Mental health

Good mental health is essential for healthy populations and economies: when people live with poor mental health, they have a harder time succeeding in school, being productive at work, and staying physically healthy (OECD, 2021[1]). The COVID-19 pandemic seriously disrupted the way people live, work and learn, and fuelled significant increases in mental distress. At the start of the pandemic, the share of the population reporting symptoms of anxiety and depression increased in all OECD countries with available data, and as much as doubled in some countries (Figure 3.19 and Figure 3.20). OECD analysis has shown that population mental health went up and down over the course of the pandemic – typically worsening during periods when infection and death rates were high, or when stringent containment measures were in place. Available data point to some recovery in population mental health as the pandemic situation improved, but also suggest that mental ill-health remains elevated. In Belgium, Korea, the United Kingdom and the United States, data from 2022 typically show small decreases in the share of the population reporting symptoms of depression, compared to 2020. However, the prevalence for 2022 remains at least 20% higher than pre-pandemic, and in some cases over double or triple the pre-pandemic rate (Figure 3.19). Persistently high levels of mental distress "beyond" the pandemic could reflect the confluence of multiple crises: the cost-of-living crisis, climate crisis and geopolitical tensions.

Shocks such as pandemics, severe weather events and financial crises can also heighten the risk of suicidal behaviour. While complex social and cultural factors affect suicidal behaviour, mental ill-health increases the risk of dying by suicide. Rates of death by suicide currently vary almost six-fold across OECD countries, and are over three times higher for men than women. Deaths by suicide were generally trending downward prior to the pandemic, falling by 28.4% on average in the period between 2000 and 2019 (Figure 4.21). There were concerns that the COVID-19 crisis would lead to more suicides, and significant increases in suicidal ideation have been observed in some countries, particularly among young people (OECD/European Union, 2022[2]). To some extent, these concerns were not realised in the first year of the pandemic: in the 27 OECD countries for which data are available, rates of death by suicide decreased by 2.4% on average between 2019 and 2020. However, this change varied across countries. In a third of countries with available data, suicides increased between 2019 and 2020 whereas for another third of the countries it decreased by 5% or more. Between 2019 and 2020 the rate of death by suicide respectively increased by 13.4% and 10.5% in Iceland and Mexico, and it decreased by 16.8% and 15.2% in Chile and Greece.

OECD countries took rapid action to step up mental health support in response to the pandemic. In a policy questionnaire in 2022, all 26 replying OECD countries reported having introduced emergency mental health services in response to the pandemic, and almost all (25 out of 26) reported that they had permanently increased mental health care support or capacity (OECD, 2023[3]). However, increases in capacity or support have not always been commensurate with need. This is not a new challenge, but one that has been exacerbated: even before the pandemic, two out of three people seeking mental health support reported difficulties in getting it (OECD, 2021[1]).

Definition and comparability

The quality and coverage of mental health data have been variable over the course of the pandemic, meaning that caution is needed when comparing the prevalence of anxiety and depression.

Figure 3.19 and Figure 3.20 use national data sources, and may not be directly comparable across, and in some cases within, countries. Differences include the number and timing of surveys, and the survey instruments used to measure depression and anxiety. In some countries, survey instruments differ across years (in France and Spain for both anxiety and depression; in Germany for anxiety). Pre-pandemic and pandemic data for depression in Italy, Spain, Greece and France have some differences in scoring methods, which could understate the increase in symptoms. Some surveys do not necessarily use nationally representative samples (Australia, Austria, Italy, Japan, Spain for depression and anxiety; Greece for depression; Germany, Korea and Mexico for anxiety). Where possible, surveys using Patient Health Questionnaire (PHQ-9) and General Anxiety Disorder (GAD-7) or similar screening tools were selected to measure depression and anxiety. For countries with regular data collections per year – Belgium, Canada, France, Germany, Korea, the United Kingdom, the United States – multiple data points for each year have been pooled where possible. Data for the "pre-COVID-19" year vary based on national data availability. The most recently available data were selected, up to 2019. Differences in the openness of populations to discussing their mental state also hamper cross-country comparability.

The registration of suicide is a complex procedure, affected by factors such as how intent is ascertained; who is responsible for completing the death certificate; and cultural dimensions, including stigma. Caution is therefore also needed when comparing rates between countries. Age-standardised mortality rates are based on numbers of deaths divided by the size of the corresponding population. The source is the WHO Mortality Database; suicides are classified as ICD-10 codes X60-X84 and Y87.0.

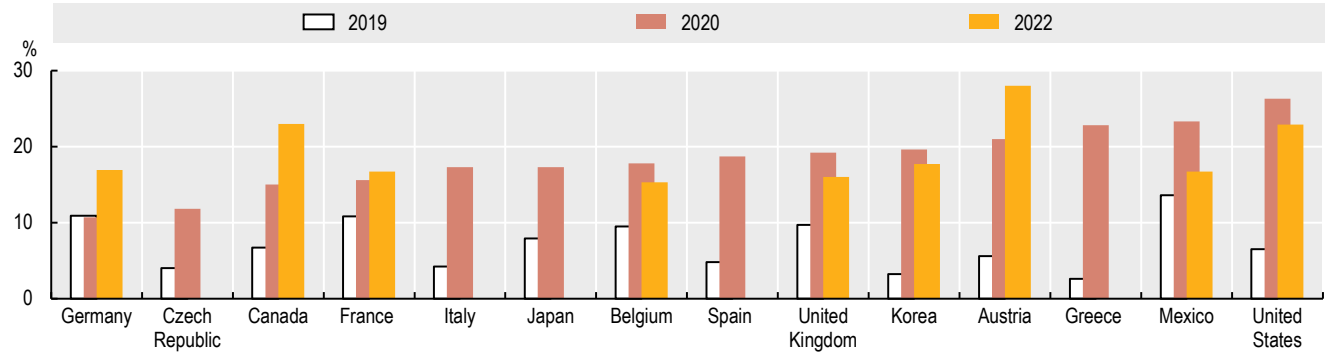
References

OECD (2023), *Ready for the next crisis? Investing in Resilient Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/5971a279-en. [3]

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

OECD/European Union (2022), *Health at a Glance: Europe 2022: State of Health in the EU Cycle*, OECD Publishing, Paris, https://doi.org/10.1787/507433b0-en. [2]

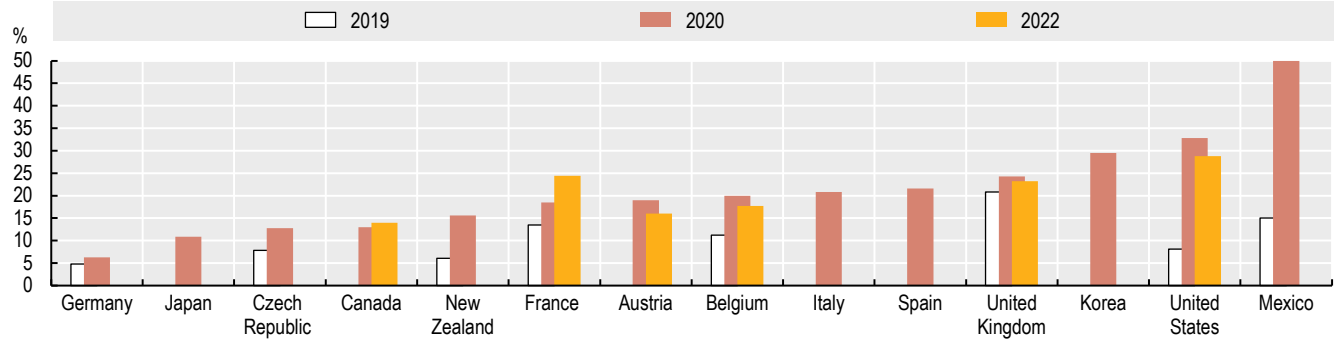
Figure 3.19. National estimates of prevalence of depression or symptoms of depression, 2019-22 (or nearest year)



Note: Survey instruments and population samples differ between countries and in some cases across years within countries, which limits direct comparability. Pre-pandemic data for the Czech Republic 2017; Canada 2015-19; Japan 2013; Belgium 2018; United Kingdom 2019-March 2020; Korea 2016-19.
Source: National data sources – see the Statlink for full details.

StatLink https://stat.link/wpe5lh

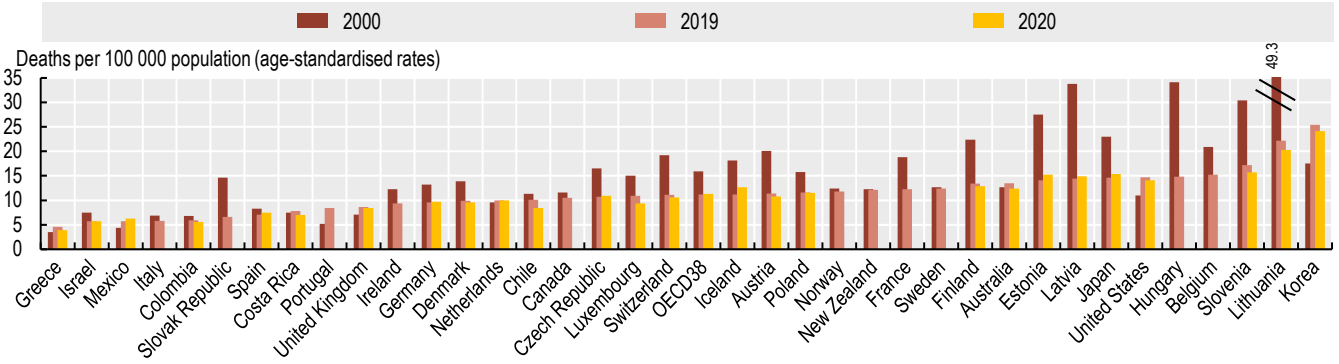
Figure 3.20. National estimates of prevalence of anxiety or symptoms of anxiety, 2019-22 (or nearest year)



Note: Survey instruments and population samples differ between countries and in some cases across years within countries, which limits direct comparability. Pre-pandemic data for the Czech Republic 2017; New Zealand 2016-17; France 2017; Belgium 2018.
Source: National data sources – see the Statlink for full details.

StatLink https://stat.link/x1w8sg

Figure 3.21. Death by suicide, 2000 and 2020 (or nearest year)



Note: Latest available data for Norway and New Zealand 2016; Italy and France 2017; Ireland, Sweden and Belgium 2018; and the Slovak Republic, Portugal, Canada and Hungary 2019.
Source: OECD Health Statistics 2023.

StatLink https://stat.link/972hqf