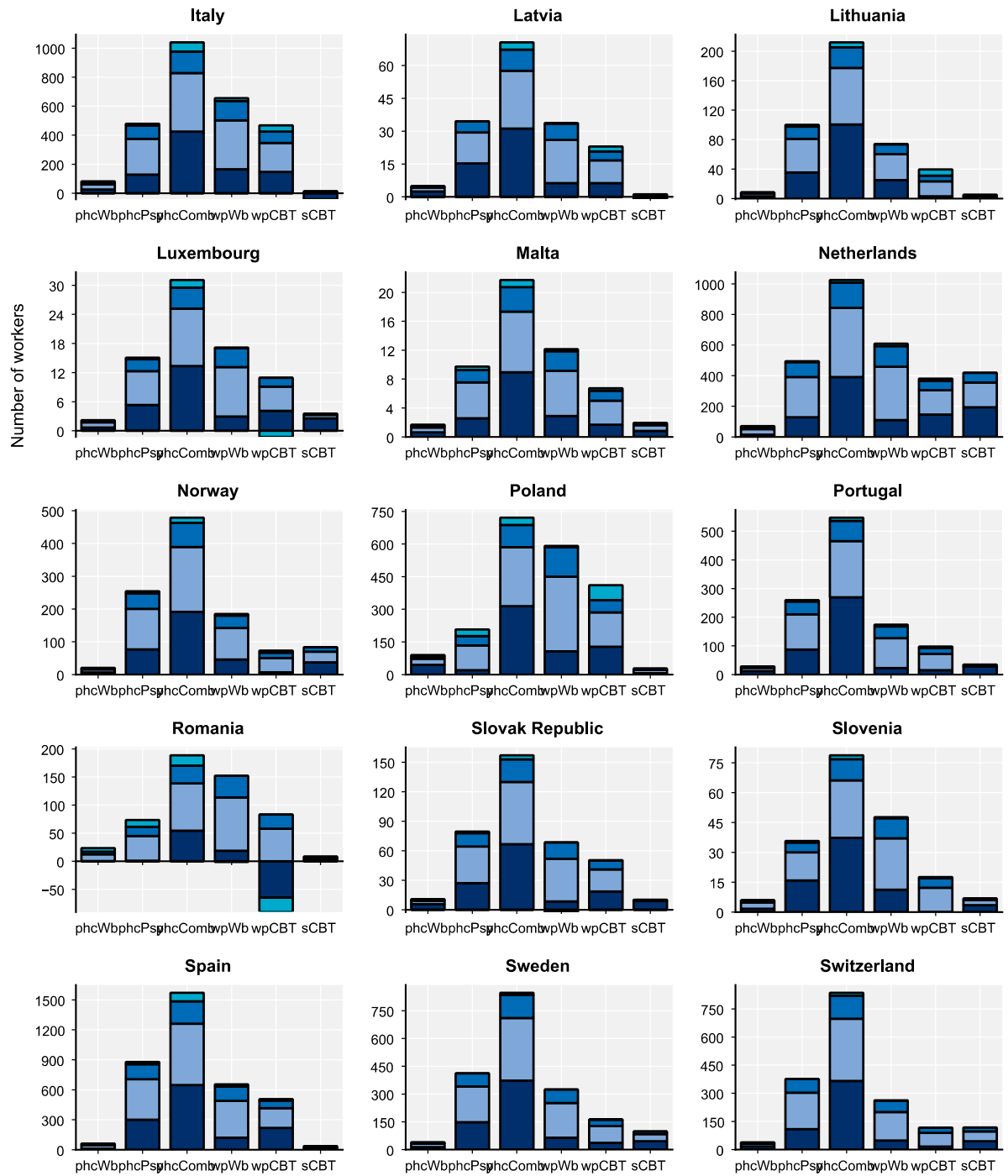
### ***Mental health interventions can enhance productivity by increasing workforce participation and productivity***

The modelled interventions are estimated to generate positive productivity gains, driven by improvements in workforce participation and performance. As shown in Figure 5.3, most of these gains stem from increased productivity, reflecting reductions in absenteeism and presenteeism, followed by higher labour market participation and decreases in early retirement. The intervention with the largest impact is combined psychotherapy and pharmacotherapy delivered in PHC settings, which would yield productivity gains equivalent to an additional 16 893 full-time equivalent workers per year across EU countries. The next most effective intervention is workplace-based CBT, which would generate the equivalent of 9 032 additional full-time-equivalent workers annually. This is followed by psychotherapy delivered in PHC settings (7 604), universal workplace-based CBT (5 726) and school-based CBT (1 827). The smallest estimated productivity gain, equivalent to 1 163 full-time-equivalent workers, is associated with web-based interventions delivered in PHC settings.

Figure 5.3. Full-time equivalent worker numbers gained annually, average 2025-2050



■ Employment      ■ Presenteeism      ■ Absenteeism      ■ Early retirement



Note: The “employment” category combines both effects on unemployment and part-time working; phcWb is PHC web-based; phcPsy is PHC psychotherapy; phcComb is PHC combined psychotherapy and pharmacotherapy; wpWb is workplace web-based; wpCBT is workplace CBT; sCBT is school CBT.

Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

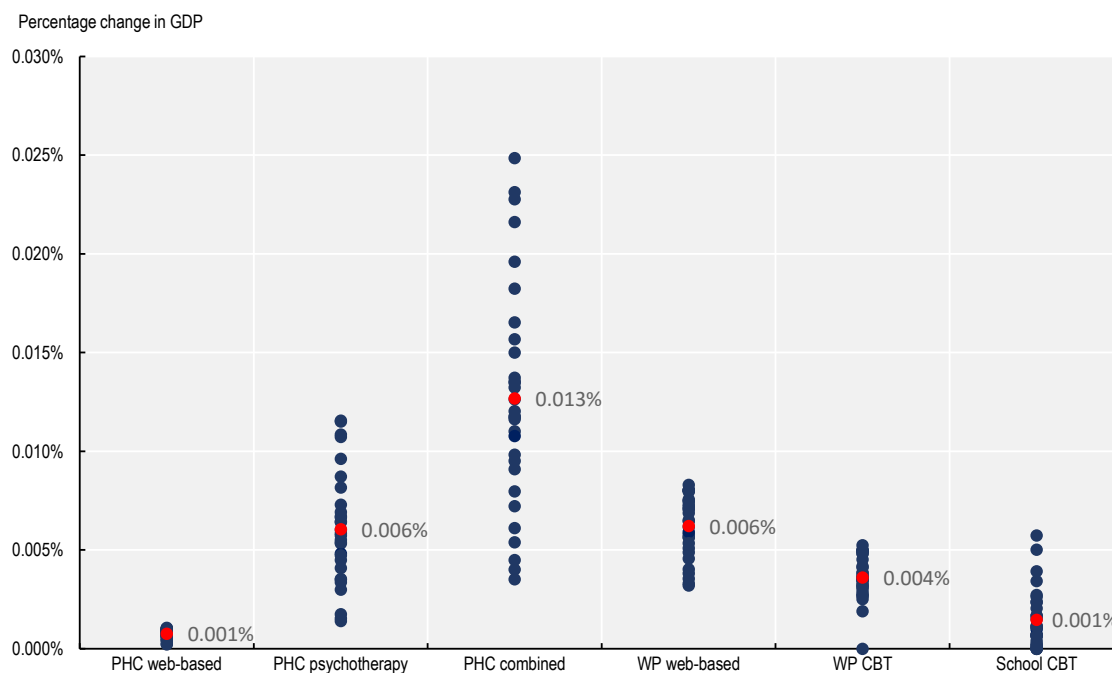
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These findings are consistent with existing evidence on the economic benefits of investing in mental health. Because mental ill health affects quality of life more substantially than life expectancy, the most significant productivity improvements arise from reductions in absenteeism and presenteeism – two of the key channels through which mental ill health generates economic losses. Interventions that successfully mitigate the adverse impacts of mental ill health on daily functioning therefore offer considerable potential to boost economic performance.

### ***Improving mental well-being has a positive impact on the economy***

The productivity improvements generated by mental health interventions are expected to translate into measurable gains in GDP, primarily through increased human capital resulting from reduced presenteeism, absenteeism and early retirement and higher labour market participation. These enhancements in workforce performance are projected to raise economic output by between 0.001% for the least impactful intervention and 0.013% for the most effective (Figure 5.4). In monetary terms, this corresponds to increases of between EUR 166 million and EUR 2.6 billion across EU countries during 2025-2050. The smallest GDP gains are associated with scaling up web-based interventions in PHC settings and school-based CBT, each generating an estimated 0.001% increase in GDP – equivalent to EUR 166 million for PHC web-based interventions and EUR 324 million for school-based CBT. Larger impacts are observed for workplace-based CBT (0.004% or EUR 880 million), web-based interventions delivered in the workplace (0.006% or EUR 1.4 billion) and psychotherapy delivered in PHC settings (0.006% or EUR 1.2 billion). The greatest GDP gains would result from scaling up combined psychotherapy and pharmacotherapy in PHC settings, which is estimated to increase GDP by 0.013% per year, equivalent to EUR 2.6 billion across EU countries over the modelled timeframe.

**Figure 5.4. The impact of interventions on GDP, 2025-2050**



Note: Blue dots represent single country estimates; the red dot represents the EU average; WP is workplace.  
Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

StatLink  <https://stat.link/f0h1ma>

## The case for investing in interventions to improve mental health and to prevent and treat mental ill health

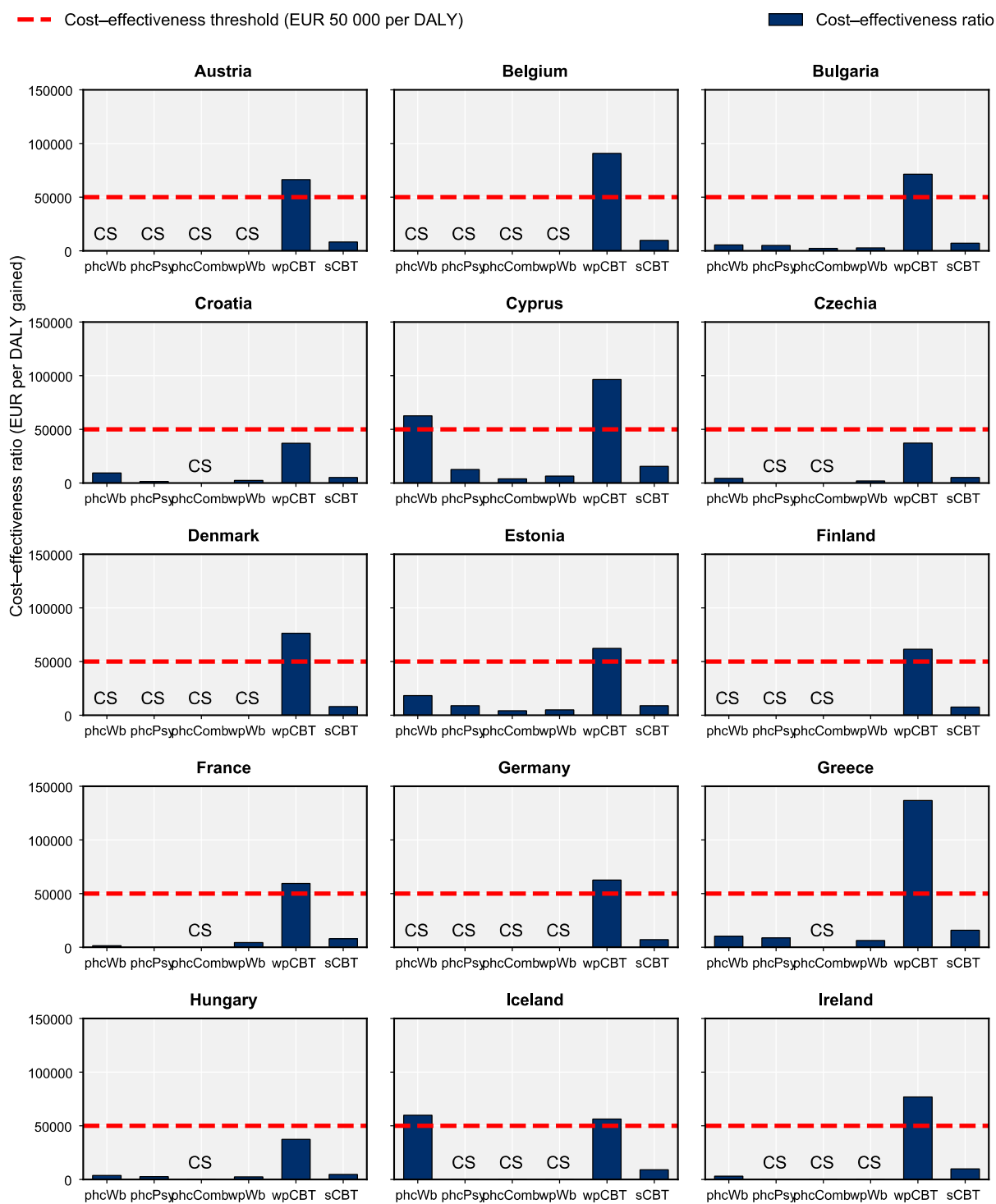
As discussed in the previous section, results from the OECD SPHeP-NCDs model indicate that, even when scaled up to realistic coverage levels that reflect workforce and budget constraints, the assessed interventions would reduce the burden of mental ill health associated with generalised anxiety and major depressive disorders only modestly. Across EU countries, the most effective interventions are estimated to lower the health burden by up to roughly 1% and to reduce related healthcare expenditure by up to 4.2%. While affordable, implementation costs are also not negligible, ranging from EUR 0.2 to EUR 3.1 per capita per year. These findings may prompt reflection across countries on whether such interventions constitute a worthwhile investment, including whether mobilising additional funding and adopting enabling policies – such as strengthening the mental health workforce – to support scaled-up implementation is economically justified.

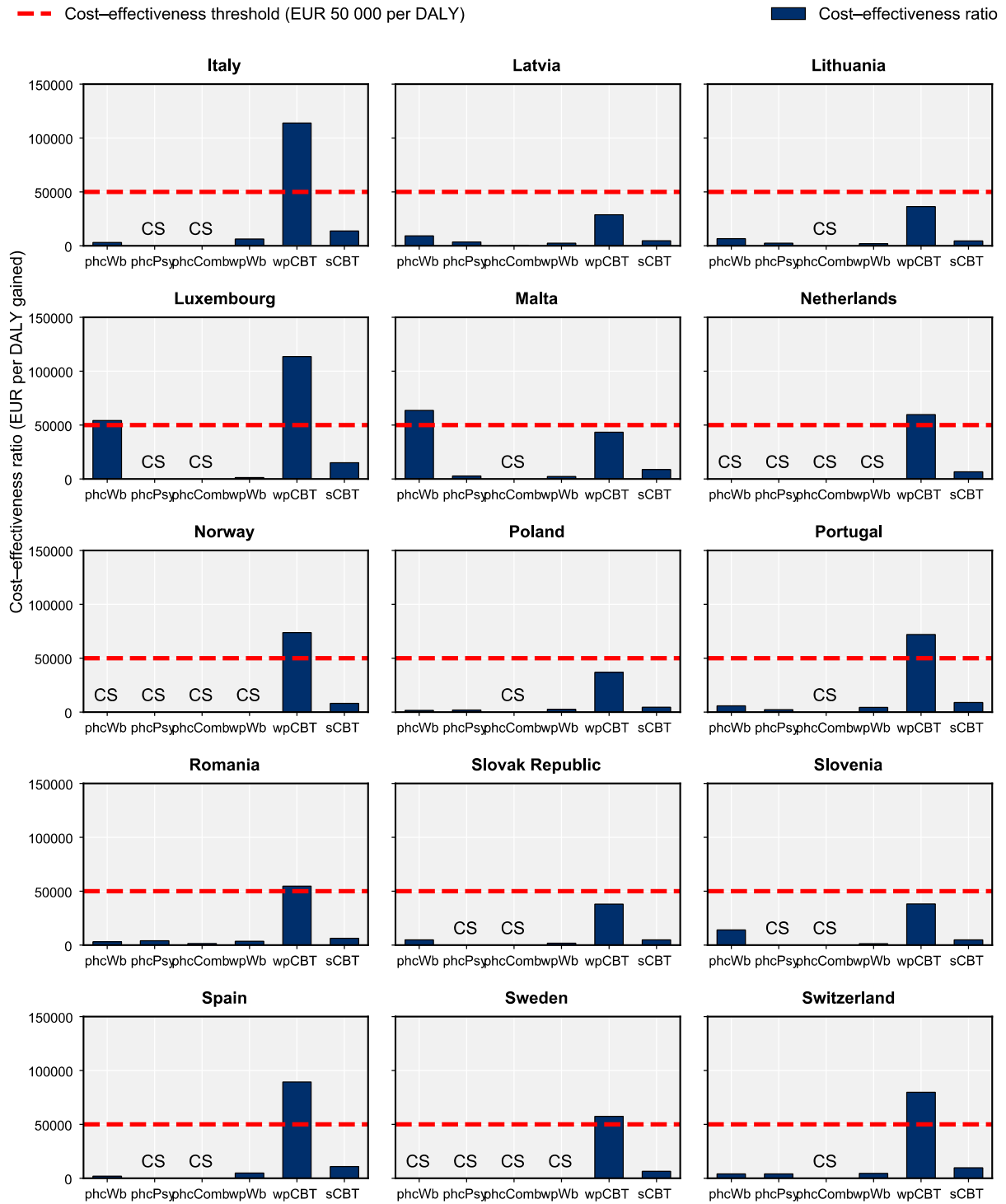
To respond to such questions, governments and public health authorities usually rely on cost-effectiveness analysis and benefit-cost metrics. These economic evaluations help to ensure that limited resources are allocated to programmes that deliver the greatest social benefits at the lowest cost. Specifically:

- Cost-effectiveness analysis evaluates the improvement in quality of life, measured in DALYs gained, relative to the cost of an intervention, net of any potential savings in healthcare expenditure. In line with thresholds commonly used at a national level, OECD analyses consider an intervention cost-effective when it delivers one additional DALY (i.e. an additional year in full health) at a cost below roughly EUR 50 000.
- Benefit-cost ratios reflect how investment in a public health intervention contributes to an economy's competitiveness by strengthening human capital through improved health. It is calculated as the total increase in GDP resulting from higher workforce productivity, divided by the cost of implementing the intervention; values above 1 indicate that the economic return exceeds the investment cost.

The majority of assessed interventions demonstrate good value for money, making them viable options for policymakers seeking efficient use of public resources (Figure 5.5). Interventions delivered in PHC settings generally perform best: psychotherapy is cost-saving in 53% of countries; combined psychotherapy and pharmacotherapy is cost-saving in 83% of countries and cost-effective in all others. School-based CBT and web-based programmes delivered in workplace settings also show favourable value for money, with all countries reporting cost-effectiveness ratios below the EUR 50 000 per DALY threshold, and workplace web-based programmes being cost-saving in about one-third of countries. Other interventions display a more heterogeneous pattern. Web-based programmes delivered in PHC settings yield mixed results, with countries distributed across all cost-effectiveness categories, although only four countries fall above the cost-effectiveness threshold. Workplace-based CBT shows the widest variation, and is considered not cost-effective in about 70% of countries. These differences suggest that while several interventions reliably deliver value for public investment, others are more sensitive to country context, implementation capacity and delivery conditions.

Figure 5.5. Cost-effectiveness ratios, average 2025-2050



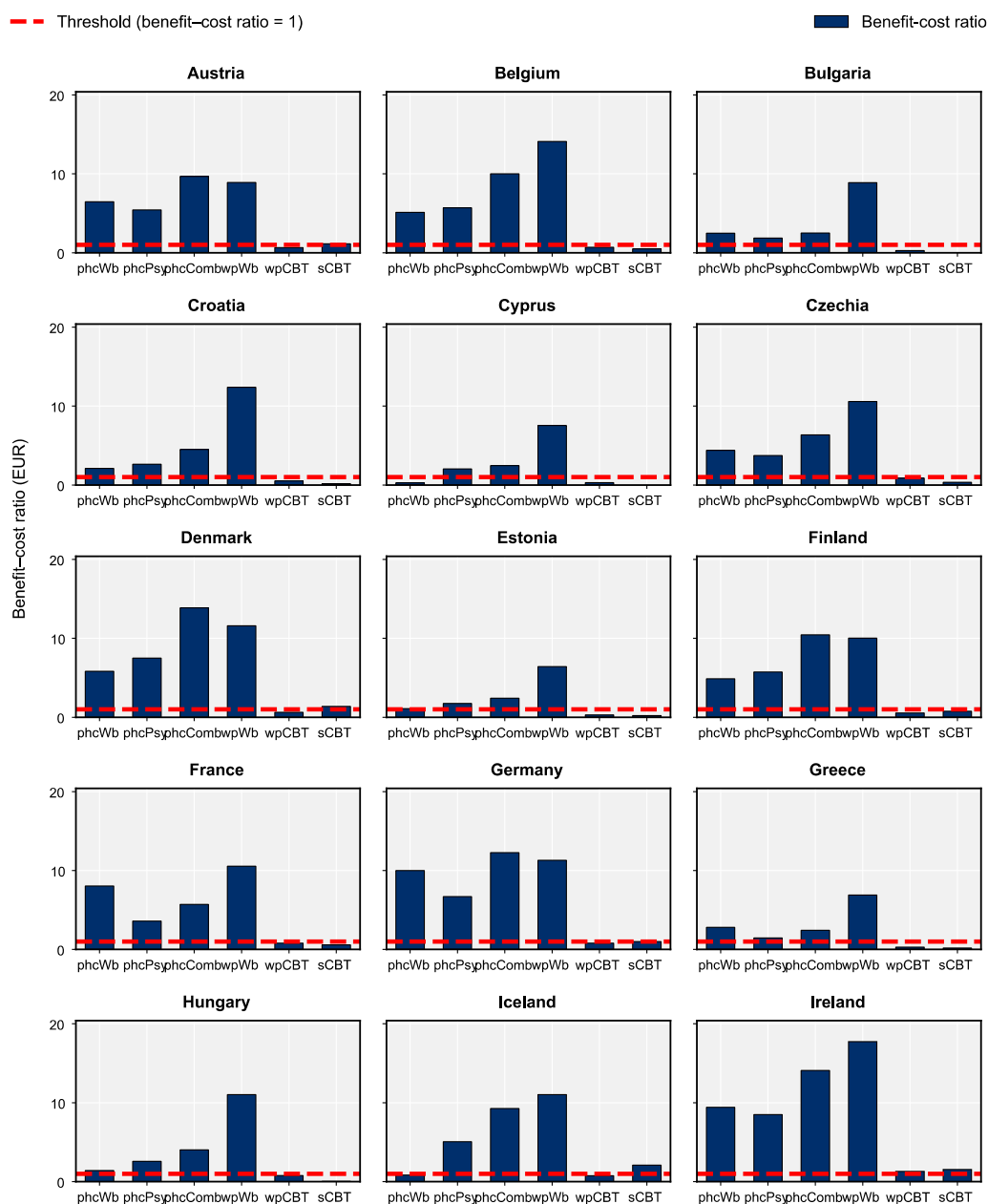


Note: CS is cost-saving; phcWb is PHC web-based; phcPsy is PHC psychotherapy; phcCom is PHC combined psychotherapy and pharmacotherapy; wpWb is workplace web-based; wpCBT is workplace CBT; sCBT is school CBT.  
 Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

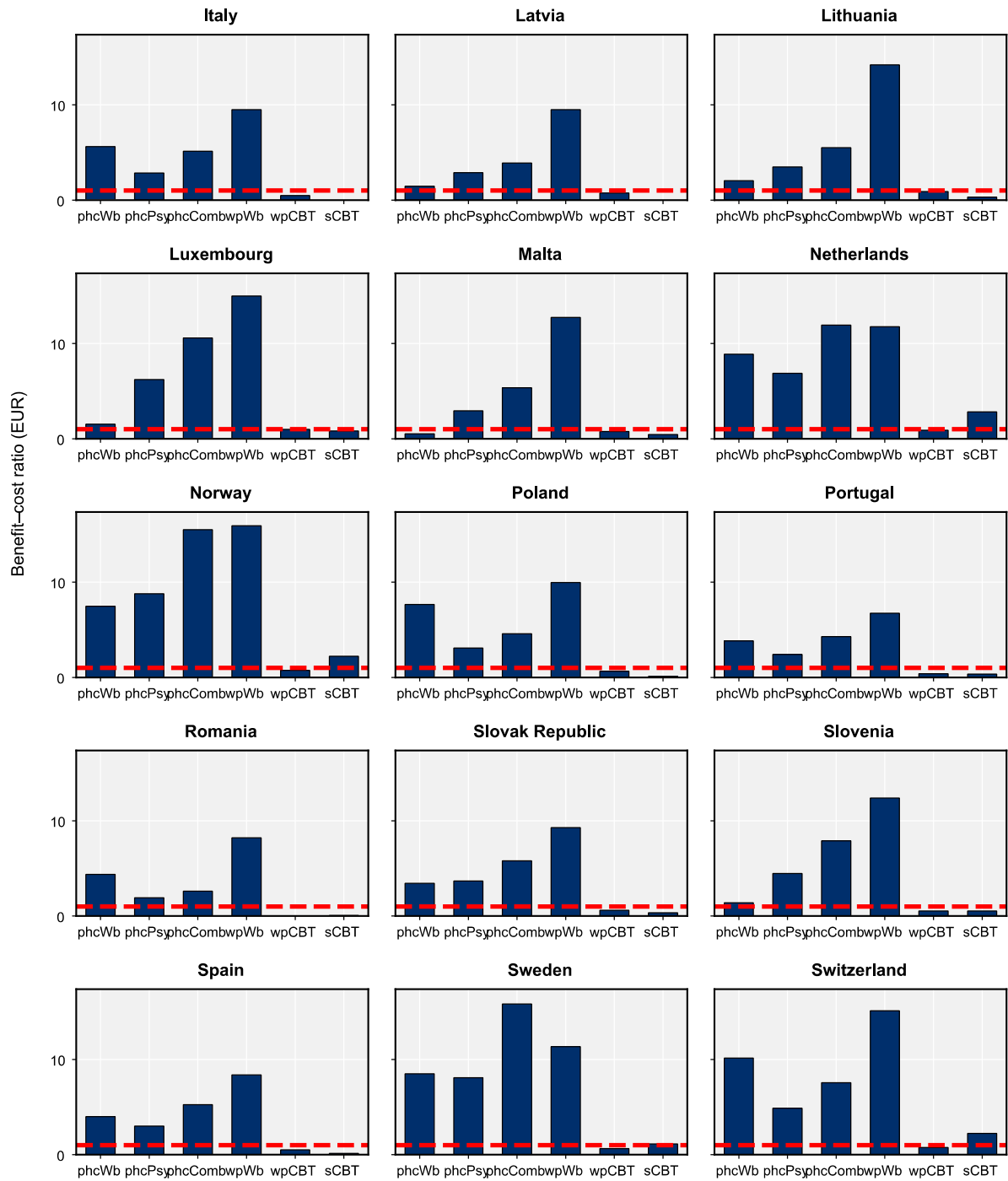
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Considering the benefit-cost results (Figure 5.6), a clear pattern emerges: interventions that target the current workforce and can be implemented at relatively low cost deliver the strongest economic returns. All options except school-based and workplace-based CBT yield a benefit-cost ratio greater than 1. Workplace web-based programmes perform particularly well, generating EUR 10.3 in GDP for every euro invested, reflecting both their low implementation cost and their direct effect on workforce productivity. Web-based interventions in PHC settings also show strong returns, with a benefit-cost ratio of 3.9, followed by combined psychotherapy and pharmacotherapy (3.3) and psychotherapy (2.6) in PHC settings. By contrast, school-based and workplace-based CBT both produce benefit-cost ratios below one (0.6), with the former reflecting the absence of short-term productivity gains among beneficiaries who are not yet in the labour market, and the latter combining higher implementation costs with more limited productivity impacts.

Figure 5.6. Benefit-cost ratio of the policies, average 2025-2050



--- Threshold (benefit-cost ratio = 1)      ■ Benefit-cost ratio



Note: Estimates for the benefit-cost ratio are the result of the total increase in GDP produced by the policy divided by the total cost of implementing the policy in these countries; phcWb is PHC web-based; phcPsy is PHC psychotherapy; phcCom is PHC combined psychotherapy and pharmacotherapy; wpWb is workplace web-based; wpCBT is workplace CBT; sCBT is school CBT.

Source: OECD analyses using the SPHeP-NCDs model.

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## Cross-sectoral action, best-practice design and high coverage are required to achieve meaningful impact

The analyses presented in this chapter highlight that, although initiatives to improve mental well-being are beneficial and offer good value for money, they should be considered as one element of a broader, multi-component mental health strategy rather than standalone solutions. Even when implemented in combination, these interventions are unlikely to generate sizeable reductions in the substantial and growing burden of mental ill health. Their impact depends not only on the scale of investment but also on implementing the most effective versions of the policies, acknowledging that the systematic reviews informing this work point to considerable variation in intervention design and outcomes. In addition, countries may wish to adopt more ambitious coverage targets, with corresponding investments to support wider implementation. Finally, efforts to improve mental well-being need to be accompanied by policy action that addresses the underlying determinants of mental ill health, including those discussed in Chapter 2. The remainder of this section examines these complementary options in greater detail.

### ***Implementing best practices for improving mental well-being will deliver better results***

A central priority for countries aiming to strengthen population mental health is to invest in interventions that reflect validated best practices and are adapted to national contexts. While the interventions modelled in this report provide a useful benchmark, their real-world impact depends on how effectively they are designed, targeted and delivered. OECD evidence shows that core public health principles – such as ensuring accessibility, promoting equity and integrating services across sectors – are critical determinants of success (OECD, 2025<sup>[11]</sup>).

Impact is further enhanced when clinical services are supported by system-level measures that promote awareness, early detection and timely access to care. Improving service availability alone is insufficient if stigma, poor mental health literacy or social barriers continue to hinder help-seeking. Communication campaigns, literacy initiatives and peer-support programmes have proved effective in normalising discussions about mental health and encouraging individuals to seek care when needed. These complementary actions expand the reach and effectiveness of clinical interventions. For example, scaling up Norway's Prompt Mental Health Care programme, combining rapid access with evidence-based psychotherapy, could yield roughly 33 DALYs per 100 000 people annually across EU countries – three times the effect of the generic psychotherapy intervention in PHC settings modelled in this report.

Countries can also strengthen intervention performance by investing in key implementation enablers. Workforce development is especially important, with best practice programmes emphasising the need to expand mental health capacity, support multidisciplinary teams and introduce new roles that improve continuity and access. In many countries, teleconsultations, digital tools and integrated care networks have become vital to extending services to underserved groups and managing rising demand. These measures improve both coverage and resource efficiency at a time when workforce shortages are widespread.

Reducing financial barriers is another crucial enabler. Expanding reimbursement for psychotherapy and lowering out-of-pocket payments have been associated with higher service uptake, earlier engagement in care and improved equity. When combined with destigmatisation and literacy initiatives, such reforms create an environment where interventions are more likely to achieve their intended outcomes. Without these enabling conditions, even highly effective programmes may fail to reach those who would benefit most.

Finally, scaling up mental health interventions requires sustained investment in research and evaluation. Although the interventions modelled in this report draw on well-established evidence, ongoing trials and implementation studies remain essential to refine existing approaches and identify promising new ones. A stronger evidence base will support more informed decision-making about which interventions to prioritise,

the contexts in which they perform best and the system features that facilitate success. This is particularly important for digital and workplace-based interventions, where evidence is evolving rapidly but remains uneven across countries.

### ***Achieving greater impact through higher coverage and system preparedness***

A second avenue for increasing the impact of mental health interventions is to raise coverage levels beyond those simulated in this analysis. The modelling presented in this chapter adopts deliberately conservative assumptions, such as assuming that 10% of GPs participate in PHC-based interventions. This reflects short-term feasibility and current evidence on workforce availability and service organisation across OECD and EU health systems. However, the potential benefits of higher coverage are substantial. Expanding participation beyond these baseline levels could generate significantly greater health gains and productivity benefits for the population, especially if countries simultaneously adopt best-practice versions of interventions. Previous OECD work on mental health performance (OECD, 2021<sup>[17]</sup>) has shown that countries with higher coverage of evidence-based psychological therapies and preventive programmes are likely to achieve better outcomes at similar or even lower marginal cost, due in part to reduced unmet needs and earlier engagement in care.

Scaling up coverage, however, has important implications for planning and financing. As highlighted in Chapter 3, providing treatment to all individuals with mental disorders would require an estimated 41% increase in mental-health-specific health spending compared with current levels. Such resources would need to be invested upfront to enable the necessary expansion in capacity and service provision. This finding is consistent with broader OECD analyses showing that mental health services are structurally under-resourced relative to disease burden: more than half of countries for which data were available allocate less than 6% of government health spending to mental health, despite mental disorders accounting for a much larger share of the total disease burden (OECD, 2021<sup>[17]</sup>). Ambitious expansion would therefore require sustained financial commitment, but these investments are likely to generate positive long-term returns by improving productivity, reducing absenteeism and lowering downstream healthcare costs.

Any substantial increase in coverage must also be preceded by deliberate efforts to strengthen the mental healthcare workforce. Without expanded workforce capacity, scaling up risks exacerbating already high levels of unmet needs and service bottlenecks. OECD work (OECD, 2023<sup>[18]</sup>) highlights persistent shortages of health professionals, uneven geographical distribution of providers and limited availability of specialised competencies. These challenges are evident in the mental healthcare workforce: two-thirds of WHO Member States globally report having only one psychiatrist per 200 000 people, and even in high-income countries the median number of specialised mental healthcare workers is only around 67 per 100 000 population (WHO, 2025<sup>[19]</sup>). Addressing these gaps requires a combination of strategies: expanding training capacity, improving retention, creating new professional roles, investing in multidisciplinary models, and leveraging digital tools and stepped-care approaches to increase efficiency. Lessons from best-practice interventions across OECD countries also indicate that rapid-access pathways, triage systems and low-threshold digital entry points can alleviate pressure on specialist services while maintaining high levels of effectiveness.

One way to keep the additional cost at an affordable level is to ensure that any expansion of services is directed first to the areas where needs are greatest. Prioritising the deployment of new capacity toward population groups, geographical areas and service settings with the highest unmet needs would allow countries to achieve stronger marginal gains in health and economic outcomes from each unit of investment. For example, by targeting resources at PHC practices with high caseloads, schools or workplaces with identified needs, or regions with clear service shortages, systems can improve the efficiency of intervention delivery while containing overall expenditure. This targeted approach helps to avoid the higher costs and logistical challenges associated with uniform expansion, promotes the

alignment of new resources with the parts of the system where they can deliver the greatest value, and supports more efficient and affordable implementation.

### ***Addressing root causes by creating environments that sustain mental well-being***

A third pillar for strengthening population mental health is addressing the underlying social and economic determinants that contribute to mental distress. As outlined in Chapter 2, evidence from a rapid literature review highlights a wide range of social, economic, environmental and lifestyle factors associated with rising rates of mental ill health. Several longer-term macro-trends are also shaping mental health trajectories. These include rapid digitalisation and problematic use of social media – which disproportionately affects younger people – as well as economically stressful environments that encompass both persistent pressures such as economic insecurity and labour-market instability and sudden shocks like the 2022 inflation surge across many OECD countries, which placed a heavy burden on low-income households (Causa et al., 2022<sup>[20]</sup>).

Collectively, these factors point to the need for upstream policies capable of mitigating both acute shocks and persistent structural drivers of mental distress. The interventions assessed in this report focus primarily on building individual and community resilience and on supporting people already experiencing mental health difficulties. While these measures are essential for improving well-being and reducing the severity of mental disorders, they cannot on their own counteract the factors that give rise to mental ill health in the first place. For this reason, preventive and clinical interventions need to be embedded within a wider set of policies that create social, economic and environmental conditions supportive of mental well-being (OECD, 2023<sup>[21]</sup>).

Social protection systems play a crucial role in shielding individuals from stressors that may precipitate or worsen mental health problems. A literature review covering OECD and European Economic Area countries finds a strong association between welfare system generosity and population mental health, with countries that devote higher levels of social expenditure generally achieving better outcomes across indicators such as suicide rates and deaths related to substance use (Ribanszki et al., 2022<sup>[22]</sup>). The review suggests that one important driver of these positive results is the way these systems mitigate social inequality, particularly by preventing those who are least advantaged from falling below critical socio-economic thresholds. Additional factors – including trust in the welfare system and the overall cohesiveness of societies – also contribute to the beneficial impact of welfare policies on mental well-being, even when they are not directly tied to specific spending measures.

Previous OECD work has highlighted that integrating mental health support into skills and employment services is essential for improving outcomes among individuals who are not in employment, underscoring the importance of co-ordinated responses across health, education and labour market systems. In 2015, the OECD Council adopted the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy (OECD, 2015<sup>[23]</sup>), which includes a detailed set of policy principles to address the impact of mental ill health on employment, education, health and social outcomes. These policy principles encourage adherents to embrace approaches to mental health policy, including seeking to improve mental well-being, prevent mental health conditions, and provide appropriate and timely services that recognise the benefits of meaningful work for people living with mental health conditions (Box 5.2). All OECD countries adhere to the Recommendation, along with a number of non-Members. This Recommendation is the recognition by OECD countries that good policies can make a significant difference when it comes to preventing mental illness at all ages, including in youth and adolescence; in supporting those experiencing mental illness to stay in the workplace; and in supporting those who have left employment to return to the labour market.

### Box 5.2. Reducing the impact of unemployment as a root cause of mental ill health: Guidance from the OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy

Addressing the root and persistent causes of mental ill health requires an integrated, cross-sectoral policy approach that should also strengthen individuals' ability to engage meaningfully in the labour market. The OECD Recommendation of the Council on Integrated Mental Health, Skills and Work Policy underscores the fact that mental well-being, prevention and timely services must be linked to the benefits of meaningful work for people with mental health conditions (OECD, 2015<sup>[23]</sup>).

Since the Recommendation's adoption, most OECD countries had introduced multi-sectoral mental health strategies, with 19 of 26 countries reporting integrated cross-government approaches to mental health governance, and at least 24 countries report that ministries other than the ministry of health have a dedicated mental health strategy. Reforms increasingly aim to prevent early disengagement from work or education. For example, Denmark, Hungary, Latvia and the United Kingdom have programmes to support students' transition into the labour market, while Canada, Estonia and Finland have adapted work-capacity assessments to facilitate partial return to work following mental health-related absences.

Several countries have adopted individual placement and support to combine co-ordinated clinical and employment assistance, demonstrating the effectiveness of integrating mental health and labour market support. However, most OECD countries still lack systematic inclusion of employment outcomes in mental health frameworks, and social protection systems rarely reflect the high prevalence of mental ill health among benefit recipients. Evidence shows that mental health treatment alone does not improve employment outcomes, while integrated approaches do (OECD, 2015<sup>[24]</sup>).

Preventing long-term unemployment remains critical, especially for young people, because (as discussed in Chapter 2) prolonged joblessness worsens mental health. Active labour market programmes can mitigate these effects by providing routine, structure and social connection. As countries respond to the growing detrimental impact of mental ill health, the OECD analysis stresses that integrated services and early intervention across welfare, education, health and employment systems are essential to tackling persistent drivers of mental ill health while enabling individuals to reconnect with meaningful work.

Source: OECD (2015<sup>[23]</sup>), *Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*, <https://legalinstruments.oecd.org/en/instruments/334>.

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# The Economic Case for Preventing Mental Ill Health

Poor mental health affects more than one in five people across OECD and EU27 countries and is estimated to reduce healthy life expectancy by 2.5 years, with young people, women, and those with low socio-economic status particularly affected. Focusing on depression and anxiety, this report sets out the strong economic case for investing in better mental health policies. It shows how evidence-based interventions in primary care, schools, and workplaces can improve health outcomes and boost economic growth through improved productivity and labour market participation. Many of these interventions are cost-effective and some cost-saving. However, the overall impact of these interventions remains low due to lack of implementation at scale. To deliver meaningful improvements, countries must adopt a more systemic approach that enhances intervention design and implementation, expands coverage and investment and tackles the root causes of mental distress.



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