OECD Health Working Papers No. 180

Understanding and addressing inequalities in mental health

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https://dx.doi.org/10.1787/56adb10f-en

OECD

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JEL classification: I10, I11, I14, I18, I38

Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs.

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Acknowledgements

The authors would like to thank the delegates of the OECD Health Committee for their feedback to this work and to Health Canada and the Public Health Agency of Canada for their additional comments and feedback to an early version of the working paper.

Furthermore, the authors would like to extend their acknowledgment to the OECD country delegates and experts who provided information to the 2023 OECD Country Questionnaire on Mental Health Inequalities and particularly to Statistics Canada for their continuous support.

We also gratefully acknowledge the extensive contributions of Stephanie Zughbi, Claudia Imaz and Lennja Hama during their internships at the OECD ELS Health Division and of Doron Wijker, who contributed to the initial shaping of the project. Within the Health Division, the authors would also like to thank Francesca Colombo, Emily Hewlett, Eliana Barrenho and Eliza-Jane Stringer for their input and feedback. The assistance of Teba Criado Fiuza is also gratefully acknowledged. Furthermore, the authors thank the feedback from colleagues of the Centre on Well-Being, Inclusion, Sustainability and Equal Opportunity (WISE) and from the Education Directorate.

Finally, we would like to express our appreciation to the Public Health Agency of Canada for providing the financial support that made this work possible.

The views expressed in this document are those of the authors and do not necessarily reflect the views of any OECD country or individual expert.

Abstract

This OECD Health Working Paper presents an overview of inequalities in mental health and mental healthcare and strengthens the evidence base on policies to address them. It first focuses on documenting the magnitude of inequalities in mental health status across key population groups and reviewing determinants and risk factors for these inequalities. The description of inequalities continues by characterising differences in access to mental healthcare and in experiences and outcomes of treatment. The second part of the paper uses information collected from 37 OECD countries to review policy developments in addressing mental health and mental healthcare inequalities. It characterises policy adoption in the promotion of good mental health and prevention of mental-ill health, access to responsive and high-quality mental care for the groups with highest unmet needs, and the improvement of treatment experiences and outcomes for groups in most vulnerable circumstances. Furthermore, it highlights relevant and innovative strategies implemented by countries and complements country information with evidence from the literature on what interventions seem effective to reinforce population mental health resilience and close the mental health gaps.

Résumé

Ce document de travail de l'OCDE sur la santé présente une vue d'ensemble des inégalités en matière de santé mentale et de soins de santé mentale et renforce la base de données sur les politiques visant à y remédier. Il s'attache tout d'abord à documenter l'ampleur des inégalités en matière de santé mentale dans les principaux groupes de population et à examiner les déterminants et les facteurs de risque de ces inégalités. La description des inégalités se poursuit par la caractérisation des différences d'accès aux soins de santé mentale et des expériences et résultats de traitement. La deuxième partie du document utilise des informations recueillies dans 37 pays de l'OCDE pour examiner les développements politiques en matière de santé mentale et d'inégalités dans les soins de santé mentale. Elle présente l'adoption de politiques visant à promouvoir une bonne santé mentale et à prévenir les maladies mentales, l'accès à des soins mentaux adaptés et de qualité pour les groupes dont les besoins non satisfaits sont les plus importants, et l'amélioration des expériences et des résultats de traitement pour les groupes les plus vulnérables. En outre, il met en évidence les stratégies pertinentes et innovantes mises en œuvre par les pays et complète les informations nationales par des données tirées de la littérature sur les interventions qui semblent efficaces pour renforcer la résilience de la population en matière de santé mentale et combler les lacunes dans ce domaine.

In Brief

Inequalities in mental health are marked across all OECD countries. Groups with poorer mental health also have higher unmet needs and worse experiences and outcomes of care.

- Women are more likely than men to experience and report depressive and anxiety disorders. This disparity contributes to a 20% higher prevalence of mental disorders among women in OECD countries, according to IHME estimates. In contrast, conditions such as conduct disorders, autism spectrum disorders, attention deficit hyperactivity disorder (ADHD) are more frequently identified in men. Substance use disorders are also more frequent among men. In fact, when substance use disorders are added to the overall count of mental disorders, the gender gap narrows, and total prevalence of mental health conditions becomes similar between men and women. Suicide rates, despite decreasing for the past decades, remain significantly higher in men than in women—about 2.7 times higher on average across OECD countries.

- Individuals with low socio-economic status, those from minority ethnic or Indigenous populations, and people identifying as LGBTIQ+ are at increased risk of experiencing mental health conditions. In OECD countries, people in the lowest income quintile are, on average, 3.5 times more likely to exhibit moderate to severe depressive symptoms than those in the highest quintile. Similarly, individuals who did not complete high school are 2.4 times more likely to report such symptoms compared to those with a college degree. Improved data is needed to better capture inequalities affecting minority groups and to enable comparisons of trends in mental health disparities over time and across countries.

- Women, people with low socio-economic status, and people who identify as LGBTIQ+ often access mental healthcare the most, but also have marked unmet needs for treatment. In OECD countries, women were 54% more likely than men to report a consultation with a psychologist, psychotherapist or psychiatrist in the previous 12 months, but also reported 88% higher unmet need due to lack of affordability. Access to mental healthcare consultations was two times higher for people with the lowest income compared to those with the highest income, but there was also a three-fold gap in unmet need between the two groups.

- Negative experiences of care for the LGBTIQ+ community, ethnic minorities and Indigenous populations are often related to stigma and discrimination when in contact with services, misdiagnosis, lack of a coherent approach to address multiple needs and poor intersectoral collaboration. Poorer treatment outcomes for these groups, as well as for people in low socio-economic status, are explained by limitations in the appropriateness and quality of care and by the patient's living environment, which influences the ability to follow-up and benefit from

treatment. More evidence is needed to understand and address disparities along the treatment pathway, which are systematically influenced by the patient demographic and socio-economic characteristics.

Three-quarters of OECD countries have policies and strategies to tackle inequalities in mental health, but certain groups receive less attention, and policies are poorly evaluated

- Inequalities by gender and socio-economic status receive the greatest attention in national or subnational mental health policies, while disparities for LGBTIQ+, ethnic groups and Indigenous populations are less commonly addressed. There is an urgent need for better knowledge of what works to address mental health inequalities: only one-third of the OECD countries has evaluated their policies and programmes on this matter. Countries should invest in policies that address risk factors strongly driving mental-ill health, namely social determinants such as poverty, debt, unemployment and precarious housing; as well as attitudes of stigma, discrimination and violence towards particular population groups.

- More than 90% of OECD countries currently report having mental health promotion and/or prevention policies that specifically target vulnerable population groups. Evidence suggests that intersectoral policies are effective but are under-used in OECD countries. Countries should prioritise proven interventions in schools, workplaces and social services, for example the use of cognitive behavioural therapy for prevention in youth, or structured group sessions providing job-seeking skills and social support for people in unemployment, fostering their mental health and emotional functioning.

Efforts to increase access to mental healthcare are widespread but do not always work for all population groups

- Even in countries that have made deliberate efforts to improve access to mental healthcare—by removing barriers or expanding service availability—not all population groups have benefitted equally. This highlights the need for more targeted strategies for vulnerable populations. For instance, expanding access to talking therapies has been a common approach, yet only one-third of OECD countries have specifically directed these efforts toward high-risk groups. Evidence from large-scale initiatives such as NHS Talking Therapies in United Kingdom and Prompt Mental Healthcare in Norway reveals persistent disparities in both access and outcomes for ethnic minorities, foreign-born individuals, and the unemployed.

- Additional efforts to minimise disparities in access to mental healthcare are being pursued by three-quarters of OECD countries by enhancing the outreach and responsiveness of care, with a particular focus on gender-based violence. However, ensuring access to services is just a first step into the support system and does not guarantee reduction in mental health inequalities. Care received should be responsive and appropriate to the needs of groups in vulnerable circumstances which consistently have poorer experiences and outcomes of treatment.

Culturally and linguistically tailored interventions and peer-based support are key strategies to reduce inequalities in experiences and outcomes of care

- Culturally and linguistically tailored interventions are essential to effectively reduce mental health inequalities. Countries should embed this approach across the full spectrum of mental health action—from anti-stigma initiatives to mental health literacy, care provision, and care management—to improve both experiences and outcomes for key population groups. Training the mental health workforce in cultural awareness and competency (implemented in 20 OECD countries), increasing workforce diversity (8 countries), and expanding peer-based support (23 countries) are strategies that can help close existing gaps. Peer support can play a role at various levels, including education, self-management, and discharge planning. In addition to promoting person-centred care, peer support enables the expansion of low-threshold services and early identification—making it especially valuable for interventions delivered outside of the formal healthcare system.

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1 Introduction

1. Inequalities, digitalisation, ageing and climate change: each of these 'megatrends' bring new challenges to both mental health and mental health systems, and direct consequences for social protection systems and labour markets. From the already large inequalities in mental health within the population that perpetuate intergenerationally to rising levels of climate change anxiety especially amongst youth, governments need to focus on introducing policies for cross-cutting mental health resilience sooner rather than later. Furthermore, policy makers need to integrate the lessons learned from the COVID-19 crisis – which drove up rates of mental ill-health by up to 20% - and ensure better preparedness for major social and economic crises.

2. The OECD is looking at the intersection of population mental health, and the delivery of mental health policies and interventions with major global trends that are transforming the way we live and work, specifically inequalities, digitalisation, demographic transformation, and climate change (OECD, 2024[1]; OECD, n.d.[2]). These four topics, termed 'megatrends', have been and will continue shaping our world and societies throughout all its domains – from our health and wellbeing to ways of working and learning, how and where we live and how we interact and connect to hear other. Understanding and addressing how these interact with other topics of concern becomes essential to achieve the goals of sustainable development, and design better policies for better lives.

3. This OECD Health Working Paper focuses on one of these 'megatrends', understanding and addressing inequalities in mental health (Box 1), introducing a new analysis and information collected from OECD countries. Building on previous OECD work, this report focuses on key population groups characterised by gender, LGBTIQ+, ethnicity and indigeneity, migration and socio-economic status (OECD, 2021[3]; OECD, 2023[4]; OECD, 2023[5]).To the extent that evidence allows, the report also discusses particular subsets of the population that might face increased vulnerability to mental-ill health, either due to the intersection of multiple forms of disadvantage or due to life circumstances such as exposure to challenging events or critical junctures across the life course (bereavement, job loss, intensive caregiving, among others). Groups in these conditions are sometimes described as people in vulnerable circumstances and include women affected by gender-based violence, refugees, people experiencing financial insecurity, unemployed people, and homeless, among others.

4. The first part of the paper focuses on understanding mental health inequalities, to establish the background for the second part which assesses policy developments addressing these disparities: promotion of good mental health and prevention of mental-ill health, access to responsive and high-quality mental care for the groups with highest unmet needs and the improvement of treatment experiences and outcomes for groups in most vulnerable circumstances.

5. This paper uses the data available across the OECD countries to describe inequalities in mental health and in access to mental healthcare for key population groups. Empirical analyses are complemented with a review of the literature. The paper was also informed by a policy and data questionnaire shared with countries in October 2023 and completed by 37 OECD countries, and complemented by select stakeholder interviews. Countries were also asked to report disaggregated data on mental health and mental healthcare. The overall limited responses to this part of the questionnaire highlight the need to improve consistent data collection and reporting of mental health (care) for key population groups. These data are key to design and monitor policies that can effectively address mental health and care inequalities.

Box 1. Note on terminology and language

The OECD adopts the World Health Organization's (WHO) widely accepted definition of mental health, referring to a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. While the WHO definition influences the focus of this working paper on inequalities in mental-ill health, the OECD acknowledges that more holistic and inclusive perspectives have called for a broader definition of mental health, with emphasis on strengths-based approaches and positive interventions, and on the concept of positive mental health.

This paper aligns language with ongoing shifts that go hand-in-hand with efforts to raise awareness and address stigma, and to ensure, where possible, language is person-centred, strengths-based, and recovery-focused. The broad term "mental ill-health" is used to describe mental and behavioural disorders but also include psychological or mental distress, i.e. symptoms or conditions that do not reach the clinical threshold of a diagnosis within the classification systems but which can account for significant suffering and hardship, and can be enduring and disabling. The terms 'disorders' or 'conditions' are used to apply to symptoms reaching the clinical threshold of a diagnosis according to psychiatric classification systems, applied by qualified practitioners.

Substance use and associated disorders are an important part of mental health and care, also with considerable comorbidity with other mental health conditions. Substance use and associated disorders are not the primary focus of this paper but are acknowledged when appropriate, considering their relevance to inequalities among particular groups, provision of mental health, and high comorbidity with other mental disorders.

While closely related to mental health, well-being and quality of life are also not part of this paper scope and have been covered by other OECD work (OECD, 2023[5]) which shows that these are strongly affected by the same economic, social, relational, civic and environmental experience that impact mental health.

The use of the term minority/ies in this paper acknowledges that the phenomena under discussion stem from active processes of structural discrimination and racism/xenophobia. This framing emphasises that minoritisation is not merely a matter of numerical representation, but a consequence of systemic exclusion and marginalisation. These population groups can also be defined as "visible minorities" referring to groups perceived as distinct from the majority population based on either physical characteristics, such as skin colour, hair texture, and facial features (commonly associated with the social construct of "race"), or cultural characteristics, including language, religion, and traditions (falling under the social construct of "ethnicity") (OECD, 2025[6]).

LGBTIQ+ is the acronym for "lesbian, gay, bisexual, transgender, intersex and queer/questioning". LGBTIQ people are defined with respect to three distinct features: sexual orientation; gender identity; and sex characteristics. The "plus" (+) leaves the demographic category open ended to acknowledge additional sexual orientations and gender identities that are not explicitly present in the acronym.

2 Inequalities in mental health status

6. Mental health status is not homogenous across national populations but differs by gender, sexual orientation, ethnicity and indigeneity, migration status and socio-economic status, as well as with a range of other social determinants (OECD, 2021[3]). This section provides an overview of what is known about inequalities in mental health for these groups, as well as a descriptive overview of some determinants and drivers of these inequalities.

7. While the causes of mental health inequalities are difficult to elicit and may differ among different groups, there are some common cross-cutting drivers. For example, inequalities in health are often driven by social and economic structural factors, generally known as social determinants of health. These include income, education, occupation, among others. Low income, debt and poverty as well as low educational attainment and unemployment are experienced disproportionately by groups with poorer mental health outcomes (Abebe, Lien and Hjelde, 2014[7]; Goodkind et al., 2021[8]; Macintyre et al., 2018[9]). Other determinants are housing and environmental factors. A poor sense of community belonging and lack of social support amongst groups at higher risk is also associated with poor mental health outcomes (Salami et al., 2017[10]). High risk of poor mental health is also tied to minority stress, which is the stress experienced by individuals from stigmatised social categories due to their minority position (Medina-Martínez et al., 2021[11]). Individuals in minority groups often experience prejudice, discrimination and stigma due to conflict with their social environment or norms set by the dominant culture (Mongelli et al., 2019[12]).

8. The assessment of inequalities in mental health remains constrained by poor data availability, particularly for some groups. Previous OECD work has found that few countries can break down their mental health data (for instance prevalence of conditions, service use rates, admissions, death by suicide) by (nationally defined) population groups (OECD, 2021[3]). The analysis in this working paper uses survey data and evidence from a range of sources to fill those gaps, at least for some key population groups (Box 2.1). Still, further quantifying disparities for all the groups at higher risk is paramount to designing policy that can effectively address inequalities and monitor its impact. Alternative data collection and reporting mechanisms and dedicated study designs should be considered to overcome the barriers of privacy, lower study recruitment and higher drop out of particular groups that are usually underrepresented in the data.

Box 2.1. Defining and measuring inequalities

The measurement and reporting of inequalities requires several methodological choices with implications on the interpretation and value judgment of the findings.

Absolute and relative inequalities

One of the important choices concerns the reporting of absolute or relative inequalities. In a simplified description, absolute inequalities refer to the difference between the levels of two groups, while relative inequalities refer to the ratio, or to the relative change between the groups. Absolute and relative inequalities for the same groups can differ considerably in their magnitude. In Figure 2.2, for instance, Czechia and Sweden have similar levels of relative inequality (44%) but different levels of absolute inequalities (1.1 percentage points for Czechia and 3.9 percentage points for Sweden). Given these differences, and the relevance of both measurements, figures in this paper report both the absolute levels of symptoms prevalence (%) in the groups studied (dots) and the relative difference between these groups in % change (grey columns).

The choice of absolute or relative measurement does also impact the study of inequalities overtime and the evaluation of policies aimed at reducing inequalities. On the one hand, reducing absolute rather than relative inequalities can be considered as a more realistic policy objective, mostly in the event of downwards trends. On the other hand, solely focusing on the change in absolute inequalities might lead to inaccurate conclusions due to an "arithmetic maturation process" that automatically leads to a decrease in inequalities in case of steadily decreasing outcomes (Mackenbach et al., 2016[13]).

Choice of inequalities measures

A wide range of inequality measurements has been developed over the past years in several research fields. These range from the simplest measures, as described above (difference in levels or ratios between groups/top and bottom of the distribution) to measures that account for the full distribution of outcomes in the population and allow further adjustments and standardisation. Past OECD work has used the slope and relative index of inequalities (SII and RII) and concentration indices to describe inequalities in health and access to health care by education and income (OECD, 2019[14]). This working paper reports absolute levels in the groups of interest and the relative difference between these groups to facilitate the interpretation of the findings.

Inequalities and inequities

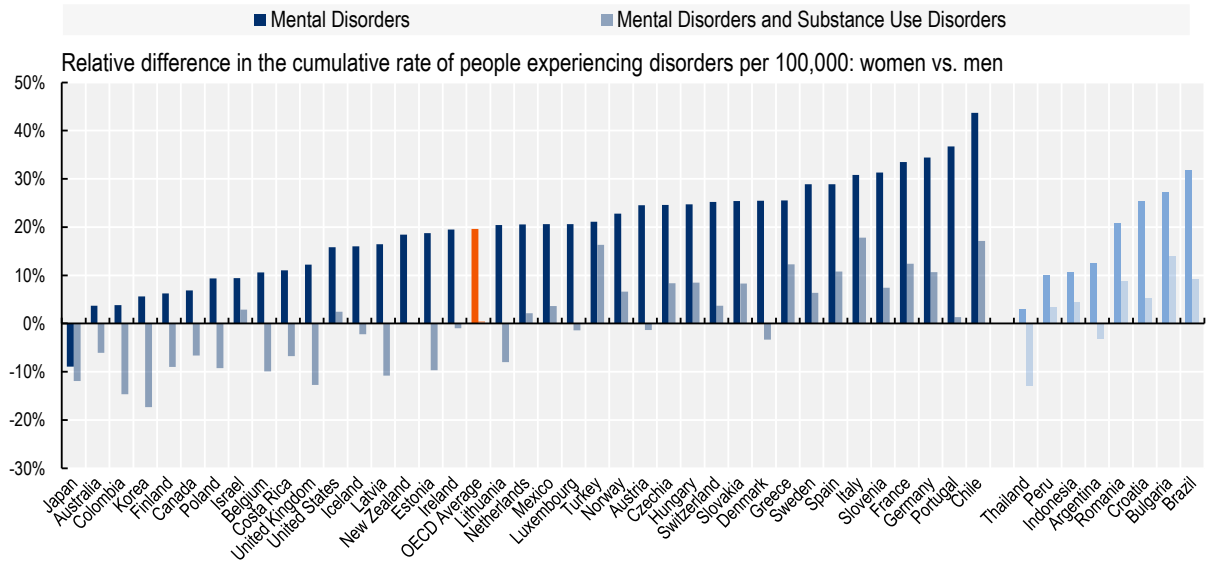
One last consideration relates to the terms used to describe the differences in mental health and care across the population groups. This report prioritizes the use of inequalities to refer to these differences, also using disparities as a synonym. It is, however, important to recognize that a large part of these inequalities are unfair, unnecessary and avoidable differences, that could therefore be better designated as inequities (Whitehead, 1992[15]). The option to consistently use the word inequalities to designate differences that might also be inequities was made with two motivations. First, to acknowledge the different use of these terms by different fields and countries, some of which prioritize the use of the term inequalities. Second, because within health services research, differences in healthcare use are particularly difficult to judge as unfair, unnecessary and avoidable, due to the complexity of measuring treatment need and how much higher(lower) access and use of care for certain groups might be due to worse(better) underlying health. The choice of the word inequalities does not intend, in any moment, to reduce their relevance as unfair, unnecessary and avoidable differences that should be addressed in our societies.

Women are more likely to experience depression and anxiety, while substance use disorders are more prevalent amongst men

9. The prevalence of different mental health conditions is distributed differently by gender. Estimates from the Institute for Health Metrics and Evaluation (IHME) for mental disorders[1] in OECD countries in 2019 show a higher prevalence in women by 20% (ranging from -9% in Japan to 44% in Chile, see Figure 2.1). This gap is attenuated to less than 1% higher prevalence in women when substance use disorders (not included in mental disorders by IHME) are included in the estimates. While a part of the gap may be due to a greater propensity of women to report these problems (OECD, 2018[16]; Smith, Mouzon and Elliott, 2016[17]), existing studies consistently show higher prevalence of internalising disorders amongst women (e.g. mood, anxiety and eating disorders) while men have higher prevalence of externalising conditions (e.g. conduct and substance use disorders) (Farhane-Medina et al., 2022[18]; Needham and Hill, 2010[19]; Herrmann et al., 2023[20]; Otten et al., 2021[21]; Mental Health Foundation United Kingdom, 2017[22]).

10. The analysis of the relative differences by disorder should be interpreted together with their absolute prevalence. Anxiety and depressive disorders, usually designated as 'common mental disorders', are the two most prevalent conditions and drive the higher prevalence of mental disorders in women. While not categorized as mental disorders by the IHME, substance use disorders are often placed together with other mental health conditions, for example in diagnosis classification systems. Substance use disorders are the third most prevalent group of conditions, following from depression and anxiety. When added to the overall count of mental disorders, the gender gap narrows, and the total prevalence of overall mental health conditions becomes similar between men and women (Figure 2.1).

Figure 2.1. Gap in the prevalence of mental health conditions women vs. men



Note: Relative difference women vs. men estimated based on the cumulative rates per 100,000 of anxiety disorders, ADHD disorders, autism spectrum disorders, bipolar disorder, conduct disorder, depressive disorders, eating disorders, other mental disorders and schizophrenia (grouped as mental disorders) and substance use disorders. The addition of the different disorder groups cumulatively might lead to an overestimate of disorders prevalence. Data was extracted from the IHME client portal selecting past estimates of prevalence for all ages for each group of disorders, from the data suite GBD (2021). Source: (IHME, 2024[23])

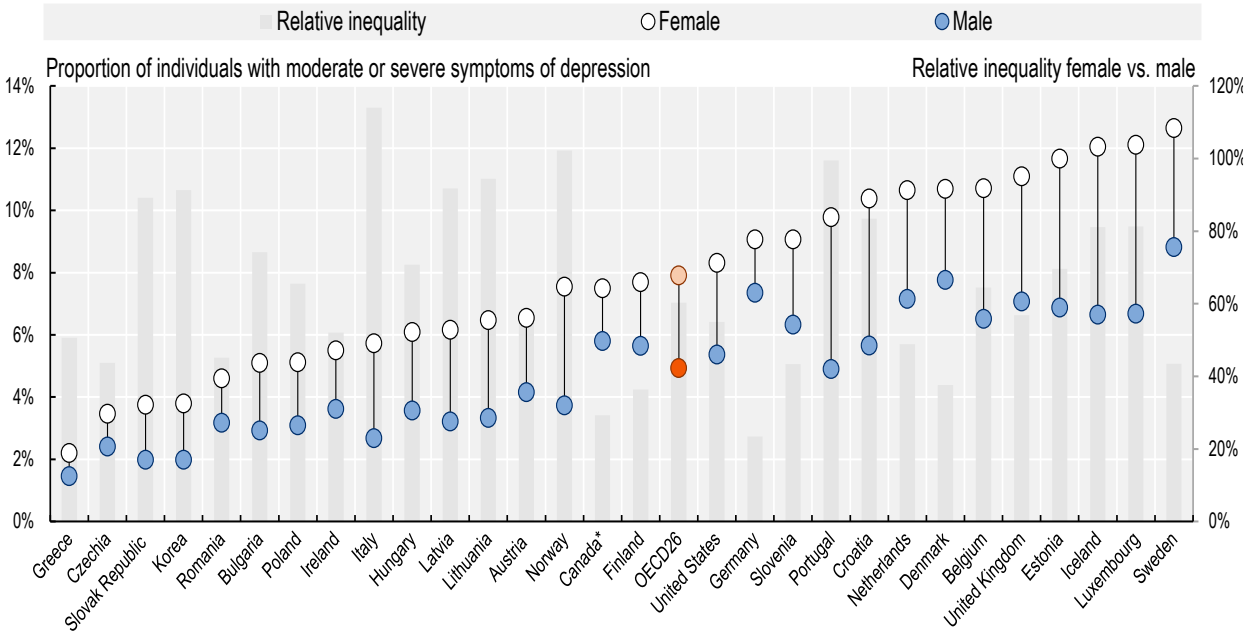
[1] Excluding Idiopathic developmental intellectual disability.

11. Based on IHME estimates for mental disorders in OECD countries in 2019, the gender gap is unfavourable to men for ADHD (- 61% gap women vs. men, on average), autism spectrum disorders (-58%), substance use disorders (-55%), conduct disorders (-45%), other mental disorders (-26%) and by small margin, schizophrenia (-5%). Conditions more frequent in women included depressive disorders (62%), anxiety disorders (81%), bipolar disorders (20%) and eating disorders (125%) (IHME, 2024[23]). To note, IHME uses several data sources and methodological approaches in an attempt to estimate the hidden prevalence of conditions, going beyond what would be captured by reported diagnosis. Furthermore, to address gaps and inconsistencies in data, IHME uses extensive statistical modelling, extrapolation, and imputation. While these approaches enable cross-country comparisons, it also introduces a level of uncertainty that must be acknowledged. As such, IHME data are best viewed as modelled approximations based on available evidence and assumptions rather than direct observations or estimates.

12. The prevalence of moderate or severe depressive symptoms is higher among females than for males for all the OECD countries studied based on data from national (health) surveys (Figure 2.2). The absolute difference in the levels of symptoms is of 3 percentage points, from 7.9% for females to 4.9% for males, corresponding to a 60.3% higher prevalence for females (relative difference, or relative inequality, represented by grey columns in the Figure). The difference between absolute and relative inequalities and is further explained in Box 2.1.

Figure 2.2. Moderate or severe symptoms of depression are more common in females than males across all countries

Prevalence of moderate or severe symptoms of depression in 2019 (PHQ-8≥10)



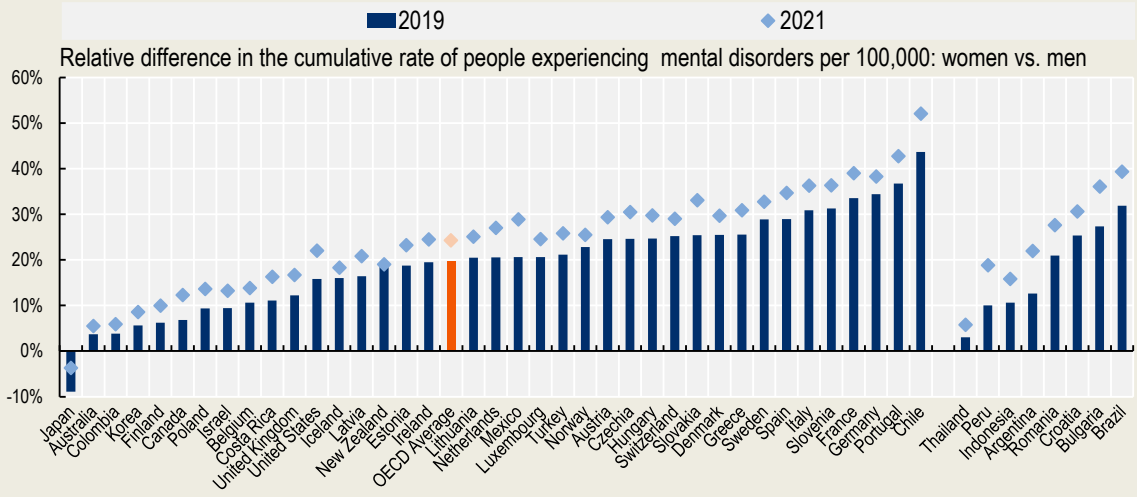
Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe depressive symptoms based on a score equal or higher than 10 in PHQ-8/9, which also corresponds to a positive screen indicating the need of further clinical assessment. Countries are displayed by increasing prevalence for females. The OECD26 average excludes Bulgaria, Croatia and Romania. *Estimates for Canada are based on a publication and include data between 2015 and 2019 for the different provinces and territories.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea; (Shields et al., 2021[24]) for Canada.

Box 2.2. Mental health inequalities beyond the COVID-19 pandemic

The COVID-19 pandemic and its mitigation measures seriously impacted the way people lived and fuelled significant increases in mental distress, including in anxiety and depression symptoms. Population mental health seems to have partially recovered since the peak of the pandemic, but levels of mental-ill health remain considerably higher than in before it started (20% higher prevalence of moderate or severe depressive symptoms in 2022 vs. 2019, based 10 OECD countries with data (OECD, 2023[25])).

A comprehensive international analysis of mental health inequalities post COVID-19 pandemic is prevented by the lack of comparable data, even though OECD countries have boosted their efforts of mental health data collection in the years of the pandemic (OECD, 2023[26]). For gender, recently released IHME estimates for 2021 seem to confirm the hypothesis that during the pandemic inequalities would have increased for the groups previously at higher risk, in this case for women. Compared to 2019, the magnitude of the mental disorder gap women vs. men increased in 2021 (20% vs. 24%; Figure 2.3), also when substance use disorders are considered (0.5% vs. 5%, not shown). Data from later points in time are needed to evaluate whether this increase persisted beyond 2021, as the pandemic faded but other societal and global crises continued to threaten population mental health.

Figure 2.3. Gender gap in the prevalence of mental disorders by gender: 2019 vs. 2021



Note: Relative difference women vs. men estimated based on the cumulative rates per 100,000 of anxiety disorders, ADHD disorders, autism spectrum disorders, bipolar disorder, conduct disorder, depressive disorders, eating disorders, other mental disorders and schizophrenia (grouped as mental disorders) and substance use disorders (not shown). The addition of the different disorder groups cumulatively might lead to an overestimate of disorders prevalence. Data was extracted from the IHME client portal selecting past estimates of prevalence for all ages for each group of disorders, from the data suite GBD (2021).
Source: (IHME, 2024[23])

Most literature suggests that mental health worsened the most for groups previously at higher risk, such as those with low income or in financial insecurity or racial/ethnic minorities, immigrants and migrants, and women and LGBTQ+ communities (Parenteau et al., 2023[27]; Herrmann et al., 2024[28]; Gibson et al., 2021[29]). However, the pandemic's mental health impact was complex. Some studies have also shown an unexpected narrowing of certain inequalities, due to steeper declines in mental health from higher status groups, for example, children from traditionally advantaged families in the United Kingdom (Miall et al., 2023[30]), high income in the Netherlands (Verra et al., 2024[31]) or economically advantaged

people and non-immigrants in Canada (Public Health Agency of Canada, 2024[32]). Overall, these seem to have been transitional situations within a context in which disadvantaged groups remained at least as adversely affected – if not more so – than advantaged groups.

13. While depression and also anxiety are more prevalent among women, men are more likely than women to develop a substance use disorder during their lifetime. Evidence indicates a male-to-female ratio of approximately 4:1 in disease burden for most substances (Connery et al., 2020[33]) . For example, 8.6% of men worldwide in 2016 had alcohol use disorders compared to 1.7% of adult women. Similarly, opioid use disorders including heroin and prescription opioid occur more frequently in men, despite women being prescribed opioids more often (Silver and Hur, 2020[34]). A key reason behind these differences might be gendered patterns in exposure to substances, rather than inherent predisposition. Men typically have greater access to substances, influenced by cultural norms that encourage risk-taking behaviours (McHugh et al., 2018[35]).

14. Gendered differences in mental health stem from a complex interplay of biological, psychological, and social factors (Farhane-Medina et al., 2022[18]). Biological factors include genetics, hormones, and neuroanatomy factors, whereas psychological and social influences are shaped by sociocultural constructs. These constructs shape individuals by the norms, rules, roles, stereotypes, and expectations prevalent in their culture (Farhane-Medina et al., 2022[18]). For example, divorced women exhibit a higher likelihood of reporting a mental disorder compared to married women across different countries, except for countries with a liberal regime where divorce is better accepted socially (Van De Velde et al., 2019[36]). Globally, typical female roles in private and social life are more prone to limitations such as lack of choice, role overload or being undervalued, with female social positions being associated with powerlessness and lower status (Van de Velde, Bracke and Levecque, 2010[37]).

15. Furthermore, there are moments across women's life course that increase vulnerability for mental ill-health. Women are at increased risk of developing or having a recurrence of mental health issues during pregnancy and in the first year after birth (Leight et al., 2010[38]; Howard and Khalifeh, 2020[39]). An increased burden as a carer can also give rise to negative mental outcomes, particularly when individuals face a double burden of paid and unpaid work (OECD, 2023[5]). The mental health impacts of unpaid work, including domestic tasks and care work for children and elderly, are highly gendered. In OECD countries, women work on average 25 minutes/day more than men, with long hours in unpaid work driving most of the gender differences in total working hours. Among employed adults, unpaid labour is negatively associated with women's mental health but not necessarily with men's (OECD, 2023[5]). Widening of gender gaps in anxiety during the pandemic have been partially attributed to heightened pressures of balancing work and family life (Scholz, 2021[40])

16. Cultural norms around gender roles heavily influence health behaviours, access to care, clinical assessment and diagnosis, as well as treatment outcomes. On the one hand, higher rates of risky behaviours and substance use in men lead to greater prevalence of overdose or the rising deaths of despair from alcohol, drugs, and suicide (OECD, 2023[41]; Patwardhan, V. et al, 2024[42]; Health Canada, 2024[43]; The Kings Fund, 2024[44]). Men may avoid preventive care more due to societal expectations of stoicism, which also impacts self-awareness of their needs and, together with stigma, leads to under recognition and reporting of mental conditions (Smith, Mouzon and Elliott, 2016[17]). On the other hand, women have historically been marginalised in healthcare decision-making and research, leading to a lack of understanding of their specific health needs with practical implications such as misdiagnoses. One example is the misattribution of higher risk of psychological distress and mental conditions to menopause, delaying accurate diagnosis and treatment including of menopause manifestations (Brown et al., 2024[45]). There is also the underdiagnosis of ADHD (Box 2.3) in girls, resulting from different symptom presentation in girls and boys and a bias in current ADHD diagnostic criteria and practice towards male presentation of

ADHD, as well as additional efforts to mask ADHD symptoms by girls, due to social sanctions (Attoe and Climie, 2023[46]).

Box 2.3. Debates around the classification of ADHD and autism

This working paper includes ADHD and autism under the broader umbrella of mental health conditions, in line with internationally recognized psychiatric classification systems such as the International Classification of Diseases (ICD, World Health Organization) and Diagnostic and statistical manual of mental disorders (DSM, American Psychiatric Association).This classification reflects their integration into mental health policy, clinical care, and support service frameworks across most OECD countries.

ADHD and autism frequently overlap with mental health issues and are often managed within mental health systems. Many individuals with these diagnoses experience co-occurring conditions such as anxiety or depression, and may exhibit symptoms (e.g., emotional dysregulation, executive function difficulties) that align with other mental health disorders. This contributes to shared service pathways, support needs, and clinical challenges in both diagnosis and care coordination.

At the same time, ADHD and autism are also categorized as neurodevelopmental conditions, and a growing *neurodiversity* perspective challenges their traditional framing as mental disorders. This perspective views conditions such as ADHD and autism not as pathologies, but as natural variations in human neurodevelopment. Advocates argue for a shift away from deficit-based models toward more inclusive, strength-based understandings that emphasize acceptance and accommodation. As a result, debates continue about whether and how these conditions should be framed within the mental health umbrella—especially when such classification may influence access to services, eligibility for accommodations, or perceptions of identity and stigma.

The debate is further complicated by emerging evidence on gender disparities in diagnosis. ADHD has been historically underdiagnosed in females, partly due to differences in symptom expression. While boys more often present with hyperactivity or disruptive behaviour, girls are more likely to display inattentiveness, internalizing symptoms (e.g., anxiety), or compensatory coping strategies that mask underlying challenges. These differences contribute to diagnostic delays and misclassification, with girls' symptoms sometimes interpreted as emotional or relational difficulties—thus reinforcing the overlap between ADHD and mental health categories in real-world clinical practice.

17. Women are also more likely to face cross-cutting drivers of mental health inequalities such as socio-economic disadvantage and financial insecurity, as they tend to have lower incomes then men across their lives (McManus et al., 2016[47]). Socio-economic factors, alongside family-related factors, have been found to explain 20% of the differences in depression between men and women (Van de Velde, Bracke and Levecque, 2010[48]). Moreover, among employed adults, unpaid labour is negatively associated with women's mental health, with effects less apparent for men. Women have joined the workforce in large numbers for the last decades, but when joining the job market they face higher risk of job inequality and economic discrimination than men (Van de Velde, Bracke and Levecque, 2010[37]). While younger women's generations are increasingly sharing childcare responsibilities with men, women continue to spend a greater number of hours on unpaid labour, which accumulates with job responsibilities for those employed, and puts them at greater risk of poorer mental health than men (Ervin et al., 2022[49]; Van de Velde, Bracke and Levecque, 2010[37]).

18. Having higher exposure to risk factors such as domestic or intimate partner violence, and childhood maltreatment is associated with increased prevalence of certain mental disorders in women (Oram, Khalifeh and Howard, 2017[50]; Afifi et al., 2014[51]), including anxiety, depression, post-traumatic

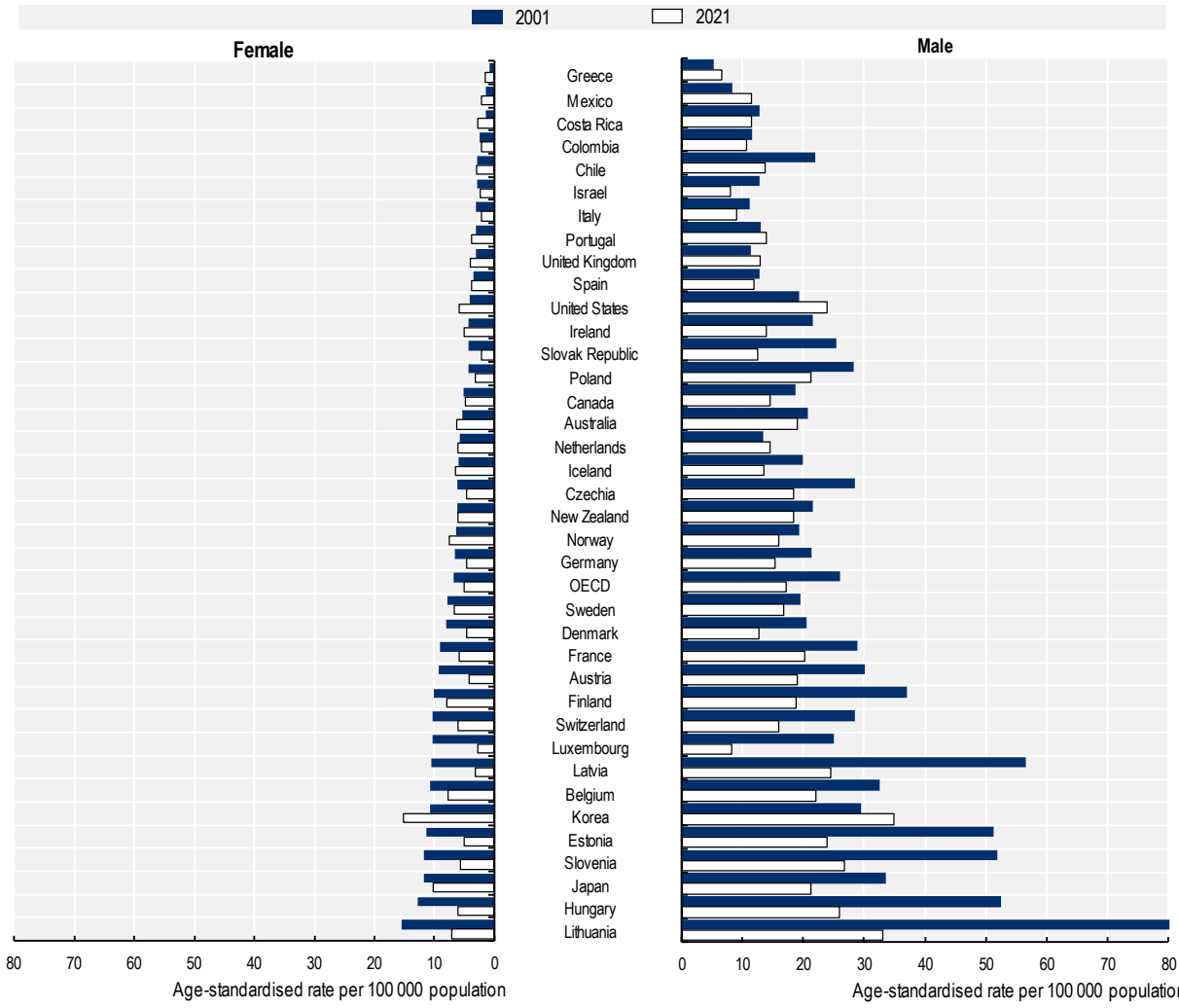
stress disorder, substance use disorders, personality disorders and psychosis, as well as higher likelihood self-harm and suicidality (OECD, 2023[5]; Garcia-Moreno et al., 2005[52]; Horwitz et al., 2001[53]; Kaplow and Widom, 2007[54]). While bidirectional in nature, there is a strong relationship between domestic or intimate partner violence and mental ill-health. Women with mental health conditions are more likely to experience abuse, and women who experience abuse are more likely to experience mental ill-health (Kaul et al., 2024[55]; Trevillion et al., 2012[56]; OECD, 2023[5]). A study of mental health service users in London found that 70% of women had experienced domestic violence in their lifetime – 27% in the past year – and 61% had experienced sexual violence during adulthood (Oram et al., 2022[57]). Although instances of such violence are experienced by men, women are more likely to have experienced repeated and severe violence (OECD, 2023[5]).

19. As well as certain externalizing conditions and substance use disorders (Otten et al., 2021[21]) men have higher suicide rates than women. In both 2001 and 2021 (or latest year available), rates of death by suicide were higher for men than women in all OECD countries (Figure 2.4). In 2021 deaths by suicide were at least two-fold higher for men in countries such as The Netherlands, Iceland, Norway, Sweden, Finland, Korea, Japan; up to seven-fold higher in Poland. Looking beyond suicide at all deaths of despair - either suicide, drug overdose or acute alcohol abuse – these were three times more likely in men than in women in the typical OECD country (OECD, 2024[58]).

20. Deaths by suicide decreased between 2001 and 2021 for both genders in about two thirds of the OECD countries, increased for both genders in seven countries and increased only for women in other seven countries (Costa Rica, Chile, Spain, Ireland, Australia, Norway and Iceland). Among the countries with increasing rates of deaths by suicide in both genders the relative change was higher for women than men in all except Netherlands. Gender differences in deaths of despair have shrunk between 2010 and 2021, almost entirely driven by falling rates for men while rates for women have remained stable for most of the period, and have started to rise since 2019 (OECD, 2024[58]).

21. While cross-country comparisons in suicide attempts are often limited by data, studies seem to consistently report a reverse gender pattern in suicide behaviour, in what has been named as a gender paradox of suicide behaviour. Women are more likely to report suicide intent and in some countries suicide attempts too, while suicide attempts in men are likely to be more severe, suggesting that differences in lethality explain at least part of the higher suicide fatality in men (Schrijvers, Bollen and Sabbe, 2012[59]; Freeman et al., 2017[60]). Data for France from 2012 to 2023, for instance, shows higher rates of hospital stays due to self-harm and attempted suicide for women than men. While self-harm hospitalizations have been decreasing for people from 25 to 65 years old, a sharp and worrying increase can be observed since 2020 for girls and young women from 10 to 24 years old (Drees, 2022[61]; Drees, 2024[62]).

Figure 2.4. Suicide remains higher for men despite decreasing in most OECD countries



Notes: Annual deaths per 100 000 inhabitants, cause of death intentional self-harm. Data for Norway and New Zealand is from 2016, Portugal and Türkiye from 2019 and Belgium, Costa Rica, France, Germany, Greece, Ireland, Italy, Slovenia and United Kingdom from 2020.
Source: OECD Health Statistics 2023.

Poorer mental health in people identifying as LGBTIQ+ driven by group-specific drivers

22. Despite limitations in data availability, there is evidence to support that sexual and gender minorities experience mental health issues at a greater rate than heterosexual and cisgender populations. For example, in a recent United States Household Pulse Survey, 39.5% of gay and lesbian individuals and 56.5% of bisexual individuals reported symptoms of anxiety disorder or depressive disorder, compared to 25.8% of heterosexual people (National Center for Health Statistics. U.S. Census Bureau, 2023[63]). The same survey found that 63.2% of transgender individuals reported symptoms, compared to 25.4% of cisgender males and 30.7% of cisgender females (National Center for Health Statistics. U.S. Census Bureau, 2023[63]). These inequalities seem to also apply when focusing on young people. During the pandemic in the United States, 76% of LGBTIQ+ high school students reported persistent feelings of sadness or hopelessness compared with 37% of heterosexual students (The U.S. Surgeon General's Advisory, 2023[64]). Studies from other countries have also found heightened rates of mental ill-health and

suicidal ideation amongst LGTBQI+ groups. An online study of adult Canadians found that 22% of the LGBTIQ+ community thought about suicide in the past year, compared to 8% of those not identifying as LGBTIQ+ (Mental Health Research Canada., 2023[65]). The same analysis found that during the COVID-19 pandemic 36% of people that identify as LGBTIQ+ self-reported high levels of anxiety and 28% self-reported high levels of depression, compared to 22% and 15% of those not identifying as LGBTIQ+ (Mental Health Research Canada., 2023[65]). An Australian study of the relationship between interpersonal violence, mental health and sexual identity found that experiences of interpersonal violence predicted poorer mental health but varied significantly by sexual identity. Homosexual, bisexual, and lesbian participants scored worse than heterosexual participants in all the five mental health indicators measured (stress, anxiety symptoms, depression, overall mental health, and life satisfaction) (Szalacha et al., 2017[66]).

23. For gender and sexual minorities, group-specific drivers of mental health inequalities are connected to experiences of homophobia, biphobia, transphobia, social isolation (McDermott, Hughes and Rawlings, 2018[67]) and 'feeling like a burden' (Baams, Grossman and Russell, 2015[68]). Experiencing discrimination has been particularly linked to depression, but also to anxiety in several minority groups including people that identify as LGBTIQ+; the frequency and volume of the discrimination experienced matters for how their mental health is impacted (OECD, 2023[5]).

24. Elevated risk of mental ill-health may also be driven by issues relating to disclosure of identity. For example, individuals may face conflict with family or peers about their identity or be forced to manage their identity across multiple life domains (McDermott, Hughes and Rawlings, 2018[67]). Attempts to conceal queer status and internalisation of negative societal views may also drive negative mental health (Mongelli et al., 2019[12]). Amongst sexual minorities, bisexual individuals seem to be at highest risk of developing mental ill-health (compared to homosexual people), despite reporting less minority stress associated with violence and discrimination (Lewis et al., 2009[69]; Plöderl and Tremblay, 2015[70]; National Center for Health Statistics. U.S. Census Bureau, 2023[63]). On the other hand, a recent study found that for sexual minority young adults, living in neighbourhoods with higher percentages of same-sex couples (controlling for neighbourhood-level factors, including relative concentration of economic disadvantage) was associated with lower levels of depression (Wienke, Whaley and Braatz, 2021[71]). Areas with higher concentrations of people with similar lived experience may allow protections from certain discrimination and a greater sense of social support and visibility (Henderson, Goldbach and Blosnich, 2022[72]).

25. In most countries there is still a shortage of data relating to sexual and gender minorities and mental health, as questions relating to these identities were traditionally not featured in population research and data collection (Garofalo, 2011[73]). Data limitations might also arise from increased rates of opting out or refuse to respond to questions pertaining to sexual orientation and/or gender identity, to avoid safety and/or social desirability issues.

Indigenous populations and most minoritized ethnic groups are at higher risk of mental health issues

26. For ethnic groups, patterns in mental health status are inconsistent and appear to vary by indicator of mental health status and ethnic group. For example, in the United States, research has shown that Black Americans have lower rates of depression and anxiety despite greater exposure to stressors and even higher rates of psychological distress (LaMotte, Elliott and Mouzon, 2022[74]; Williams, 2018[75]). However, when Blacks and Hispanics experience mental disorders, their episodes tend to be longer and more severed and debilitating than for other ethnic groups (Williams, 2018[75]). Racism can affect mental health via discrimination, but also through structural and institutional mechanisms that are embedded in a broader culture (Williams, 2018[75]; OECD, 2023[5]). One British study found evidence of the enduring effects of racism (direct experiences of interpersonal racial discrimination) on physical and mental health,

which operate over time both directly and indirectly through lower income and poorer prior health (Stopforth et al., 2022[76]). Also in the United Kingdom, some evidence suggests that the percentage of people who experienced a common mental disorder does not vary by ethnic group for men, but it does for women (NHS Digital, 2017[77]). A survey found that in the prior week, 29% of Black British women had experienced a common mental disorder, compared to 21% of White British women and 16% of non-British White women (McManus et al., 2016[47]).

27. In countries where evidence is available, Indigenous groups tend to experience the highest rates of psychological distress and mental health conditions compared other groups, and extremely high rates of death by suicide. In Australia, from 2015 to 2019, the age-standardised proportion of Australians reporting high or very high levels of psychological distress was 31% for Indigenous people, compared to 13% amongst non-Indigenous Australians; while the rate of suicide for First Nations Australians was twice the rate for non-Indigenous Australians (Australian Institute of Health and Welfare and National Indigenous Australians Agency, 2023[78]). In New Zealand, Māori people experience the highest levels of mental-ill health and/or addiction of any ethnic group. While the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are also 30% more likely than other ethnic groups to have their mental illness undiagnosed (Cunningham, Kvalsvig and Peterson, 2018[79]). Such inequalities may be driven by the ongoing impacts of colonisation, barriers to accessing services, a 'Western' model of health and lack of culturally appropriate services (Theodore et al., 2022[80]; New Zealand Government, 2018[81]).

28. Inequalities in mental health outcomes among Indigenous and racialized populations are rooted in broader systematic and structural drivers. Colonial legacies have inflicted intergenerational trauma and social suffering on Indigenous communities, directly contributing to disproportionate mental health burden and hindering access to culturally appropriate care (Smye et al., 2023[82]). In Canada, prolonged exposure to colonialism and racism has placed Black Canadians at a disadvantage in both mental well-being and access to support services (Olanlesi-Aliu, Alaazi and Salami, 2023[83]). Intergenerational studies also suggest that the traumas of slavery and systemic oppression become biologically embedded, with descendants showing evidence of transgenerational stress responses (Alang, Carter and Blackstock, 2023[84]). For Indigenous Australians, the ongoing impacts of colonization include loss of culture, disconnection from country and lack of teachings of spirituality, especially in early childhood (an important foundation for a healthy self-identity) (Martin, Lovelock and Stevenson, 2023[85]).

29. Research continues to link racial discrimination with higher rates of psychological distress (OECD, 2025[6]; Kairuz et al., 2021[86]). During the COVID-19 pandemic, anti-Asian xenophobia surged, with nearly 70% of Asian-Americans reporting experiences of racism (Hahm et al., 2021[87]). Such pandemic-related discrimination translated into acute mental health impacts, where Asian adults who encountered frequent COVID-era bias had higher odds of screening positive for anxiety and depression (Ormiston et al., 2024[88]). Furthermore, adults from racialised minority backgrounds reported higher levels of psychological distress compared to White individuals throughout the pandemic period in both the United Kingdom and in the United States (Nguyen et al., 2022[89]).

30. Furthermore, literature suggests that there may be cultural differences in help-seeking behaviours amongst ethnic minorities (Guo et al., 2015[90]). Minority populations are generally less likely than majority populations to seek professional mental health care (Hines, Cooper and Shi, 2017[91]). This disparity is influenced by multiple factors, including stigma, mistrust and culturally specific understandings of mental illness. For example, Asian Americans tend to face greater stigma and hold narrower concepts of mental disorders correlating with more negative attitudes toward help-seeking (Tse and Haslam, 2021[92]). Similarly, Black individuals also cite stigma as a barrier and prefer informal support systems such as faith communities (Ward et al., 2013[93]).

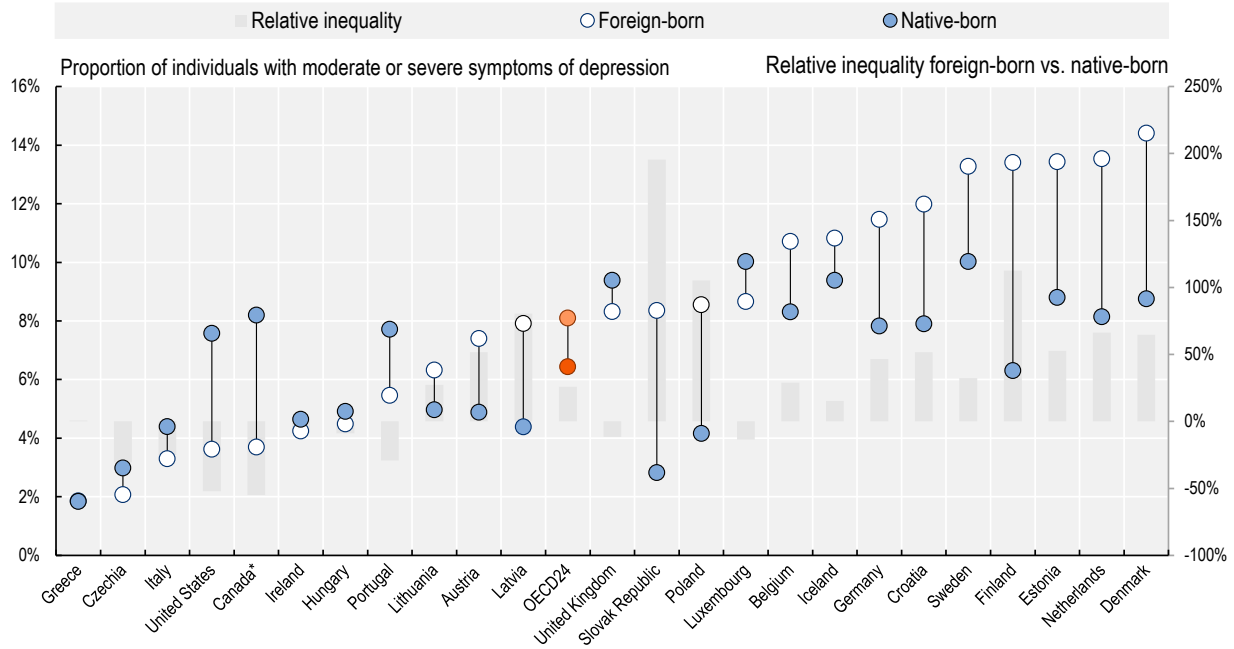
The association of migration status with poorer mental health depends on the country of origin and destination, and time spent in the host country

31. Evidence on inequalities by migration status is mixed, with some data suggesting that foreign-born individuals experience a slightly higher rate of mental-ill health compared to those who were born in the country, while some studies point to no significant differences. Among 24 OECD, 15 countries register a higher prevalence of symptoms of severe depression amongst the foreign-born population, between 1% higher in Greece and 195% higher in Slovak Republic (according to the relative inequality displayed in Figure 2.5 – grey columns). For the remaining 9 countries the prevalence is higher in native-born individuals (Czechia, Italy, Canada, United States, Ireland, Hungary, Portugal, United Kingdom and Luxembourg).

32. Differences is rates of and vulnerability to mental health condition may also depend on country of origin, destination and experience in the new country. A Finnish study found that incidence of post-traumatic stress disorder was most frequently diagnosed in men (2.7%) and women (2.4%) from the Middle East and North Africa, compared to the average of foreign-born (0.7%) or Finnish-born with a foreign background (0.6%) (Finnish Institute for Health and Welfare, 2022[94]). On the other hand, studies from Canada found that immigrant status was associated with a lower prevalence of psychiatric disorder, with an added protective effect for immigrants living in neighbourhoods with higher immigrant concentrations (Menezes, Georgiades and Boyle, 2011[95]).

Figure 2.5. Differences in depressive symptoms by migration status differ by the country

Prevalence of moderate or severe symptoms of depression in 2019 (PHQ-8≥10)



Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe depressive symptoms based on a score equal or higher than 10 for the PHQ-8/9, which also corresponds to a positive screen indicating the need of further clinical assessment. Countries are displayed by increasing prevalence for foreign-born. The OECD25 average excludes Croatia. *Estimates for Canada are based on a publication and include data between 2015 and 2019 for the different provinces and territories.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), and National Health Interview Survey (NHIS) 2019 for the United States; (Shields et al., 2021[24]) for Canada.

33. Additionally, some literature suggests that time lived in the host country affects mental health status. A Canadian study found those who had migrated to Canada within five years had better self-perceived mental health scores than those who had migrated to Canada more than 10 years before. Prior studies have shown that within about 10 years of living in Canada, migrant health deteriorates and converges to Canadian-born levels of mental health (Salami et al., 2017[10]). For Mexican, African and Caribbean immigrants in the United States the rates of mental disorders increased with time spent in the country (Miranda et al., 2008[96]).

34. Where there is heightened risk of mental ill-health amongst immigrant communities, this may be driven by various social and structural factors. A study comparing those born abroad by two foreign-born parents and registered as residents in Norway to Norwegian-born children with immigrant parents found that heightened risk for mental-ill health amongst immigrant populations is driven by a higher risk of acculturative stress, poor social support, deprived socio-economic conditions, multiple negative life events, experiences of discrimination and traumatic pre-migration experiences (Abebe, Lien and Hjelde, 2014[7]). A poor sense of community belonging can be associated with poor mental health outcomes amongst immigrants (Salami et al., 2017[10]).

35. For refugees, both pre- and post-migration stressors can drive poor mental health, and post migration factors may moderate the ability of refugees to recover from pre-migration trauma (Hynie, 2018[97]). Post-migration stressors include complexity in the asylum and resettlement processes, poor social integration or loneliness, worrying about family and friends overseas and economic stressors (lack of satisfaction with or concerns about income and employment) (Chen et al., 2017[98]; Goodkind et al., 2021[8]).

People with low socio-economic status have consistently higher levels of mental health problems

36. Socio-economic status can be captured by a multitude of indicators which are related to each other and to mental health. Mental disorders are concentrated among those of low socio-economic status, as defined either at the individual level (income, education, socio-economic position, employment (Muntaner et al., 2004[99]; Blas and Kurup, 2010[100]; Yu and Williams, 1999[101]; Sareen et al., 2011[102]) or through area-based measures (neighbourhood socio-economic conditions, social capital, built environment (Silva, Loureiro and Cardoso, 2016[103]; Rehkopf and Buka, 2006[104]).

37. Inequalities by socio-economic status are extensively documented particularly for depression and anxiety (Silva, Loureiro and Cardoso, 2016[103]; Fryers, Melzer and Jenkins, 2003[105]; Lorant et al., 2003[106]), although literature most often reports association rather than causation. There is also evidence of disparities in suicide and suicidal behaviour being more frequent among those of low socio-economic status (Rehkopf and Buka, 2006[104]; Huang et al., 2017[107]; Milner et al., 2013[108]; Ying and Chang, 2009[109]). For severe mental disorders the evidence is less consistent. While results from early studies indicated that socio-economic status disparities would be less pronounced for conditions such as bipolar disorder or schizophrenia more recent research suggests that methodological and measurement limitations influenced these findings and that severe disorders are also concentrated amongst people with low socio-economic status (Cai et al., 2022[110]; Eid et al., 2013[111]).

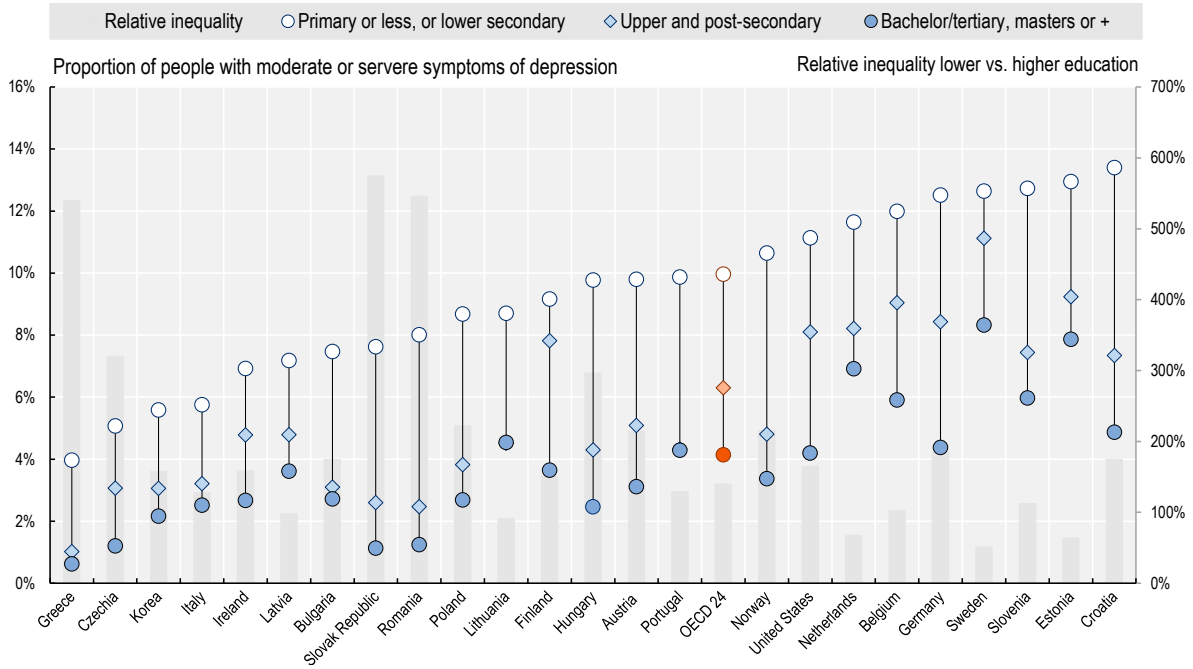
38. Focusing on education, all the 27 countries studied registered substantially higher prevalence of moderate or severe depressive symptoms among individuals with the lowest education attainment (no education, primary or lower secondary education) compared to those that completed at least tertiary education or a bachelor (Figure 2.6). For the intermediary education group, those that completed upper secondary education, the prevalence of moderate is severe symptoms is either in between the prevalence

for the lowest and highest education groups or much closer to the latter (overlapping for Greece, Bulgaria, Lithuania and Portugal).

39. Mental-ill health is associated with poorer academic performance through a variety of mechanisms. One potential pathway is increased likelihood of skipping or missing classes or turning in incomplete assignments. Students with mental health conditions are more likely to have lower levels of academic self-efficacy, contributing to feelings of being overwhelmed and unable to focus, and to engaging in procrastination behaviours. Other mechanisms can include higher fatigue and inability to focus due to disrupted sleep patterns and poorer sleep quality, for example in individuals with depression; or the disruptions of working memory processes due to high levels of anxiety surrounding academic performance. The relationship between mental health and academic achievement is bidirectional, with poor school performance also exacerbating, or even causing mental-ill health (OECD, 2023[5]).

Figure 2.6. The prevalence of moderate or severe depressive symptoms more than doubles for those that only completed primary or lower secondary education

Prevalence of moderate or severe symptoms of depression in 2019 (PHQ-8≥10)



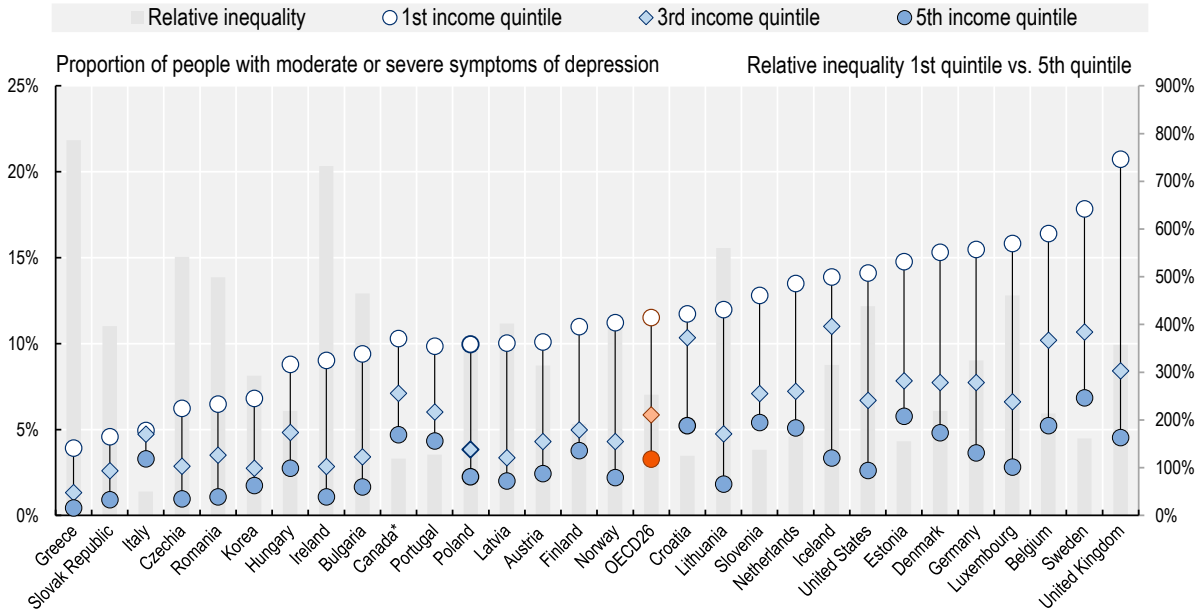
Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe depressive symptoms based on a score equal or higher than 10 for the PHQ-8/9, which also corresponds to a positive screen indicating the need of further clinical assessment. Countries are displayed by increasing prevalence for "Less, primary or lower secondary". "Less, primary or lower secondary" education corresponds to ISCED levels 0-2, "Upper and post-secondary" education to ISCED levels 3-4 and "Bachelor/tertiary, masters of +" to ISCED levels 5-8. The OECD25 average excludes Bulgaria, Croatia and Romania.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea.

40. A clear gradient in the increased likelihood of moderate or severe depressive symptoms is seen across all countries as income decreases: people in lower-income groups are at markedly at higher risk than those in the middle or top of the distribution. In 28 of the countries studied the likelihood of having moderate or severe symptoms of depression is more than double for those in the lowest household income group (1st quintile), compared to the highest household income individuals (5th quintile; Figure 2.7); in 21

countries this likelihood is more than 3 times higher. For most countries, the prevalence of symptoms for individuals in the middle of the distribution (3rd quintile) is closer to the higher-income groups; for a few countries there is barely difference in prevalence between the lowest (1st quintile) and second lowest (2nd quintile) income groups (Iceland, Italy, Greece, Romania and Slovak Republic - results not shown).

Figure 2.7. In most countries people in the lowest income group are three-times more likely to have moderate or severe depressive symptoms than those with the highest income

Prevalence of moderate or severe symptoms of depression in 2019 (PHQ-8≥10)



Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe depressive symptoms based on a score equal or higher than 10 for the PHQ-8/9, which also corresponds to a positive screen indicating the need of further clinical assessment. Countries are displayed by increasing prevalence for 1st income quintile. The OECD26 average excludes Bulgaria, Croatia and Romania. *Estimates for Canada are based on a publication and include data between 2015 and 2019 for the different provinces and territories.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea; (Shields et al., 2021[24]) for Canada.

41. Systematic reviews show that people with the lowest incomes are 1.5 to 3-fold more likely to report symptoms of depression and anxiety. Several mechanisms explain this relationship – current income determines what people can afford today but also smooths consumption and builds future wealth, allows investment in economic and human capital, and acts as a backstop for future unexpected events (OECD, 2023[5]). More severe forms of mental-ill health are also highly concentrated among those with low income: people with severe mental distress are 83% more likely than expected to live in low-income households, on average, and more than twice as likely in Israel, Chile, Denmark, Finland, Hungary, Latvia and the United Kingdom (OECD, 2021[112]). Higher rates of deaths of despair are also associated with income poverty (OECD, 2023[5]).

42. Challenges in quantifying how socio-economic status drives mental health arise from the bidirectional nature of this relationship (OECD, 2023[5]). That is, low socio-economic status can undermine mental health, and mental ill-health can directly lead to low socio-economic status. 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[113]). Across the OECD, people with mental health conditions generally have lower wages and incomes, and higher rates of dependence on all types of working-age benefits

(OECD, 2021[112]). For those who are employed, mental health issues can affect performance at work and result in lack of productivity, prolonged sick leave, underemployment, fragmentation of social relationships or ultimately labour market exit (OECD, 2021[112]; Knifton and Inglis, 2020[114]). For younger people, whose mental health status also depends on their parents' mental health and any genetic predisposition, mental health issues can affect their education outcomes (OECD, 2021[112]). In the vast majority of OECD countries, those with mental health conditions are less likely to complete tertiary education than those not experiencing mental health conditions (OECD, 2021[112]).

43. The impact of socio-economic status on mental health becomes evident when individuals experience shocks that abruptly change their income or their employment situation. Becoming unemployed or having a substantial reduction in household income increases the risk of mental disorders, especially mood disorders (Barbaglia et al., 2015[115]), a phenomena that was also observer during the COVID-19 pandemic (Dragano, Reuter and Berger, 2022[116]). Furthermore, adverse life events such as personal injury, jail or separation from a spouse result in greater risk of mental disorders for disadvantaged socio-economic groups. According to Australian longitudinal data, between 25% and 40% of mental health inequalities in favour of higher-income groups are explained by life shocks, mostly those related to financial hardship (22% to 35%) and to a lesser extent negative life events such as serious personal injury, being detained in jail or separation from a spouse (2% to 5%) (Hashmi, Alam and Gow, 2020[117]).

44. The experience of unemployment or the transition to unemployment can also heighten the risk of poor mental health through increased stress, lower life satisfaction, doubt and lower self-esteem (Amin, Korhonen and Huikari, 2023[118]; Escudero-Castillo, Mato Diaz and Rodriguez-Alvarez, 2022[119]; OECD, 2021[112]). In Australia in 2020-21, 12-month prevalence of mental disorders was 22.3% in employed individuals compared to 39.5% in unemployed people and 29.1% in people outside of the labour force (Australian Bureau of Statistics, 2022[120]). Longer durations of unemployment spells are associated with higher burden of disease; unemployment can leave lasting negative mental health effects, many of which may outlast the period of unemployment itself (OECD, 2021[112]). Greater exposure to unemployment is also associated with higher relative risk of suicide (Milner, Page and LaMontagne, 2014[121]).

45. The relationship between poor mental health and labour market outcomes goes beyond unemployment. Those with poor mental health are much more likely to report being unable to work due to a permanent disability. When working, individuals with poor mental health are more likely to report feeling insecure in their employment or having a temporary contract. While being employed can be a protective factor against mental health conditions, this safeguard effect depends on the quality of the job, namely the level of job strain and of job control (OECD, 2023[5]).

46. The several dimensions of socio-economic status intersect at the individual and group level, and with other sociodemographic characteristics such as gender and/or race, increasing the risk of poor mental health (Trygg, Gustafsson and Månsdotter, 2019[122]). According to the intersectionality concept the combined effects of several markers of disadvantage or vulnerability circumstances are not equal to the sum of individual inequalities and these effects can be either synergistic or antagonistic. Understanding the complex reality in which inequalities are intertwined is critical to design intersectionality-informed approaches that can focus on multiple simultaneous disparities and support the subgroups in circumstances of major vulnerability (Nyamande et al., 2020[123]).

47. For instance, Sweden found that while income was the strongest single predictor of poor mental health, the interplay of multiple social positions revealed patterns of disadvantage that would not have emerged from examining income alone (Fagrell Trygg, Månsdotter and Gustafsson, 2021[124]). Furthermore, a study across 33 countries showed that adolescent mental well-being is shaped not only by immigration background, socioeconomic status, and gender, but also by how these factors interact within national contexts (Kern et al., 2020[125]). In countries with inclusive immigration policies and high levels of income equality, adolescents facing multiple disadvantages, such as low-income immigrant girls, reported better mental health than expected. In contrast, similar groups experienced worse outcomes in countries

with more restrictive policies and greater inequality. These findings show that broader social and policy environments can either lessen or worsen the mental health effects of overlapping disadvantages.

48. The effect of socio-economic status on mental health also extends intergenerationally, from parents to offspring (Kirkbride et al., 2024[126]). Early-life circumstances are strong determinants of children's well-being and their mental health, including during pregnancy and immediately after birth (first 1000 days). Children and adolescents at socio-economic disadvantage are two to three times more likely to develop mental disorders. Among several indicators of socio-economic status, low parental education and household income substantially impact children and youth mental health (Reiss, 2013[127]). There is also prominent role for poor parenting styles such as angry parenting and poor consistency and inductive parenting (e.g. being authoritarian by setting limits without explaining the reasons behind) in the development of mental health problems by children and adolescents of low socio-economic status (Gautam et al., 2024[128]).

49. Mental health inequalities by socio-economic status are observed both at the individual and the area-level (Silva, Loureiro and Cardoso, 2016[103]). At the area-level the magnitude of the association between low socio-economic status and mental-ill health increases as the size of the area studied decreases (Rehkopf and Buka, 2006[104]), but disparities can even be observed at the regional level. For example in England, rates of common mental disorders are higher for wealthier regions such as the south east (13.6%, age-standardised) and east of England (14.4%) whereas these are almost a third lower than rates in regions with higher deprivation levels such as the south-west, north-west, west midlands and London (20.9%, 19.0%, 18.4% and 18.0%, respectively) (McManus et al., 2016[47]). Associations between neighbourhood characteristics and mental health reflect both the characteristics of the individuals living in the area and characteristics of the neighbourhood themselves (Silva, Loureiro and Cardoso, 2016[103]).

50. The place where people live is connected to their mental health through the shelter, safety and privacy it provides but also through neighbourhood circumstances such as the built-in environment, green spaces, geographical location and social environment (OECD, 2023[5]). The relevance of housing affordability and quality to mental health has been document. Good quality housing can have significant positive impacts on population mental health, just as poor or insecure housing or lived environments can have a negative impact on mental health, or make mental health conditions harder to manage (Mind, 2017[129]; European Parliament, 2020[130]; OECD, 2021[3]; Kim et al., 2021[131]). The lack of housing affordability can negatively influence mental health, in part because it limits households' ability to cover food, education and other life necessities, and the negative mental health effects of lack of affordability have been shown to accumulate (Bentley, Baker and Mason, 2012[132]). In the opposite direction it is also be more difficult for those with severe mental conditions to obtaining stable housing.

51. A particular case of the bidirectional association between housing and mental health is homelessness (Moschion and van Ours, 2021[133]; OECD, 2023[5]). While conducting studies in homeless populations presents a number of challenges, several single city/country studies in OECD countries suggest alarmingly high levels of mental health conditions among this group (60% in Denmark, 67% in Madrid, 70% in Melbourne) (OECD, 2023[5]). Homeless people are substantially more likely to have substance use disorders (pooled prevalence in several countries of 38% for alcohol and 24% for illicit drugs) than same-age groups of the population (Fazel et al., 2008[134]). The prevalence of psychotic disorders in this group appears to be as higher as the prevalence of depression, contrasting largely with lower prevalence of psychotic conditions in the general population and even of groups in vulnerable circumstances such as refugees and inmates (Fazel et al., 2008[134]). Homeless is a risk factor for mental health but can also be a life-event resulting from living with mental disorders, often rooted in adverse childhood experiences and together with several other risk factors (e.g. poverty and low education) (OECD, 2023[5]). Homelessness poses considerable challenges for mental health service delivery, resulting in hard-to-reach groups (Mitchell et al., 2023[135]).

3 Inequalities in mental healthcare access, experiences and outcomes

52. Inequalities in access to mental healthcare are persistent and are more likely to negatively impact people in vulnerable circumstances, as well as key population groups at higher risk of poor mental health. Reporting the exact magnitude of these inequalities is challenging. Population groups with higher prevalence of mental distress and conditions naturally need more treatment and crude rates or shares of access to and utilisation of services that do not account for different treatment needs are likely to provide an incomplete picture of disparities. For example, data showing that groups such as women or low-income people access care the most might still hide unfavourable inequalities in access for these groups, which would only be properly estimated if their treatment needs could be fully captured. Most existing research and evidence on (mental) healthcare inequalities are unable to properly account for the different levels of health and treatment needs of the groups studied.

53. Various factors drive disparities in access to mental healthcare. Some are generic barriers that are not unique to groups in vulnerable circumstances but disproportionately affect them. Examples include out of pocket payments, lengthy waiting times, lack of sick leave or flexibility in employment to seek medical care, limited access to transportation, limited capacity to cover cost of transportation and living in areas with fewer services and higher levels of deprivation. A lack of integrated care and/or poor coordination between services and care settings may also influence accessibility. At the same time, people in vulnerable circumstances have lower access because of group-specific barriers, namely limited availability of dedicated services, as discussed below.

54. There is a shortage of studies addressing treatment experiences and outcomes of different population groups and people in vulnerable circumstances. Most findings suggest that experiences and outcomes of care are more commonly negative for groups at higher risk of poor mental health. For example, data from the NHS Talking Therapies (previous Improving Access to Psychological Therapies - IAPT) program in England shows that some minority groups have lower symptom reduction when treated with talking therapies. Part of the negative findings reported in the literature appear to be related to stigma and discrimination when in contact with services, for example prejudice or lack of understanding reported by those in minorities, lack of a coherent approach to address multiple needs and poor intersectoral collaboration, and some cases of misdiagnosis.

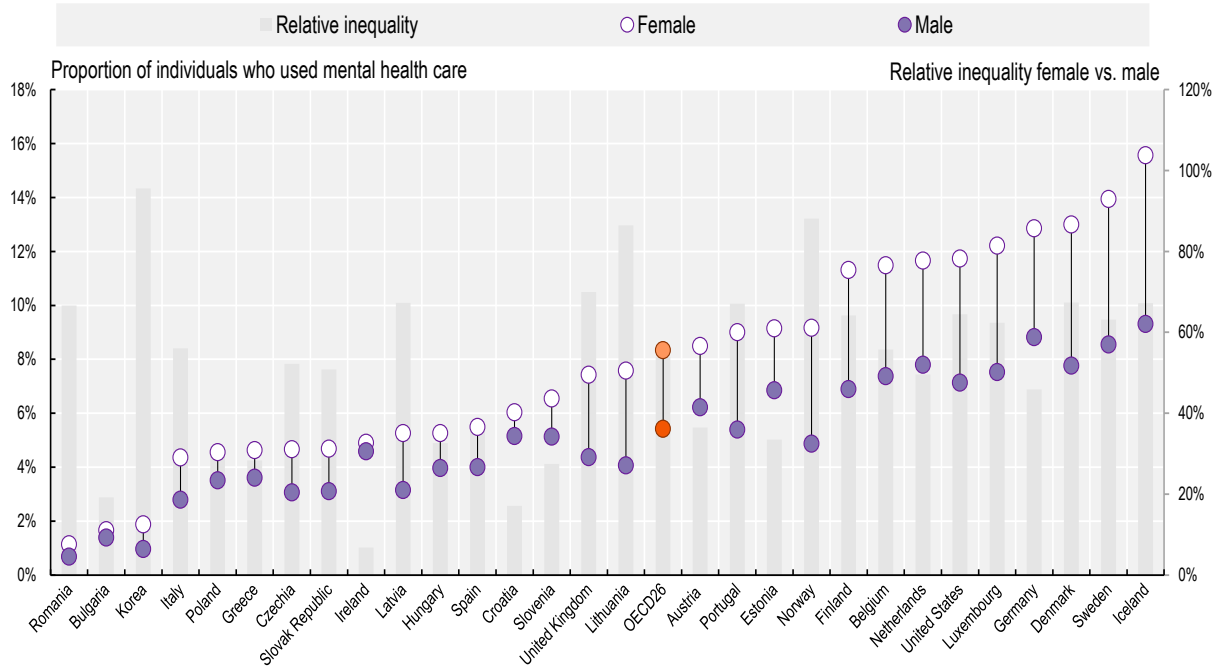
Women access outpatient mental healthcare more but also report higher treatment needs than men due to lack of affordability

55. Figure 3.1 shows that females are 54% more likely than males to have had a consultation with a psychologist, psychotherapist or psychiatrist in the previous 12 months, on average for the OECD countries (relative difference, corresponding to an absolute difference of 8.3% for females vs. 5.4% for males). Such differences in access to care are probably partially explained by the differences in mental health status described in Figure 2.1 and Figure 2.2. Similar patterns are also reported by national surveys conducted in the United Kingdom and the United States, in which women are more likely to have received mental

health treatment than men (McManus et al., 2016[47]; Terlizzi and Norris, 2021[136]). However, this is not necessarily the case for all the types of care. Desegregated service use collected through the OECD Country Questionnaire on Mental Health Inequalities suggests that there is a majority of countries in which mental health inpatient admissions is more common among men than among women (Box 3).

Figure 3.1. In most countries females are more likely to have mental healthcare consultations than males

Proportion of individuals who had a consultation with a psychologist, psychotherapist or psychiatrist in the past 12 months



Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not age-standardised. Countries are displayed by increasing use of mental healthcare consultations for females. The OECD26 average excludes Bulgaria, Croatia and Romania.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), and National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea.

Box 3. Gender disparity in mental healthcare: inpatient, outpatient and primary care related services

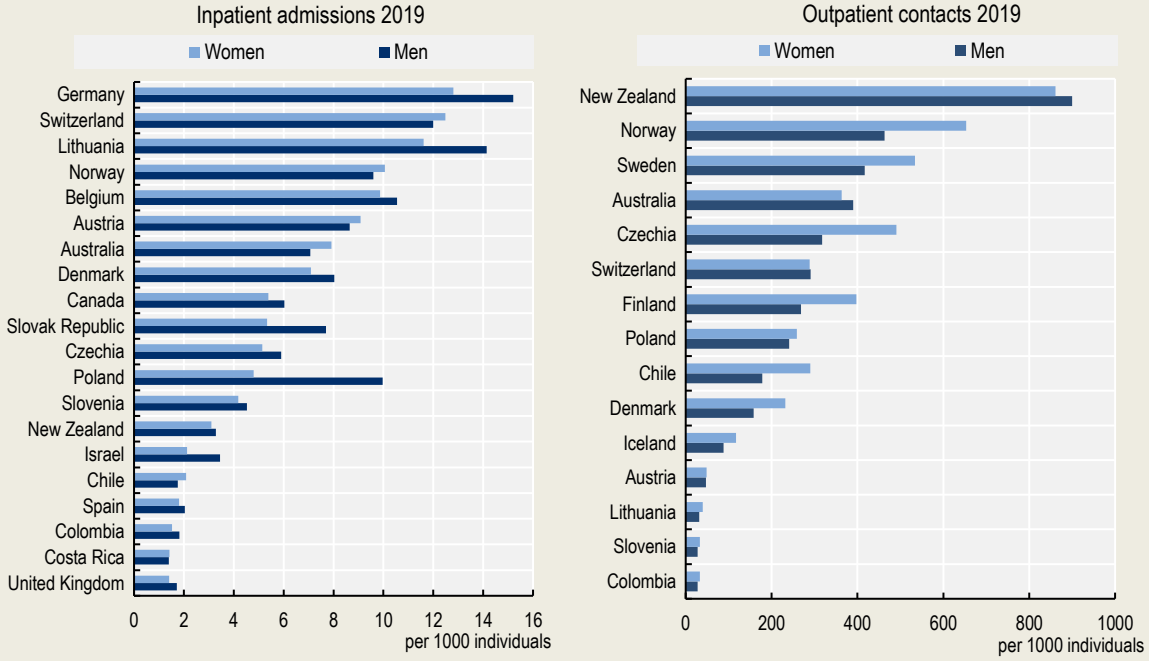
In response to the OECD Country Questionnaire on Mental Health Inequalities several countries provided disaggregated data by gender on mental health service use: inpatient admissions to mental health beds (20 countries), outpatient clinic appointment/contacts (15 countries), and mental health-related primary care appointment/contacts (10 countries). Gender patterns differ across these countries and depend on the type of care. For 2019, a higher rate of inpatient admissions was seen among men vs. women for 14 countries (26% higher, on average). Admissions were more frequent in women in Australia, Chile, Switzerland, Norway and Austria (8% higher, on average, Figure 3.2).

When considering outpatient care, women use these services more frequently than men in most countries studied, except in Australia, New Zealand and Switzerland, where men's rates were higher by 4% in 2019 (Figure 3.2). Considerably differences of more than 40% in outpatient appointment rate for women are observed in Chile, Czechia, Finland, Denmark and Norway. Higher use of outpatient care by women is also

observed based in Figure 3.1, based on self-reported data on access to consultations in the last 12 months. Figure 3.1 portrays larger relative differences for women vs. men than Figure 3.2, potentially due to under-reporting by men or an attenuation when repeated utilisation over time is considered (i.e. if men have a higher rate of appointments per patient than women this is captured in Figure 3.2).

Although data is available only for a smaller number of countries, gender patterns for mental health-related primary care appointments/contacts show even higher use by women, compared to men (more than a 50% difference in 8 out of the 10 countries, results not shown).

Figure 3.2. Differences in inpatient and outpatient mental healthcare: women and men



Note: Data provided by Australia are from 2018-2019. The definition of outpatient contact might not be directly comparable across all countries in the analysis.
Source: OECD estimates based on data provided through the OECD Country Questionnaire on Mental Health Inequalities and UN Population by 1-year age groups and sex (2022), retrieved February 27, 2024.

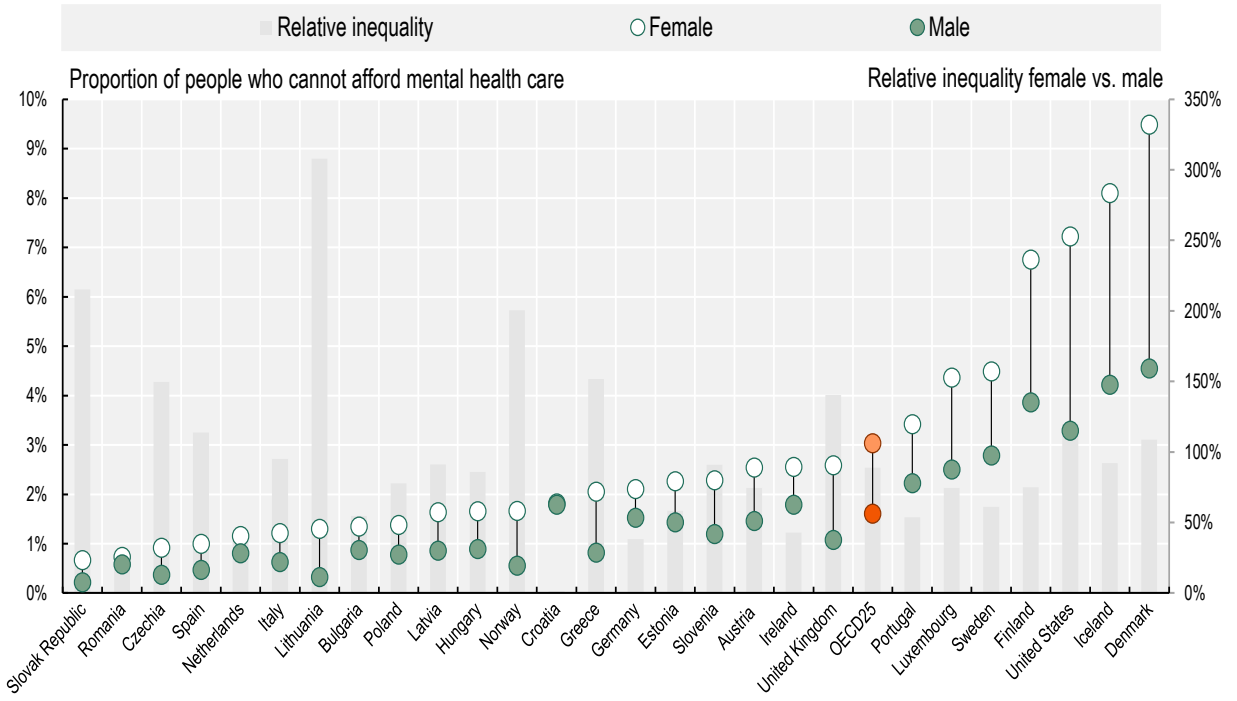
56. At the same time, higher need for females does not necessarily translate into commensurate access to treatment. Figure 3.3 displays the proportion people who reported affordability issues to obtain mental healthcare in the past 12 months. With the exception of Croatia, self-reported unmet need for mental healthcare due to affordability was higher for females in all countries studied (OECD average 88% higher), even though females had higher access to mental healthcare consultations (Figure 3.1). Importantly, results based on self-reported unmet need are strongly impacted by individuals' perception of their need, which might differ between countries and between genders. In general men are less likely to identify their mental health problems and have lower willingness to seek care, influencing these self-reported estimates.

57. Young men experience embarrassment, fear or shame when considering mental health support, often perceiving help-seeking as a threat to masculine ideals (Lynch, Long and Moorhead, 2018[137]). These concerns can be intensified in male-dominated environments, where societal stigma-especially perceptions linking mental health struggles as personal weakness or failure- reduces men's willingness to disclose mental health issues (McKenzie et al., 2022[138]). Across various settings, men consistently report

fears of being judged as weak, vulnerable, or unable to handle stress, which can lead to masking symptoms or entirely avoiding care. For example, professional and university-level football players feared exclusion and loss of team status if they disclosed mental health challenges, leading many to conceal their symptoms (Wood, Harrison and Kucharska, 2017[139]; Delenardo and Terrion, 2014[140]). Some studies suggest that certain contexts may exacerbate these barriers. Men working in construction, manufacturing, and other manual labour sectors described avoiding help-seeking due to fear of being perceived as weak, but also to protect themselves from hurting their professional relationships (Mahalik and Dagirmanjian, 2019[141]). These jobs often prize physical endurance and self-reliance, so emotional struggles are kept private. Furthermore, men have also described feeling judged or dismissed by health professionals themselves (Ferguson et al., 2019[142]; Samuel, 2015[143]).

Figure 3.3. Females are also more likely to report unmet need for mental healthcare due to affordability

Not being able to afford care by a psychologist, psychotherapist or a psychiatrist in the past 12 months



Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not standardised. Countries are displayed by increasing prevalence of unmet need for females. The OECD25 average excludes Bulgaria, Croatia and Romania

Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea.

58. Additionally, structural discrimination can create barriers where young women's mental health symptoms are more likely to be dismissed or attributed to anxiety or seen as a part of being a young women (Tinner and Alonso Curbelo, 2024[144]). Factors explaining inequities in access to care are multiple and range from financial barriers to the complexity of entering and navigating the mental healthcare system. Low mental health literacy and stigma, and intersectional marginalization, are also important aspects that lead some groups to underestimate their need for care and refrain from seeking support.

Limited attention to impacts of gender-based violence and gender stereotypes might hinder women's access and experiences of mental healthcare

59. Despite the clear relationship between gender-based violence and trauma and poor mental health, trauma-informed services are infrequent. In the United Kingdom in 2018, the Women's Mental Health Taskforce found that for women that had experienced violence and/or trauma, contact with mental health services could at times be re-traumatising, for example through restraint or observations (Department of Health & Social Care, 2018[145]). Beyond such direct experiences, survivors could also confront internal barriers, including feelings of shame, confusion, and feeling frozen, all of which inhibit their willingness or ability to seek help (Saint Arnault and Zonp, 2022[146]). Some survivors perceive the abuse as not serious enough or normalise it, leading them to minimise their need for support (Fugate et al., 2005[147]). Additionally, survivors of intimate partner violence—a common form of gender-based violence—often cite social stigma and fear of disbelief as obstacles to seeking care (Wright et al., 2022[148]).

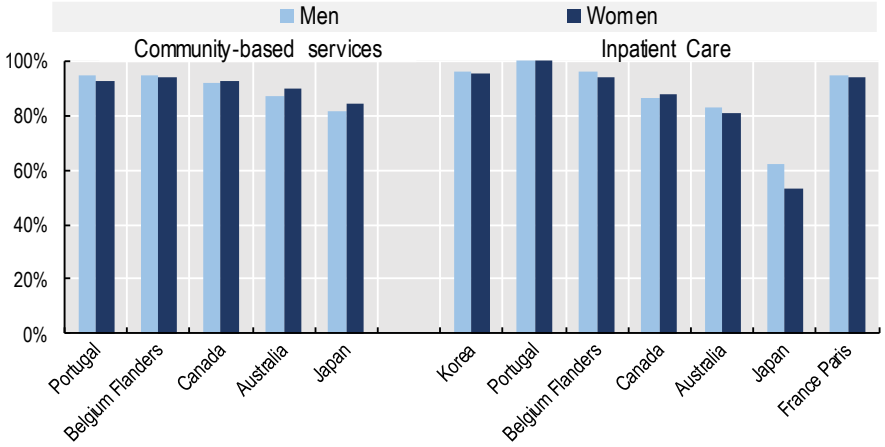
60. There may also be a lack of coherent approach to addressing multiple needs. Women who have faced abuse and violence may also require support with addiction and homelessness, and a lack of coherent approach may be a barrier to access. Additionally, studies have found that services often do not adequately account for women's roles as mothers and carers. For instance, The Women's Taskforce of Mental Health in the United Kingdom noted that women reported inadequate provision of services to help maintain their relationships with children and family, and reluctance to seek support for fear of having children removed (Department of Health & Social Care, 2018[145]).

61. There is also evidence that experience of misdiagnosis may play a role in gendered differences in experiences and outcomes of mental healthcare. There is a concern that gender-related experiences and stereotypes may influence diagnosis. For example, studies from Germany and the United States suggest that older women are more likely to be diagnosed with depression than older men when presenting with the same symptoms (World Health Organization, 2002[149]). A recent Cochrane Review found that training may be positive for attitudes and that it can lead to improvements in identification, safety planning and documentation but may make little to no difference to referral practices (Kalra et al., 2021[150]).

62. Despite the findings above, results from a few countries' patient reported outcomes suggest positive and relatively equal experiences of generic mental healthcare for men and women. Mental healthcare users' perceptions of whether care providers treated them with courtesy and respect was high in both community-based and in inpatient care. Relative differences between women and men vary by country but are rather small, ranging mostly between -5% and 5%, except for inpatient care in Japan (-17%) where women report being less likely to be treated with courtesy and respect than men (Figure 3.4).

Figure 3.4. Most patients report being treated with courtesy and respect, regardless of their gender

Share of inpatient service users who were treated with courtesy and respect by care providers by gender, 2020-22



Note: Samples are not representative of service users in each country and vary largely in their size from < 100 observations for Korea to around 30 000 observations for Australia.
Source: OECD Health Statistics 2023

Stigma, lack of understanding and discrimination negatively influence LGBTIQ+ community experiences and outcomes of mental healthcare

63. While the evidence is inconclusive, some studies have shown that sexual minorities may access mental healthcare at a higher rate or more frequently than heterosexual individuals, which would be at least partially explained by their higher need (Platt, Wolf and Scheitle, 2018[151]; Filice and Meyer, 2018[152]; Baams, De Luca and Brownson, 2018[153]; Mental Health Research Canada, 2023[154]).

64. Negative experiences are commonly cited by people that identify as LGBTIQ+ which can feel unsafe or uncomfortable in mental healthcare settings because of stigma, lack of understanding and discriminatory attitudes (Medina-Martínez et al., 2021[11]; Rees, Crowe and Harris, 2021[155]; Ramsey et al., 2022[156]). For example, dealing with the healthcare staff assumptions of patients being cisgender and/or heterosexual (Medina-Martínez et al., 2021[11]) or feeling pathologised for their sexuality and left under-treated for their primary mental health problem (Rees, Crowe and Harris, 2021[155]). This creates or compounds a lack of confidence and trust in the health system.

65. Some data shows that there are treatment outcome inequities for bisexual and lesbian patients. For example, in England, those identifying as bisexual were less likely than heterosexual, gay or lesbian people to experience improvement in their condition and recover after NHS Talking Therapies (formerly IAPT program) and those identifying as gay or lesbian were less likely than heterosexual people to improve or recover from their condition after the same therapy (Baker and Kirk-Wade, 2023[157]). Furthermore, lesbian and bisexual women had higher final-session severity for depression, anxiety and functional impairment when compared to heterosexual women. Similarly, compared to heterosexual and gay men, bisexual men had higher final-session severity for depression, anxiety and functional impairment (Rimes et al., 2019[158]).

Lower access to appropriate care and with worse experiences for ethnic minorities and Indigenous populations

66. Most evidence suggests that certain ethnic groups or Indigenous populations are less likely to have been in contact with mental health services, and particularly when considering their higher treatment needs. Data from the Unites States suggest that differences in patterns of service use for different racial and ethnic groups are bigger than differences in their rate of mental health conditions (Substance Abuse and Mental Health Service Administration, 2015[159]). Specifically, Black and African American populations, Asian populations and Hispanic populations were less likely to use mental health services than White, Native American or Alaska Native populations, or people with 'Two or More Races' (Substance Abuse and Mental Health Service Administration, 2015[159]; OECD, 2021[3]). One other study reported non-Hispanic White adults were more likely than non-Hispanic Black, Hispanic and non-Hispanic Asian adults to have received any treatment (Terlizzi and Norris, 2021[136]). In the United Kingdom, people in the Black ethnic group had particularly low treatment rates (McManus et al., 2016[47]).

67. Some minority groups may be more likely to take different pathways to treatment. For example, in the United Kingdom, people from Black-African and Caribbean communities are 40% more likely than White-British people to come into contact with mental health services through the criminal justice system (UK Government, 2018[160]). Roma and traveller communities can have similar difficulties to those who are homeless (i.e., their living status makes it more difficult to access mental healthcare (UK Government, 2018[160]; NHS, 2020[161]).

68. In New Zealand, findings show that Māori have higher prevalence of mental health problems, but these are often underdiagnosed (Cunningham, Kvalsvig and Peterson, 2018[79]). In secondary care, Māori are more likely to be admitted to hospital, to be readmitted after discharge, to be secluded during admission, and to be compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and in forensic services (Cunningham, Kvalsvig and Peterson, 2018[79]). The outcomes for Māori who access mental health services are poorer across a variety of measures and diagnoses (Cunningham, Kvalsvig and Peterson, 2018[79]). Within Indigenous populations, particular groups might be in more vulnerable circumstances. Interviews with Māori mothers highlighted a fear of stigma and discrimination; lack of cultural competency from health professionals; and feeling isolated in non-Māori (White New Zealander)-centric support groups and services (Office of the Health and Disability Commissioner, 2020[162]).

69. There is also evidence that ethnic minorities may be more likely to delay or not seek treatment in OECD countries. In England, many Black-African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their mental health condition (UK Government, 2018[160]). Black and minority ethnic patients are less likely to rate their overall experience as high compared to White-British patients (44 versus 49%) (Care Quality Commission, 2018[163]). Despite some improvements, the recovery rate for Black and minority ethnic users of NHS Talking Therapies (formerly IAPT program) is below that of White-British users (NHS, 2020[161]; Public Health England, n.d.[164]), and persistent disparities in outcomes of IAPT have also been reported for Black, Asian and non-British White people compared to the British White group (National Collaborating Centre for Mental Health, 2023[165]; Health and Social Care Committee, 2021[166]).

Patterns in access to and experiences of care by migration status depend on the country of origin, country of residence and duration of stay

70. In some countries foreign-born populations seem to access mental health services at lower rates than natives. A systematic review for the United States found that immigrants from Asia, Latin America

and Africa used services at lower rates than non-immigrants, despite an equal or greater need (Derr, 2016[167]). This underutilisation may be explained by cultural, language and affordability barriers as well as a lack of awareness or understanding on how to access mental healthcare (Pollard and Howard, 2021[168]; Kang, Tomkow and Farrington, 2019[169]; Satinsky et al., 2019[170]). In the United Kingdom, availability and quality of language interpretation services is inconsistent across the country (Pollard and Howard, 2021[168]) and accessible mental healthcare relies on both patient and service provider being able to express themselves clearly. However, duration of stay may matter: in the United Kingdom, foreign-born residing in the country for less than 10 years were less likely to use psychological treatment than natives, after adjustment for probable sociodemographic predictors of need, life adversity, and physical/psychiatric morbidity at baseline) (Bhavsar et al., 2021[171]). Similarly, a Swedish study found lower use of psychiatric care during the first decade, in contrast with higher use among migrants with a longer duration of stay (Hollander et al., 2020[172]). In Australia in 2011, the proportion of people accessing mental health-related services varied from 7.5% among those born overseas who spoke English at home to respectively 6% and 5.6% for those born in Australia and born overseas who spoke a language other than English at home (Mental Health Services - Census Data Integration Project, 2011[173]).

71. OECD estimates based on self-reported consultations with a psychologist, psychotherapist or psychiatrist in the past year suggest a country split in terms of access to mental healthcare: in about 14 of the countries native-born individuals report having used more consultations with a psychologist, psychotherapist or psychiatrist while in other 11 these were more frequently used by foreign-born (Slovak Republic, Ireland, United Kingdom, Croatia, Netherlands, Finland, Denmark, Slovenia, Iceland, Germany, Lithuania). Relative differences between the countries are below a third in most cases, with exception of Slovak Republic, Poland, Hungary, Estonia, Greece and United States. Self-reported unmet need for care due to affordability is either balanced or slightly higher for foreign-born individuals in most countries, with just a few countries where this difference is larger (Slovak Republic, Germany, Sweden, Bulgaria, Iceland, Finland, Denmark) and two exceptions in which native-born populations report higher unmet needs (Croatia and United States). Importantly, ensuring the representativeness of foreign-born samples is challenging in general (health) surveys, potentially leading to overestimation of care use in these results.

72. For some groups of migrants, such as refugees and asylum seekers, literature points more consistently at underutilisation of mental health support. This underutilisation may be explained by cultural-specific barriers which need to be addressed to increase treatment demand, as well as barriers associated with language, lack of awareness, stigma and negative attitudes towards and by providers. A British qualitative study found that confusion over National Health Service structures and how to access healthcare or arrange appointments were barriers to primary healthcare (Kang, Tomkow and Farrington, 2019[169]; Pollard and Howard, 2021[168]). A Scottish study found that uncertainty and lack of trust in service providers reduced mental healthcare seeking (Quinn, 2014[174]).

73. The evidence on satisfaction for foreign-born individuals with mental healthcare is mixed. Despite scarce information about subjective satisfaction specifically with mental healthcare, United States data on perceptions of general health services suggest that Asian-Americans are less satisfied with their medical care than their European-American counterparts (Abe-Kim et al., 2007[175]). Some qualitative studies indicate that non-European immigrants to Canada are frequently dissatisfied with formal mental health services, perceiving these services to be overly impersonal and medication-focused (Islam and Oremus, 2014[176]). Nonetheless, some studies have suggested that immigrants can be more satisfied with mental healthcare than non-immigrant counterparts. A Canadian study found that immigrants (as a whole) reported a lower frequency of healthcare services utilisation but higher health services satisfaction scores than non-immigrants. Most immigrants in this study had lived in Canada for over 10 years, with a mean duration of residence of 20 years (Whitley, Kirmayer and Groleau, 2006[177]). This is despite several reported barriers to positive experiences and outcomes for foreign-born, including communication difficulties. For example, in the United Kingdom, availability and quality of interpretation services is inconsistent across the country and health-worker training in working with interpreters is necessary (Pollard

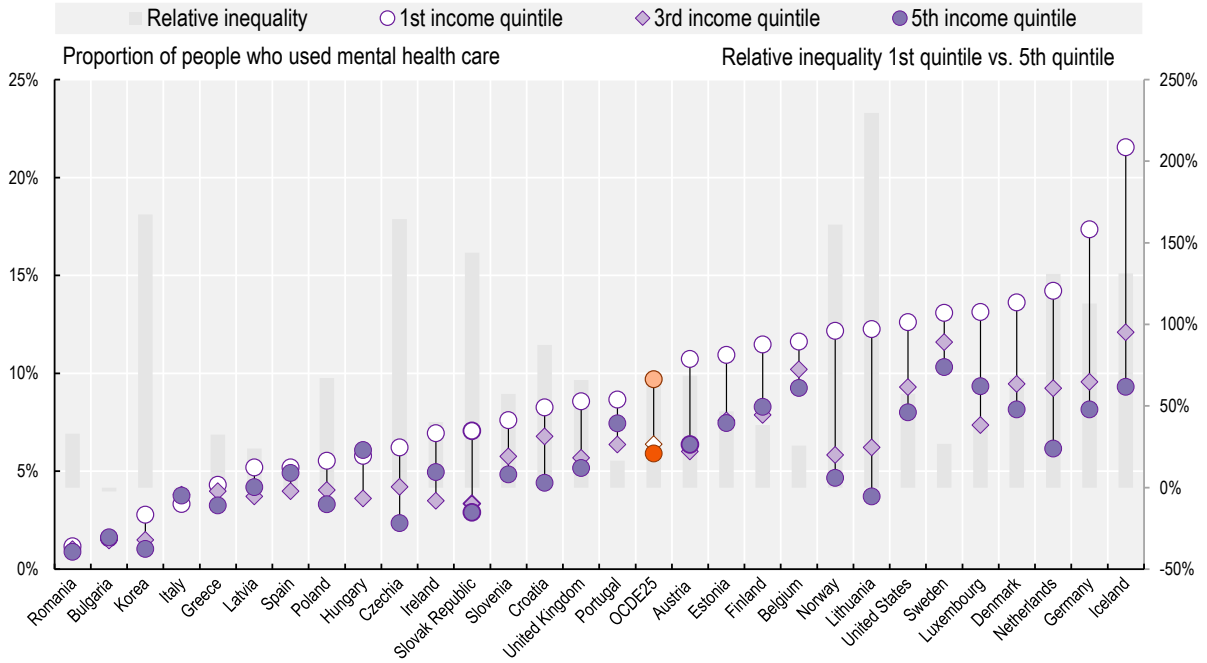
and Howard, 2021[168]). Mental healthcare involves expressing complex emotions and doing this in an unfamiliar language is challenging (Majumder, 2019[178]).

Inequalities in access, experiences and outcomes of care are harmful to people in low socio-economic status

74. In two-thirds of the countries studied, Figure 3.5 shows a higher likelihood of self-reported access to mental healthcare consultations for people with the lowest income, compared to those with the highest (two or three-fold higher in 60% of the countries; no adjustment for need). Considering other parts of the income distribution, Figure 3.5 also shows that the likelihood of accessing care for people in the 3rd income quintile is closer or even similar to people in the 5th (highest) quintile.

Figure 3.5. In two-thirds of OECD countries people from lower-income households report more use of mental healthcare consultations

Proportion of people who had a consultation with a psychologist, psychotherapist or psychiatrist in the past 12 months



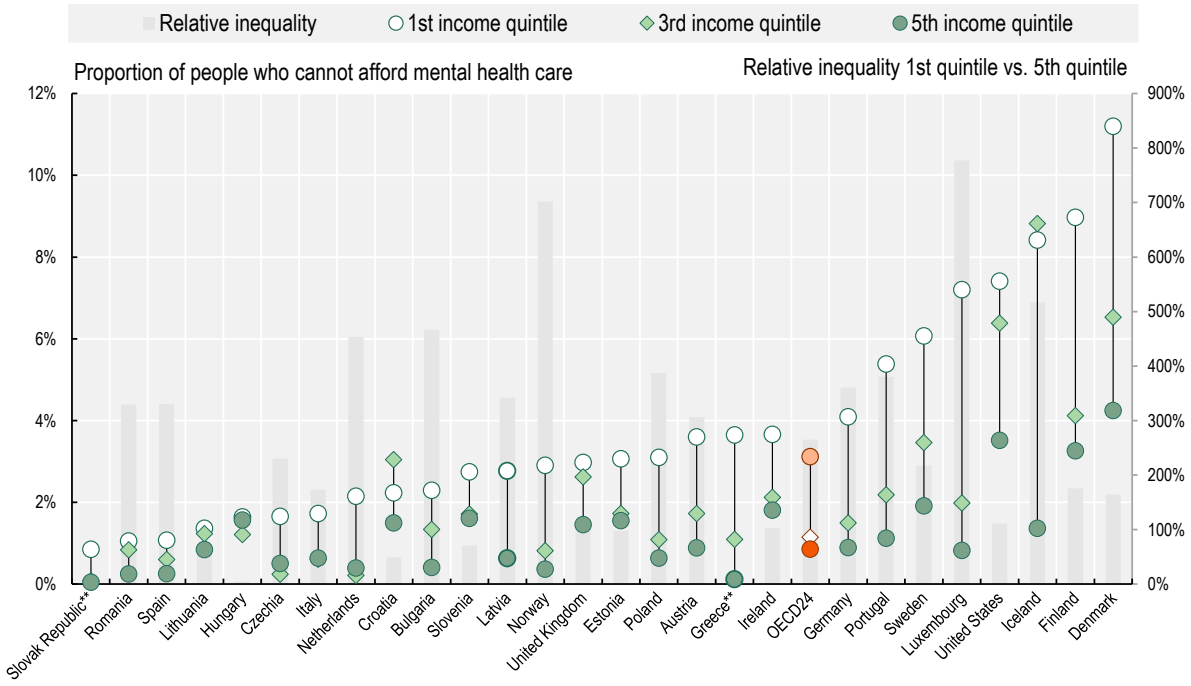
Note: Results were estimated using survey weights and are not standardised. Countries are displayed by increasing use of mental healthcare for the 1st income quintile and not ranked by absolute (difference between dots) or relative inequality (grey columns, see Box 2.1). The OECD25 average excludes Bulgaria, Croatia and Romania.
Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey (2018-2020), National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea.

75. Despite higher access to mental healthcare consultations, individuals in lower income groups still report higher treatment unmet need due to affordability issues in most countries studied (Figure 3.6). Unmet need among the lowest income group is more than three-fold higher than for the highest income group more than half of the countries for which data is available, often because of very low unmet need for the latter group (Figure 3.6). Differences by educational status are less salient and consistent but support a similar conclusion of higher unmet need among those with lowest education. On average for the 25 OECD countries studied those with lower education are more likely to access mental healthcare

consultations by 64% but also more likely to report unmet needs for mental healthcare due to lack of affordability, by 10% (absolute rates of unmet needs around 2%). Importantly, estimates suggesting higher access to mental healthcare by those in low socio-economic status do not account for the higher treatment need of these groups, which have higher prevalence of mental health conditions as described in Chapter 2. Accounting for the different levels of mental health in the different income groups might attenuate or even revert this pattern, showing that conditionally on their need low-income people access mental health care the least.

Figure 3.6. People from lower-income households report higher unmet needs for mental healthcare that they cannot afford

Not being able to afford care by a psychologist, psychotherapist or a psychiatrist in the past 12 months



Note: The Figure presents both absolute (dots) and relative (grey columns) inequalities - see Box 2.1 for the definitions. Results were estimated using survey weights and are not standardised. The OECD24 average excludes Bulgaria, Croatia and Romania. Countries are displayed by increasing prevalence of unmet need for the 1st quintile. **Relative inequality not represented for Slovak Republic and Greece due to very high numbers.

Source: OECD estimates based on the 3rd wave of the Eurostat European Health Interview Survey, National Health Interview Survey (NHIS) 2019 for the United States and Korea Community Health Survey 2019 for Korea.

76. Unfavourable patterns in access to care for those less well-off are confirmed by available literature for several OECD countries. In England, those living in lower-income households are more likely to have requested but not received a particular mental health treatment (McManus et al., 2016[47]). In Australia, an evaluation of a publicly-funded program to expand access to mental healthcare found that the program had increased access, but people living in major cities in lower socio-economic status areas and in regional areas experienced relatively lower (or sometimes negative) growth in rates of uptake and utilisation compared to their counterparts living in higher status and/or urban areas (Pirkis et al., 2022[179]). Those on the lowest incomes are least likely to access services. For example, in 2021, 5.1% of those in the lowest socio-economic quintile used the treatment services compared with 6.6% in the highest quintile (Pirkis et al., 2022[179]). In the same year, only 56.5% of those in the lowest quintile proceeded to treatment from a plan compared with 69.3% of their high-income counterparts (Pirkis et al., 2022[179]). The wait times

to treatment for those who did progress from a plan to treatment were also longer for those in the lowest income quintile; their median wait time was 22 days whereas the median wait time for those in the highest quintile was 17 days (Pirkis et al., 2022[179]).

77. Experience and treatment outcomes are worse for low-income groups. In England, people with common mental disorders in lower income households were more likely to have an unmet treatment request than those living in higher income households (8%of those in the lowest income tertile vs 4.2% in the highest income tercile reported requesting but not getting a particular mental health treatment in the past year) (McManus et al., 2016[47]). Further, people living in more deprived areas may be less likely to experience improvement or recovery after treatment than those living in less deprived areas, even though referrals to mental health services may be higher in more deprived areas (McManus et al., 2016[47]; Baker and Kirk-Wade, 2023[157]).

4 Closing inequalities in mental health status

78. In responding to the OECD questionnaire, countries provided an overview of their current policy-landscape to address mental health inequalities, including how it has been shaped by the impact and learnings of the COVID-19 crisis. While not all countries have dedicated mental health policies to address inequalities, most countries conduct promotion and prevention efforts focusing on key population groups, or people in vulnerable circumstances. A small number of countries are concerned with implementing strategies that address multiple disadvantages and evaluating the impact in reducing inequalities of the policies and strategies implemented.

Most countries have policies in place to address mental health inequalities, but better data and evaluations are needed

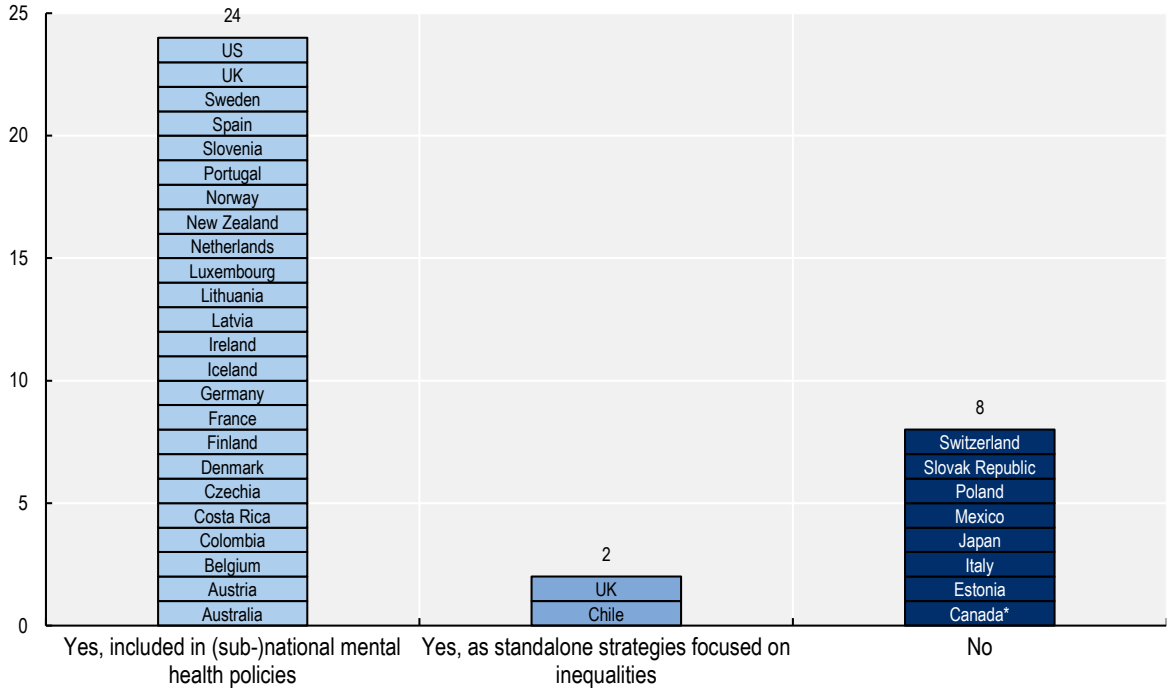
79. Most OECD countries have policies and strategies to address inequalities in mental health, mostly as part of national or subnational mental health policy. Three-quarters of OECD countries have implemented strategies to address inequalities (Figure 4.1)[2]. Substantial efforts focus on inequalities by socio-economic status and gender, which are addressed in 78% and 70% of countries with policies or strategies, respectively. Inequalities addressed to a lesser extent are those by migration status (59%), ethnicity and/or indigeneity (48%) and LGTBQI+ (48%) (Figure 4.2).

80. Few OECD countries have standalone strategies dedicated to the topic of mental health inequalities; most countries cover inequalities as part of broader mental health policies and strategies. Exceptions include the Advancing Mental Health Equalities strategy in England, which outlines specific actions to be implemented by NHS England and NHS Improvement, to address disparities in mental health services, particularly for communities experiencing greater challenges. Derived from the NHS Mental Health Implementation Plan 2019/20-2023/24, this strategy is rooted in the broader ambitions of the NHS Long Term Plan for mental health and sets the expectation that all systems need to reduce mental health inequalities by 2023/24. Meanwhile, in Scotland, the Mental Health and Wellbeing Delivery Plan 2023-2025 dedicates a considerable part of its strategies to addressing inequalities for key population groups, outlining a comprehensive approach to tackling disparities in mental health services even though the plan covers mental health policy more broadly (OECD, 2023[180]).

[2] A total of 37 OECD countries responded to the OECD Mental Health Questionnaire and to this question. Non-response was occasionally registered, resulting in a total number of respondents per question that ranges between 31 and 37 countries.

Figure 4.1. Most countries have mental health policies or strategies aimed at tackling inequalities in mental health

"Does your country have a national or sub-national mental health policy or strategy aimed at tackling inequalities in mental health status?" Number of countries responding in each category

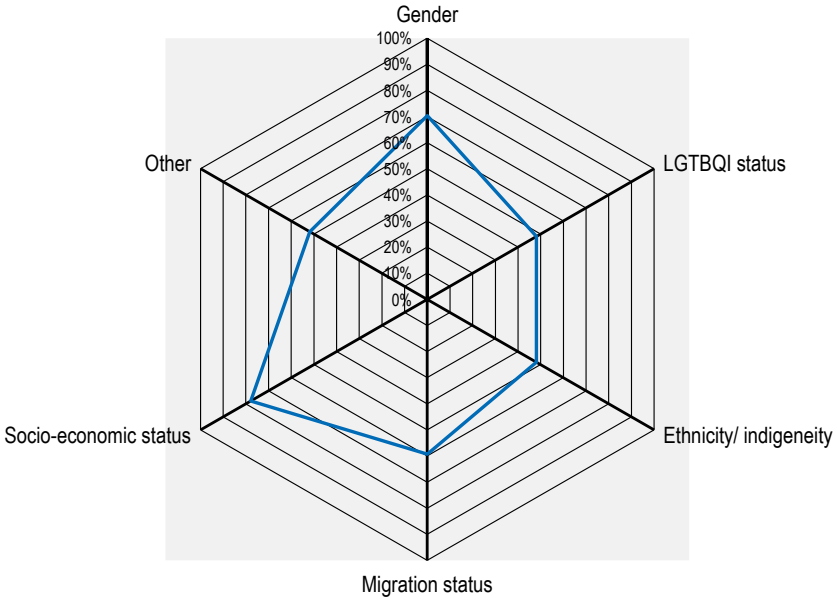


Note: 37 countries responded. Greece, Hungary, Israel, and Korea are not represented in the figure as they answered affirmatively but did not specify whether their mental health strategy was part of other policies or a standalone piece. Countries that responded affirmatively might have selected several options and be represented in the figure more than once.
* Only pertains to the national, federal Government of Canada and does not encompass the provinces and territories.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

81. Addressing multiple disadvantages is also prioritised and just over half of OECD countries reported having policies or programmes that focus people who face multiple inequalities. Canada, as part of the culturally focused program Promoting Health Equity: Mental Health of Black Canadians Fund, a project focusing on Black LGBTIQ+ Canadians, has developed a virtual bilingual training to increase mental health professionals' understanding of the needs of Black communities and anti-racist mental healthcare (OECD, 2023[180]). Slovenia has tailored measures for the Roma population through its National Programme of Measures for Roma (2021-2030), which aims to address social exclusion and poverty within the Roma community. Acknowledging the mental health challenges they face, the strategy aims to increase the trust of the Roma community in healthcare institutions and improve accessibility of healthcare services within their living environments (Government of the Republic of Slovenia, 2021[181]). France and Spain have initiatives focusing on individuals in prison. In France, strategies involve conducting national studies on their mental health and care pathways from incarceration to release, enhancing mental healthcare pathways through the development of penitentiary outpatient services and specialised hospital units, and establishing exit support structures to ensure continuity of care (Ministère de la Justice and Ministère des Solidarités et de la Santé, 2019[182]).

Figure 4.2. Inequalities by socio-economic status and gender are the most addressed by mental health policy

"If yes, which inequality does it aim to address?" Proportion of countries whose policies address inequalities in each category



Note: Based on the 27 countries responding affirmatively in Figure 4.1. No details on key population groups provided by Israel.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

82. Programmes to tackle mental health inequalities are rarely evaluated. Despite commonly implementing policies to address mental health inequalities, only just over 30% of OECD countries have conducted evaluations that would identify effective interventions in reducing the gaps. In most countries epidemiological research is also not consistent enough to support or surveillance and monitoring activity that would provide the basis for planning, implementation and evaluation of interventions. A few countries promote initiatives or resources aimed at systematically supporting evidence-based practice. In Germany, projects and practices aimed at reducing health inequalities can be documented and reviewed in a database (*gesundheitliche-chancengleichheit.de*). Currently, the database lists 793 projects in the mental health domain. Initiatives implemented in 2023 predominantly addressed the needs of older people, children, pregnant women, and homeless individuals. Similarly, the Netherlands maintains a digital database of recognised lifestyle interventions (*Loketgezondleven.nl*), including those focusing on the mental health of certain groups, such as children and young people, older people, and low socio-economic status individuals. Interventions can apply to be recognised and are classified and organised according to their level of effectiveness and evidence, including through graphical representation. The Advancing Mental Health Equity (AMHE) resource, developed by the United Kingdom National Collaborating Centre for Mental Health (NCCMH) provides detailed guidance and methods to identify and reduce inequalities related to mental health support, care and treatment. The resource outlines practical steps to improve mental health equality at the local level, including supporting information on positive practice examples ongoing in several organisations (OECD, 2023[180]).

83. To close gaps in mental health outcomes, countries must also strengthen data surveillance systems that allow expanded monitoring and inform action on social determinants of health. Evidence from England shows that combining housing, socio-economic, and environmental indicators can reveal stark disparities in mental health outcomes and support action (Symonds et al., 2024[183]). In Canada, the Public Health Agency developed a national Positive Mental Health Surveillance Indicator Framework to monitor both outcomes and determinants of mental well-being across the four domains: individual, family,

community, and societal (Orpana et al., 2016[184]). International guidance calls for countries to routinely collect and report core mental health indicators through health and social informant systems, enabling governments to track trends and evaluate the impact of intervention (Peitz et al., 2021[185]). Embedding mental well-being metrics alongside other social outcomes ensures that policymakers can identify emerging issues early and coordinate across sectors.

Addressing mental health inequalities requires acting on social determinants and better promoting good mental health and preventing mental-ill health

84. Addressing social determinants of mental health should be a core element of strategies to reduce mental health inequalities. Mental health is influenced by a range of social, economic, and environmental determinants including education, housing, income, employment, childcare and early childhood development (see chapter 2). Integrated and cross-sectoral policies that aim to improve these determinants while simultaneously addressing mental health have a great potential to reduce the gaps. Violence, discrimination, and stigma are also risk factors towards mental-ill health, usually cumulative to the social determinants described above, or experienced to greater extent by minorities based on their ethnicity, indigeneity, gender or sexual orientation. Rather than just mitigate their effects policy aiming at narrowing mental health inequalities should also aim at reducing violence, discrimination and stigma themselves, acting at the origin of the problem.

85. Evidence from the COVID-19 crisis suggests that an important strategy to limit the mental health impact of the pandemic resulted from the combination of actions addressing social determinants (e.g. employment programs or youth education programs aimed at increasing enrolment) with access to care (e.g. increased community-based specialist mental health services; coordination of multidisciplinary and measurement based care enabled through technology; and post-suicide attempt assertive aftercare) (Atkinson et al., 2020[186]) Programmes aiming at keeping people employed such as JobKeeper were effective strategies for mitigating the adverse mental health impacts during the early stages of the pandemic (Atkinson et al., 2020[186]). The *Pacte des Solidarités* in France aims to combat poverty by focusing on social investment, employment, rights access and fostering solidarity amidst ecological transition. It supports youth (aged 16-25) in precarious situations towards autonomy, including funding for mental health actions under local solidarity contracts (Ministère du Travail de la Santé et des Solidarités, 2023[187]).

86. Promotion of good mental health and prevention of mental ill-health strategies with a specific focus on groups at higher risk are currently in place for more than 90% of OECD countries (Table 4.1). Among the groups, a significant emphasis is placed on children and young people, targeted by 78% of the countries, women affected by gender-based violence (63%), pregnant women and/or new mothers (59%), and older people (56%). LGBTIQ+ groups (44%), refugees (41%), immigrants (38%), unemployed people (34%) and homeless people (34%) would be focused in about one third of the countries with promotion and prevention policies. Fewer countries reported having policies in place to support the mental health of people experiencing financial insecurities (28%), ethnic groups (25%) and Indigenous populations (25%), a finding that contrasts with the disproportionately high rates of mental ill-health and suicidality outlined earlier in this chapter for these groups.

Table 4.1. Groups covered in specific policies or strategies to promote good mental health and/or prevent mental ill-health

Country	Pregnant and/or new mothers	Gender-based violence[1]	LGBTIQ+	Ethnic minorities	Indigenous populations	Immigrants	Refugees	Financial insecurity	Unemployed	Children & young people[2]	Older people[3]	Homeless people	Other
Australia	√	√	√	√	√	√	√			√			√
Austria	√	√	√	√		√		√	√	√	√	√	
Belgium						√		√	√	√	√	√	√
Canada		√	√		√	√	√			√			
Chile	√		√		√					√	√		
Colombia		√		√	√								
Czechia	√									√	√		
Estonia	√	√					√	√	√	√	√		
Finland		√				√	√					√	√
France	√					√	√	√	√	√	√	√	√
Germany	√		√							√	√		√
Hungary							√						
Iceland	√	√	√						√	√	√		√
Ireland		√	√	√	√	√	√					√	
Italy										√			
Japan	√									√[4]			
Korea	√	√							√	√			
Latvia													√
Lithuania	√	√								√	√		√
Luxembourg	√	√	√			√	√			√	√	√	
Mexico		√											
Netherlands	√		√			√		√		√	√		√
New Zealand	√	√	√	√	√			√	√	√		√	√

Country	Pregnant and/or new mothers	Gender-based violence[1]	LGBTIQ+	Ethnic minorities	Indigenous populations	Immigrants	Refugees	Financial insecurity	Unemployed	Children & young people[2]	Older people[3]	Homeless people	Other
Norway	√	√	√							√	√	√	
Slovak Republic	√	√								√	√	√	√
Slovenia				√									
Spain		√						√		√			√
Sweden			√	√	√	√	√		√	√	√		√
Switzerland							√			√	√		
United Kingdom								√	√				√
United States	√	√	√	√	√	√	√	√	√	√	√	√	

Note: 1. Women affected by gender-based violence; 2. Ages up to 24; 3. Ages over 65; 4. Ages up to 18. Source: OECD Country Questionnaire Mental Health: Inequalities and Digital (2023).

87. Early intervention and prevention programmes to promote child mental health and well-being can support better long-term mental, physical, and social outcomes (Regan, Elliott and Goldie, 2016[188]). Mental health coaching programmes for young people have been adopted by several countries. For example, Germany's *Mental Health Coaches* prevention programme provides young people with a space for information exchange and discussions on mental health, and Lithuania's Mental Health Ambassador programme (*Žvelk giliau*) employs ambassadors who share their experiences to change attitudes and promote positive behaviour towards mental health disorders. While the body of research on mental health coaching is small and further evaluation is necessary, the overall findings indicate that universal coaching interventions have a positive impact on mental health outcomes and promote well-being (OECD, 2015[189]; Bishop, Hemingway and Crabtree, 2018[190]; Bleck et al., 2023[191]; Bora et al., 2010[192]).

88. For pregnant women and/or new mothers both professional and lay psychological and psychosocial interventions have proven effective in reducing the likelihood of post-partum depression. Promising interventions include the provision of intensive, individualised postpartum home visits by public health nurses or midwives, peer-based telephone support and interpersonal psychotherapy (Dennis and Dowswell, 2013[193]). In Chile, a programme to support transgender and gender non-conforming adolescents (*Acompañamiento para niños, niñas y adolescentes trans y genero* no conforme) has been designed to enhance the overall health and well-being, psychological well-being, and personal fulfilment of transgender and gender non-conforming children, adolescents, and young adults. In Greece, efforts to foster a more inclusive and supportive environment for the LGBTIQ+ community has led to policies that include the prohibition of conversion practices for minors and individuals under legal custody (Law 4391/2022), establishment of a helpline for LGBTIQ+ psychological support, and development of two residential services offering short-stay accommodations and psychosocial assistance (OECD, 2023[180]).

89. Promotion of good mental health and prevention of mental ill-health has gained particular attention since the COVID-19 pandemic, when 94% respondent countries either expanded or introduced new measures. While one-third of the countries implemented generic measures for the general population, heightened risks of mental ill-health for some population groups were directly targeted by the other two-thirds, which directed their measures at general population and key population groups simultaneously. Children and young people, and older people were most often targeted. Belgium implemented initiatives centred around early detection and prevention, aligning with mental healthcare reforms initiated in 2010. The budget for these initiatives was stratified across the country, which considered local vulnerabilities such as socio-economic level, population size and prevalence. In France, a national information campaign for children and youth included dedicated helplines and online chats, social media awareness campaigns and access to free psychological consultations. With a focus on prevention, Iceland incorporated mental health screening into routine outpatient appointments for COVID-19 patients (OECD, 2023[180]).

90. Australia responded to the unequal distribution of mental health challenges arising with the COVID-19 pandemic through a range of initiatives. The National Mental Health and Wellbeing Pandemic Response Plan, established on May 15, 2020, specifically targeted the unique mental health challenges arising from the pandemic. In addition to this, efforts included expanding access to mental health services for older individuals and refugees, funding digital and telephone counselling services, and supporting young Australians through programmes like headspace (ref). Moreover, tailored support was extended to First Nations peoples, frontline health workers, and new or expecting parents, ensuring access to culturally appropriate resources and mental health services aligned with their specific needs. Portugal implemented a measure that provided temporary regular status to migrants who had initiated the regularisation process. This facilitated access to social services, including mental healthcare. Like Australia, the UK's COVID-19 Mental Health and Well-being Recovery Action Plan (2021-2022) included actions focusing on specific groups and social determinants of mental health. Measures included initiatives like *Student Space* for students' mental health, respite rooms for women facing violence and abuse, a furlough scheme to assist employers and support for local councils to continue day services (OECD, 2023[180]). Strategies

implemented during the pandemic to address the unequal vulnerability to mental-ill health provide important lessons to be adopted in other times of crisis, as proven by the Slovenian example (Box 4.1)

Box 4.1. Slovenia's psychological support for vulnerable population groups in emergencies

In October 2020, an Operational Group for the implementation of psychologic support during the pandemic was established by Slovenia's NIJZ and MoH, comprising of 39 stakeholders (public institutions, ministries, and NGOs). The group developed an action plan to foster collaboration and coordination among stakeholders providing psychological support, aiming to enhance efficiency and outreach, and to identify the needs of vulnerable population groups. NGOs played a crucial role in identifying groups in vulnerable circumstances overtime, due to their direct contact with the population. Groups identified as requiring dedicated attention included children and young people, older people, LGBTI+ community, people subject to violence or domestic abuse, single mothers, individuals facing multiple inequalities (e.g., unemployment, poverty, disability), immigrants, and homeless people. Some of the interventions implemented are described in Table 4.2.

Table 4.2. Similarities between crisis support models in Slovenia

Psychological support model during the pandemic	Psychosocial support model in flood affected areas
Bi-monthly collection and reporting of information on the needs of vulnerable groups, obstacles to assistance, and proposals for action by participating NGOs.	Needs of vulnerable individuals identified by mobile teams providing psychological support in the field, through coordinated action with civil protection, NGOs, and social workers. Bi-monthly meetings to ensure timely implementation of activities addressing the needs identified.
24/7 free telephone support service for psychological assistance. Weekly reports on call content used to prepare guidelines/materials to support counsellors in addressing issues such as domestic and intimate partner violence, child abuse, and psychological trauma due to the pandemic.	Psychological support telephone helpline established by the Slovenian Psychologist's Association. Additionally, the call centre 114 offered advice to affected individuals and aid in accessing flood relief procedures.
Training in psychological first aid provided to mental health coordinators at NIJZ, teachers, and parents. Dissemination of materials to support loss (e.g., informing children about a loved one's death and addressing loss and mourning during the pandemic).	Training provided to school staff on supporting pupils in crisis and disaster situations. Dissemination of materials online and to affected local communities and schools on first aid for mental distress in floods, and mourning loss in natural disasters.
Creation of a team of psychologists to provide psychological support to employees in critical infrastructures (NGOs, social welfare institutions).	Supervision meetings to support providers of psychosocial assistance in the mobile teams.

The experience with the Operational Group in place during COVID-19 served as a foundation in the development of the psychosocial support plan for the municipalities affected by the flood crisis in August 2023. A Coordination Committee was again set up by the NIJZ and MoH and periodically reviewed the needs in the affected areas and coordinated the activities carried out by the institutions involved in the response, subject to with the agreement of stakeholders at the regional level. While part of the interventions adopted were informed by the COVID-19 experience (Table 4.2) a comprehensive, tiered approach was used to structure the psychosocial services. The four tiers of the approach ranged from 1) immediate practical support addressing risk factors for poor mental health in the population affected (e.g. safe alternative living arrangements and financial assistance) to 2) community support promoting protective factors (e.g. activities to promote social inclusion and intergenerational integration) and to 3)

targeted non-specialist (relief talk and counselling by multidisciplinary teams) and 4) specialist support (for individuals with mental disorders, facilitating their care integration during the crisis).

As per the different nature of the crisis, population groups receiving particular attention did also differ, as well as the NGOs involved in the Coordination Group, which were mostly humanitarian (e.g. Caritas). These were key to provide support door-to-door, and to identify groups at higher risk such as individuals with previous mental health conditions or people living in poverty and isolation, as well as the exacerbation of behavioural problems such as alcohol use.

Note: CDZO: Adult Mental Health Centre; NIJZ: National Institute of Public Health; MoH: Ministry of Health, NGOs – Non-governmental organisations.
Source: Interview to NIJZ and materials provided as a follow-up.

91. Policies to promote good mental health and prevent mental-ill health are often designed or implemented outside of the healthcare system boundary, in schools or workplaces (OECD, 2018[16]). School-based interventions have demonstrated beneficial improvements in mental health among students (Werner-Seidler et al., 2021[194]; Zhang, Wang and Neitzel, 2023[195]), including those from population groups such as LGBTQ+, ethnic minorities, and low-income backgrounds (Schlief et al., 2023[196]; Fung et al., 2019[197]; Cardemil et al., 2007[198]). Both universal and targeted interventions have proved effective in several circumstances (Werner-Seidler et al., 2021[194]), from the use of cognitive behavioural therapy (CBT) for youth mental health promotion and prevention (Kuosmanen, Clarke and Barry, 2019[199]) to "job-club" interventions for the unemployed —structured group sessions providing job-seeking skills and social support', with effects on depressive symptoms and emotional functioning (Moore et al., 2017[200]; McGrath et al., 2021[201]).

92. Whether scaling up generic promotion and prevention measures to all the population or tailoring these to groups at higher risk is a more effective approach to closing inequalities may depend on the country and the group in question. The findings of direct comparisons between universal and targeted promotion and prevention approaches are mixed and context dependent. In multiple country settings, the CBT-based anxiety programme FRIENDS has demonstrated effectiveness in reducing anxiety symptoms in both targeted and universal formats (Kuosmanen, Clarke and Barry, 2019[199]). However, the CBT-based Penn Resiliency Program for preventing depression was effective in reducing depression symptoms when targeted to early adolescent girls in schools, but not when implemented universally in classroom-based programmes in the Netherlands and the United Kingdom (Kuosmanen, Clarke and Barry, 2019[199]). In preventing poor mental health in young people, Salazar et al. observed that universal interventions were superior in tackling interpersonal violence, while selective interventions were more effective for addressing general psychological distress (Salazar De Pablo et al., 2021[202]).

93. Despite ongoing debates on universal versus selective prevention measures, many studies emphasize the benefits of multilevel programmes that integrate universal, selective, and indicated approaches. Among suicide-related interventions in Indigenous populations, multilevel programmes were more effective for reducing suicide attempts (Leske et al., 2020[203]). Multilevel prevention approaches that begin with universal strategies and advance to targeted approaches have also proven effective in reaching immigrant-origin youth (Arora et al., 2021[204]), for suicide prevention in older adults (Sakashita and Oyama, 2022[205]), prevention in students with disabilities (McMillan and Jarvis, 2013[206]) and parenting support aimed at promoting the well-being of children and families (Sanders, 2023[207]).

94. Addressing workplace-specific barriers faced by those with at higher risk of mental-ill health conditions is essential to prevent inequalities. Workplace stigma, lack of paid sick leave, and the underutilization of support programs such as Employee Assistance Programs (EAPs) create challenges to receiving timely mental health support (Hogg et al., 2023[208]; Asfaw, 2024[209]). Policymakers and employers can take evidence-based actions to tackle these barriers at the occupational level. Anti-stigma campaigns and training can foster a culture where seeking support is accepted and encouraged, which

leads to higher rates of help-seeking. Expanding access to paid sick leave, including time off for mental health reasons, can particularly benefit lower-income workers and help reduce stress-related disparities (Hogg et al., 2023[208]; Stoddard-Dare et al., 2018[210]). Improving how EAPs and other support mechanisms are designed and communicated can increase employee uptake and ensure that more workers access the care they need at early phases (Abdul Aziz and Ong, 2025[211]; Moore et al., 2017[200]).

95. There are also life circumstances that require dedicated support to some groups in well-defined temporal windows, either due to critical junctures across the life course or to exposure to challenging events (e.g. bereavement, job loss, intense caregiving, among others). In the domain of maternal health antenatal interventions targeting vulnerable pregnant women led to a decrease in maternal distress, unlike universal approaches covering all pregnant women which proved ineffective in comparison (Fontein-Kuipers et al., 2014[212]). To support (groups of) people that have been exposed to critical events and prevent the deterioration of their mental health, Lithuania has developed a psychological crisis management service that operates nationally and provides support in the field (Box 4.2).

Box 4.2. Psychological support in moments of crisis and critical junctures of the life course in Lithuania

From the recognition that individual mental health can be particularly vulnerable at critical junctures of the life course, including those created by unexpected events, Lithuania has developed a psychological crisis management service that combines a call centre and mobile teams to provide early intervention and prevent mental health deterioration following a crisis event.

According to the Act- V1163, three *Mobile Psychological Crisis Management Teams* have been available since 2021 to provide state-funded support to institutions (schools, businesses, organisations, etc.), communities, and families or groups of people (2 or more) that are affected by crisis events. Crisis events include acute mental states, violent and unexpected deaths, suicides or attempts to, crimes and traffic accidents. Support has also been provided to people affected by mass lay-offs, geopolitical crises and events that receive high negative attention of society and media.

Services are state-funded and can be activated through the short toll-free number 1815, linked to the *Psychological Crisis Incidents Call Center* that manages the mobile teams. The teams include psychologists with experience in the field of crisis management and provide group and/or individual consultations, psychoeducation, management and communication support to control the crisis situation and inform the community and media about what occurred. These interventions aim at supporting a better understanding and normalisation of feelings during a crisis, the identification of mental health risks and behaviours that can reduce them and informing people how to maintain good care of their psychological state. The support is mostly provided locally throughout the Lithuanian territory, or in certain instances remotely.

In 2022-23 the call centre received 2059 calls and mobile teams provided services in 152 events, to 2676 people, a considerable part of which is related to suicide or attempted suicide of a relative or colleague (39% of the cases in 2023).

Source: Interview to stakeholders in the Institute of Hygiene and Minister of Health and follow-up materials.

5 Closing inequalities in access to and experiences and outcomes of mental healthcare

96. Increasing access to mental health care has been a priority for many OECD countries, with dedicated attention to key population groups and people in vulnerable circumstances. Efforts have focused on increasing coverage and decreasing financial barriers, but also increasing the availability of particular therapeutic approaches, such as talking therapies. Improving outreach and responsiveness of services is also a strategy followed to increase access by harder to reach groups, potentially also contributing to improving their experiences with care.

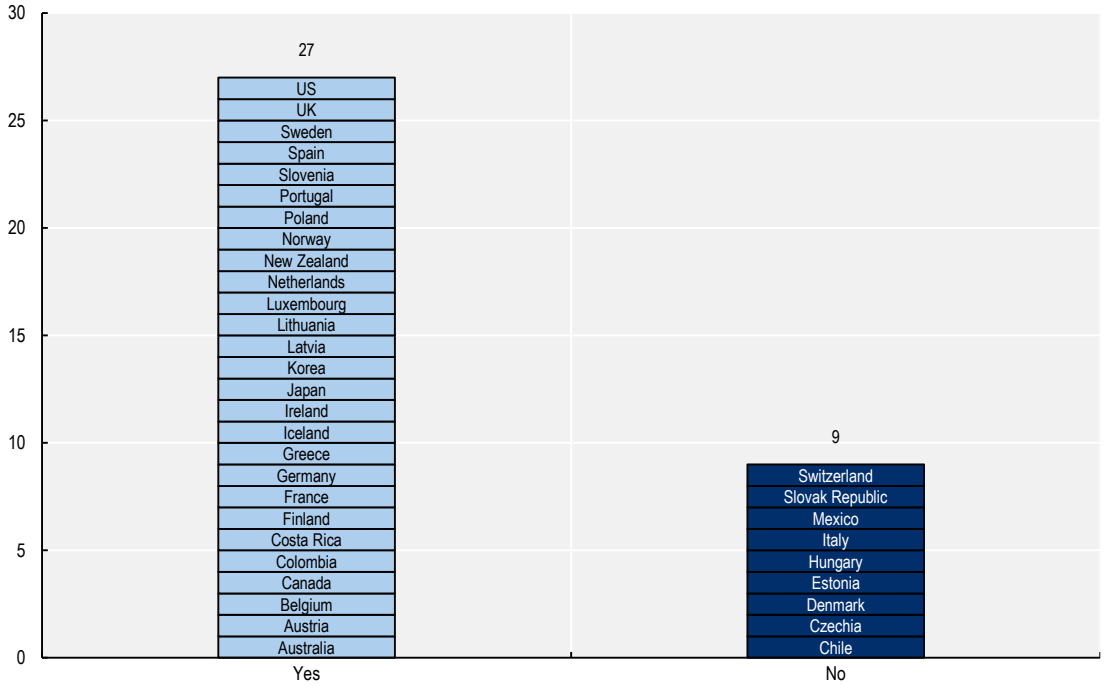
97. While receiving less policy attention than inequalities in access to services, disparities in experiences and outcomes of care are also a concern. Several types of health workforce strategies have been adopted in this regard, with a focus on achieving culturally and linguistically tailored services. Most countries have forms of care coordination and case management to meet the needs of people with complex needs, despite the lack of evidence about their effectiveness for different population groups. Other important approaches to address inequalities in experiences and outcomes of care include incorporating peers in the provision of mental health support, and empowering patients to co-design and co-produce more responsive care.

Efforts to increase access to mental healthcare are widespread but do not always work for all population groups

98. Policies and programmes aimed at addressing inequalities in access to healthcare are widespread in the OECD, with more than 70% of OECD countries having them. Such efforts are most often address inequalities by socio-economic and migration status (both with 63% of countries with policies) and by gender (58%) (Figure 5.1 and Figure 5.2). A larger number of countries report efforts to address mental healthcare inequalities in subgroups at greater risk of poor mental health, either through measures that improve access to generic services or group-specific measures to introduce and expand targeted services. Most efforts focused on children and young people (23 countries), pregnant women and/or new mothers (17 countries), older people (13 countries), and women affected by gender-based violence, immigrants and refugees (12 countries for each) (Table 5.1).

Figure 5.1. Policies or programmes designed to tackle inequalities in access to mental healthcare are often in place

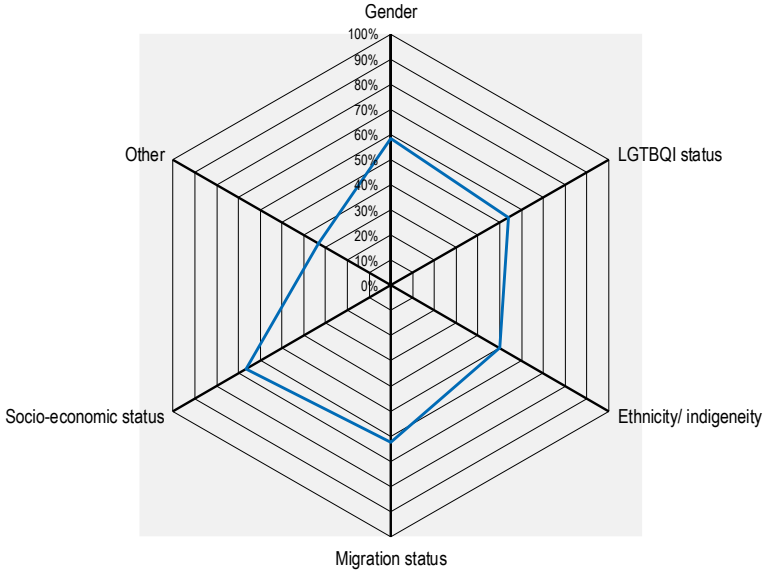
"Does your country have any policies or programmes designed to tackle inequalities in access to mental health care?" Number of countries responding in each category



Note: 36 countries responded.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

Figure 5.2. Policies most often address inequalities in access by socio-economic and migration status

"If so, by which factors?" Proportion of countries whose policies address inequalities in each category



Note: Based on the 24 countries responding affirmatively in Figure 5.1. No details provided by Finland and Iceland.Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

Table 5.1. Groups addressed by countries' policies, strategies or programmes to improve access to mental healthcare services

● Measures to improve access to generic services, ● Measures to expand or introduce targeted services

	Pregnant / new mothers	Gender-based violence[1]	LGBTIQ+	Ethnic minorities	Indigenous populations	Immigrants	Refugees	Financial insecurity	Unemployed people	Children and young people[2]	Older people[3]	Homeless people	Physical health conditions	Other
Australia	● ●	● ●	● ●	● ●	● ●	● ●	● ●			● ●	●			
Austria	● ●	● ●	● ●	● ●		● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	
Belgium				●	●	●	●			● ●	● ●	● ●	● ●	
Chile	● ●	●	● ●	●	●	●	●	● ●	●	● ●	●	●	● ●	● ●
Colombia	● ●	● ●		● ●	● ●	● ●				● ●	● ●		● ●	
Costa Rica	● ●	● ●			● ●		●			● ●	● ●			
Czechia	●													
Estonia	● ●	●					● ●		●	● ●	● ●		●	
Finland		● ●			●	● ●	● ●		●					
France	● ●	●				● ●	● ●	● ●		● ●	● ●	● ●	● ●	● ●
Germany	●		● ●			●	●			● ●	●			
Hungary				●			●							
Iceland	● ●	●	●				●			● ●			●	
Ireland	●		●	● ●	● ●	● ●				● ●		●		
Japan	● ●							●		● ●			●	
Korea	●	●						●	●	● ●	● ●	●	● ●	
Latvia	● ●									● ●				
Lithuania	● ●	●				● ●	● ●		●	● ●	● ●	●	●	
Luxembourg	●	● ●	● ●			● ●	● ●			● ●	●	● ●	● ●	● ●
Mexico	●	● ●								●	●			
New Zealand	● ●	● ●	● ●	● ●	● ●				●	● ●		●	●	
Norway	●		●		●		●	●		●			●	
Slovak Republic	● ●	●								● ●	● ●	● ●		
Slovenia	● ●	● ●	● ●	● ●	●	●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	
Spain							●		●				●	
Sweden	● ●	● ●	●	●	● ●	● ●	● ●			● ●	● ●	●	●	
United Kingdom	●	●	●	●		●	●	●	● ●	● ●	●	● ●	● ●	
United States	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	● ●	

Note: Italy did not specify which key population groups are addressed. 1. Women affected by gender-based violence. 2. Ages up to 24 years. 3. Ages over 65 years.
Source: OECD Country Questionnaire on Mental Health Inequalities 2023.

99. Countries vary in the extent to which mental health services are fully or partly covered by basic healthcare. Previous OECD work has shown that in at least a third of countries psychological therapies and counselling are only partially covered, requiring additional co-payments (OECD, 2021[213]). Some countries address financial barriers in access to mental healthcare for particular groups as a policy to tackle inequalities. In Iceland all mental health services are free of charge for children, as well as prenatal and postnatal mental healthcare. In Lithuania, particular groups are state insured for their mental healthcare: this includes pensioners, unemployed people, pregnant women, caregivers of children up to 8 years old, youth up to 18, students, recipients of social benefits, people with disabilities and refugees. In Ireland, refugees arriving under the Irish Refugee Protection Programme are granted access to tiered mental health services through both primary care and specialist mental health services (OECD, 2023[180]).

100. However, simply increasing coverage does not necessarily address inequalities in access to mental healthcare. Despite the introduction of the Affordable Care Act (ACA) in the US, disparities persist. While Medicaid expansions have been associated with enhanced access to mental health services, some gains were not sustained after the first years (Robertson-Preidler et al., 2020[214]) and results are mixed for different population groups. A study observed a higher likelihood of treatment for low-income adults with behavioural disorders (Wen, Druss and Cummings, 2015[215]), another noted an effect on outpatient mental health visits but no other types of services (Breslau et al., 2020[216]), and some suggest no significant impact on mental health service utilisation (Lieff et al., 2024[217]; Golberstein and Gonzales, 2015[218]). Evidence does also suggest increased care utilisation among White people but not for minority groups such as Latinos, African-Americans, and Asian-Americans (Creedon and Lê Cook, 2016[219]; Saloner et al., 2017[220]).

101. In increasing access to care, one effective approach is to incorporate mental health services into existing service settings, such as primary care, community, and school-based settings (Moitra et al., 2023[221]; Thornicroft et al., 2019[222]). In the United States, bringing mental health services into primary care was especially promising for improving access for children from low-income families (Hodgkinson et al., 2017[223]; Sarvet et al., 2010[224]). Also, within the primary and community care umbrella, New Zealand is rolling out new mental health and addiction services as part of the *Access and Choice Programme* initiative. The programme provides free and immediate support for people with mild to moderate mental health and addiction needs and has rolled out services dedicated to Kaupapa Māori, Pacific, youth and rainbow young people, providing these groups greater access to, and more choice of services (Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission, 2022[225]).

Low-threshold interventions and telehealth can contribute to better support for particular population groups

102. New service implementation and/or service transformation efforts to expand access to youth care have been widespread, often through collaborative efforts between community organisations and researchers. One-stop shop models designed for youth mental healthcare have been implemented and studied in many countries, from Australia (*headspace*) to Ireland (*Jigsaw*) and France (*Maison des Adolescents*). While differing in several features, these multi-layered models of care have, as a key feature the easy access, from walking in, through self-referral, to low-threshold interventions that are available to young people without requiring any formal diagnosis. Additionally, these initiatives are usually designed after principles of adolescent and young adult-friendly services and include components of early intervention services, integrated and comprehensive care (including other healthcare and social services), youth participation and peer support. (Hetrick et al., 2017[226]; Boonstra et al., 2023[227]). The user profile of these youth care initiatives suggest they perform well in attracting usually underserved groups, particularly non-White ethnic groups and Indigenous populations, people who identify as LGBTIQ+ and youth not engaged in education or employment (Hetrick et al., 2017[226]).

103. In the adult settings, initiatives to expand access also include community efforts and low-threshold interventions, often cross-sectoral and involving front-line actors or lay health workers. Task-sharing strategies offer a solution to the shortage of mental health professionals, enhancing service availability, particularly in rural and underserved areas (Mongelli, Georgakopoulos and Pato, 2020[228]; Grant, Simmons and Davey, 2018[229]; Hoeft et al., 2018[230]). In the US, a lay-led behavioural intervention called "Do More, Feel Better" improved activity levels and decreased depression severity among older adults attending senior centres (Raue et al., 2022[231]). Other examples include Mental Health First Aid (MHFA), a skills-based training course addressing mental health and substance use issues (Mongelli, Georgakopoulos and Pato, 2020[228]; Morgan, Ross and Reavley, 2018[232]; Hurley and O'Reilly, 2017[233]). Luxembourg's *Plan National Santé Mentale* (2024-2028) includes the strengthening of low-threshold support and rapid mental healthcare focusing on people suffering serious intellectual or physical disabilities. It also foresees the development of synergies between mental health services and social services for people exposed to violence, and the implementation of "community health nursing" focused on homeless people, which is organised in a network, at low-threshold, and operating in the field (OECD, 2023[180]).

104. Tele-mental health initiatives have also broadened access to mental health services, facilitating virtual connections between specialists and primary care providers and between patients and providers (Mongelli, Georgakopoulos and Pato, 2020[228]). Furthermore, research findings suggest that telehealth can address access disparities among racial and ethnic minorities who often encounter barriers to in-person care (Chumbler et al., 2023[234]; Ramos and Chavira, 2022[235]). In the US, the Project Extension for Community Healthcare Outcomes stands out as an effective and potentially cost-saving model. It enhances knowledge-sharing and patient access to healthcare in rural and underserved areas by empowering primary care providers to manage mental health conditions and substance use (Mongelli, Georgakopoulos and Pato, 2020[228]; Hoeft et al., 2018[230]; Bessell et al., 2023[236]; Baker et al., 2020[237]; Komaromy et al., 2019[238]; Buysse et al., 2022[239]). Also telepsychiatry has proven effective and culturally appropriate for Hispanic and Chinese individuals, providing access to specialised care tailored to their language and cultural needs (Moreno et al., 2012[240]; Baker-Ericzén et al., 2012[241]; Choi et al., 2012[242]).

105. Access challenges are particularly difficult to solve in rural and remote areas, where healthcare infrastructure and specialist availability are limited. In France some rural regions have fewer than 200 doctors per 100,000 people (comparing to 800 per 100,000 in Paris) (Clarke, Macdonald and Observer, 2018[243]). In such contexts, tele-mental health has become a critical means of expanding access. In the United States, Medicare data from 2010-2017 show that rural patients with serious mental disorders dramatically increased their use of telepsychiatry by 425%, partially offsetting a decline in-person visits, though not fully closing the rural-urban gap (Patel et al., 2020[244]). A recent systematic review confirms that these services are clinically effective, particularly for depression and anxiety, and that rural program completion rates range from 73% to 100%, indicating strong patient engagement (Watanabe et al., 2023[245]).

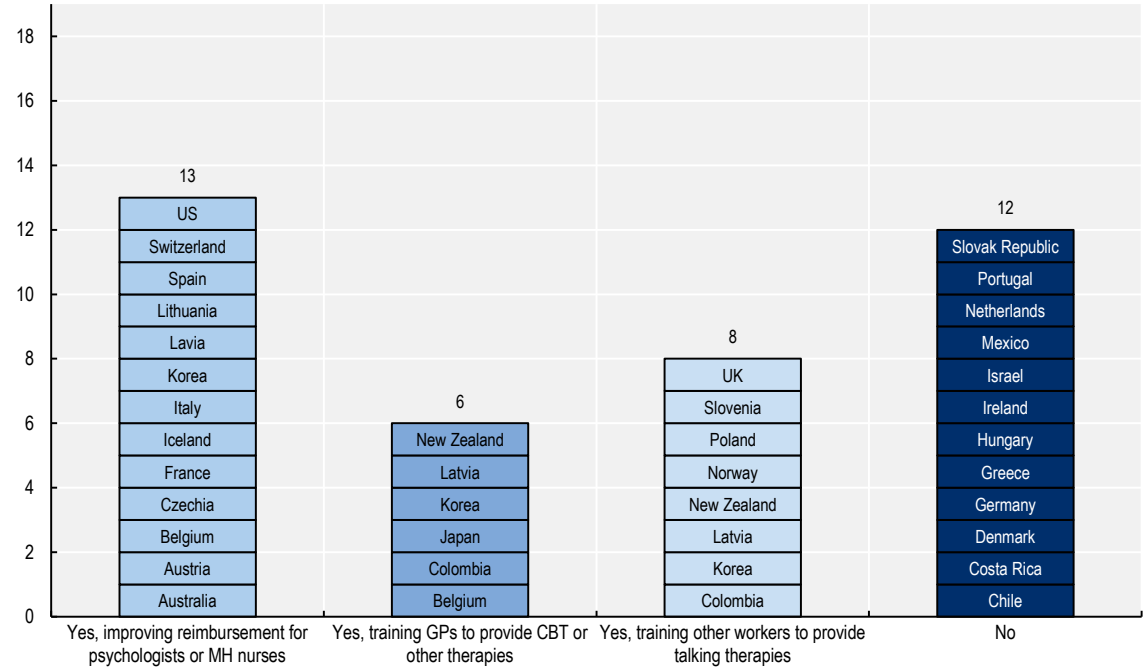
Despite the expansion of talking therapies some groups remain having lower access and worse outcomes

106. A considerable part of country policies to scale up access to mental healthcare has been focusing on talking therapies. Talking therapies refer to a therapeutical approach that includes evidence-based psychological treatments such as cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) often recommended as first-line treatments for depressive and anxiety disorders, among others. Close to 66% of OECD countries have expanded access to talking therapies (Figure 5.3). In more than half of these countries, access has been expanded to the general population, with the remaining countries also

implementing specific measures for groups at greater risk of poor mental health. Children, young people, older people, and people with disabilities emerged as the predominant focus of group-focused efforts.

Figure 5.3. Countries that expanded access to talking therapies by improving reimbursement or training professionals

"Did your country expand access to talking therapies by training additional professionals or improving reimbursement?" Number of countries in each category



MH: mental health; GPs: general practitioners; CBT: cognitive behavioural therapy.
Notes: 36 countries responded. Finland, Luxembourg, and Sweden answered affirmatively without further details. Countries that responded affirmatively might have selected several possible strategies and be represented more than once in the Figure.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

107. Improving the reimbursement of psychologists and mental health nurses or providing additional training to the workforce were equally adopted strategies to expand access to talking therapies (Figure 5.3). In France, the *Monsoutienpsy* scheme was introduced to facilitate the reimbursement of psychological support sessions for people with mild to moderate psychological distress by the *Caisse Nationale d'Assurance maladie*, which covers most French population. Sweden has implemented higher cost reimbursement for clinics offering mental health talking therapies and Iceland subsidizes private practicing psychiatrists and increased the number of psychologists that are part of Iceland Health (national health insurance act). Among the countries investing in workforce training to expand access, five countries have focused on GPs, while seven countries targeted other professionals. In Poland, two new specialisation training programmes were introduced in 2023, in psychotherapy and addiction psychotherapy. These programmes are open to individuals with a master's degree in various fields, including nursing, midwifery, social work, psychology, pedagogy, special education, sociology and public health, and aim at expanding the pool of qualified professionals (OECD, 2023[180]).

108. Some countries implemented large expansion programs such as the IAPT in England, currently named NHS Talking Therapies, or Prompt mental healthcare (PMHC) in Norway. Despite several positive findings on the improvement of access and outcomes for the average population, evidence suggests that

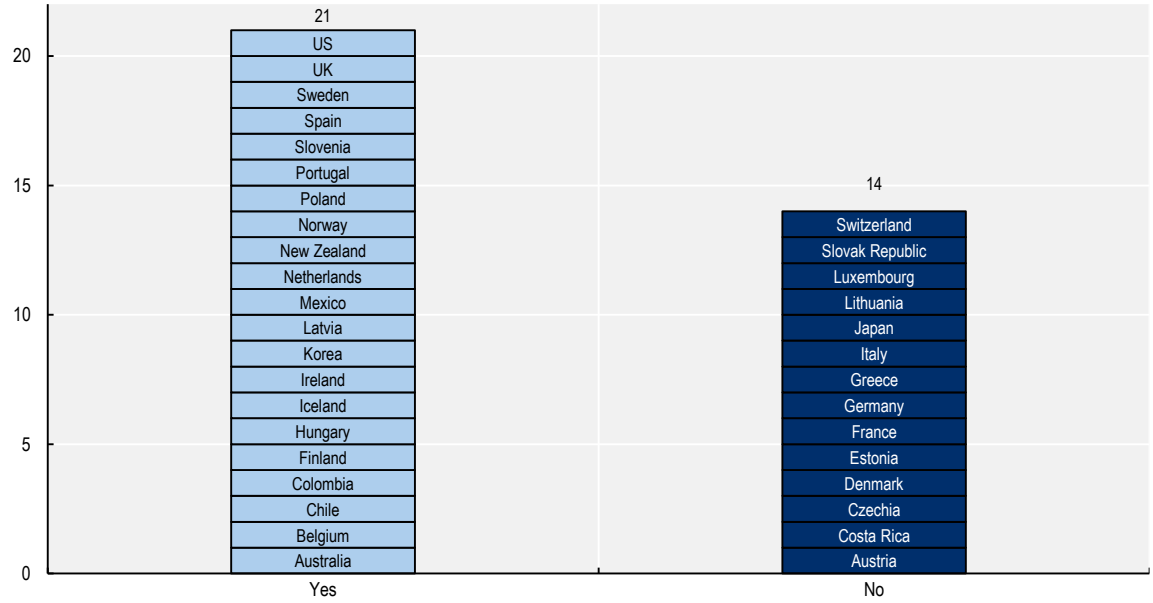
disparities persisted and were observed within these programmes as well, despite the efforts to remove barriers to treatment. On NHS Talking Therapies (former IAPT) improvements and recovery rates were lower for minority ethnic users and non-British White users, compared with White-British users (NHS, 2020[161]; Public Health England, n.d.[164]; National Collaborating Centre for Mental Health, 2023[165]; Health and Social Care Committee, 2021[166]) and for bisexual, gay or lesbian, compared to heterosexual people (Baker and Kirk-Wade, 2023[157]). Evidence from Norway's PMHC program demonstrated that immigrant background or unemployed status were notable predictors of poorer treatment response (Knapstad, Nordgreen and Smith, 2018[246]). On the other hand, the group-specific Australian initiative *Improved Access to Psychological Services in Aged Care Facilities* has demonstrated improvement in the access to and outcomes of psychological services for aged care residents (Australian Healthcare Associates, 2022[247]).

Ensuring equal access to care is just a first step in reducing inequalities, and efforts to improve outreach and responsiveness are necessary

109. Ensuring access to services is just a first step into the support system. Care received should be responsive and appropriate to the needs of different groups, leading to positive experiences and improvement in outcomes. However, despite evidence about the poorer experience and outcomes of key population groups, only 57% of OECD countries have policies or programmes designed to tackle these inequalities (Figure 5.4); a considerably lower proportion than countries with measures to reduce disparities in access to care. Differently than the groups focused by access related efforts (Figure 5.2), policies to improve experiences and outcomes of care have most often designed to address inequalities by ethnicity/indigeneity and gender (50% of the countries), migration status (44%) and for LGBTIQ+ (39%) Figure 5.5

Figure 5.4. Countries that have policies or programmes designed to tackle inequalities in experiences and outcomes of mental healthcare

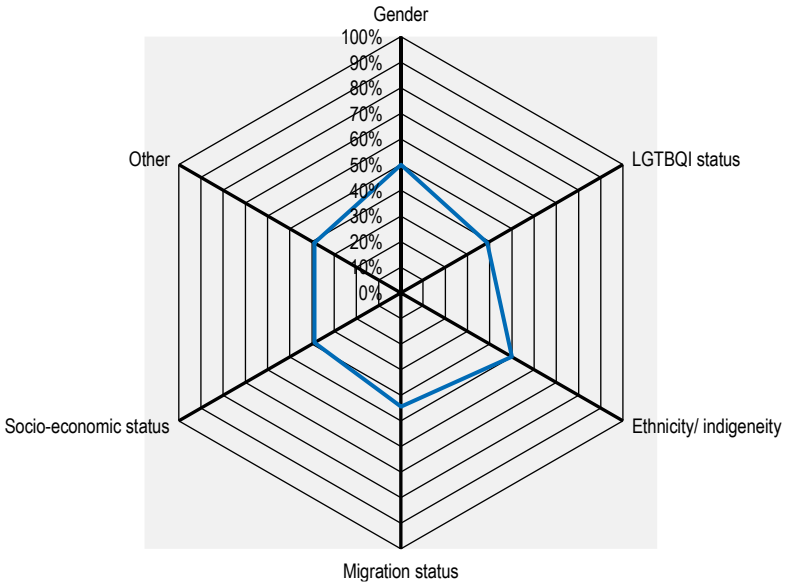
"Does your country have any policies or programmes designed to tackle inequalities in experiences and outcomes of mental health care?" Number of countries in each category



Note: 35 countries responded.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023.

Figure 5.5. Inequalities in experiences and outcomes of mental healthcare by gender and ethnicity/indigeneity are most often addressed

"If so, by which factors?" Proportion of countries whose policies address inequalities in each category

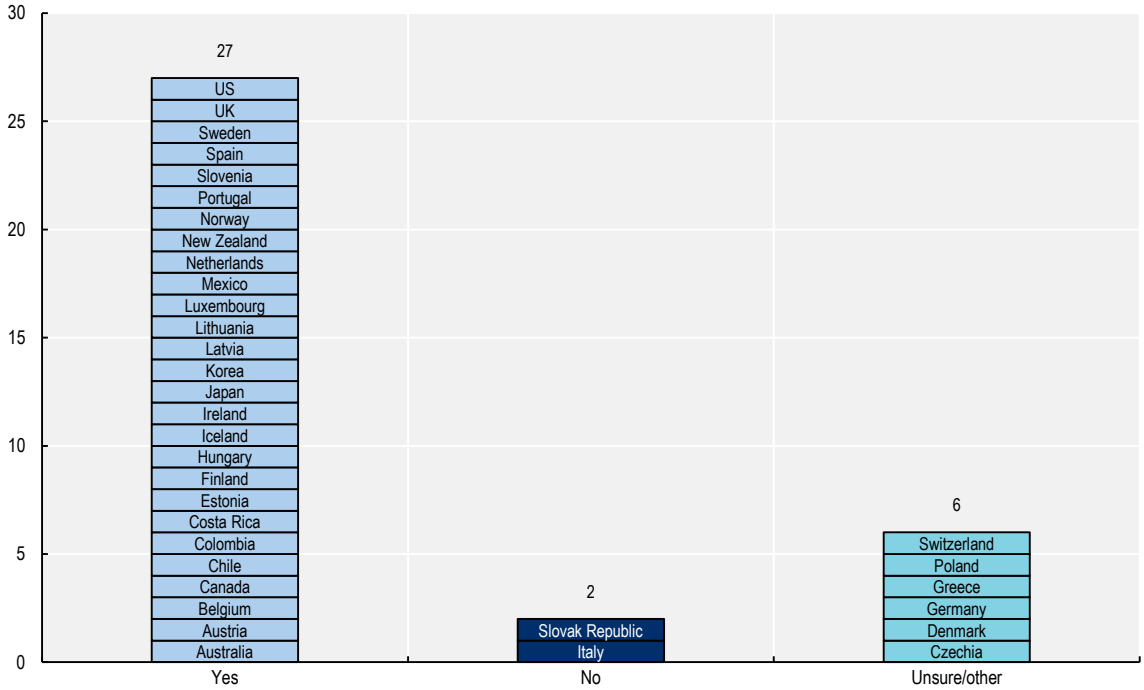


Note: Based in 18 countries that responded affirmatively in Figure 5.4. No details for Poland and Sweden.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023

110. At the interface between improving access and experience and outcomes of care, three-quarters of countries have invested in programmes to enhance the outreach and responsiveness of care to the needs of people in vulnerable circumstances (Figure 5.6). The most common focus of these strategies has been individuals affected by gender-based violence. In Iceland, all prenatal care recipients are screened for domestic violence at primary healthcare centres. The country has a variety of programmes and community outreach services, including harm reduction programs for individuals facing homelessness, addiction, domestic violence, etc. In Ireland, the Health Service Executive (HSE) is developing a national domestic, sexual and gender-based violence training strategy to assist frontline staff in recognizing and responding to victims of domestic, sexual, and gender-based violence in vulnerable or at-risk communities. In 2022, Poland initiated a pilot program of therapeutic interventions addressed to persons with experience of trauma, assessing the effectiveness of these interventions in several domains. As of May 2023, 1 327 patients have participated in the programme, with 7 003 services provided. The Australian Program of Assistance for Survivors of Torture and Trauma (PASTT) supports these individuals to tackle psychological and psychosocial issues resulting from their experiences, contributing to successful resettlement of people arriving to Australia on humanitarian grounds (OECD, 2023[180]).

Figure 5.6. Countries that have policies or programmes to enhance the outreach and responsiveness of support to the needs of people in vulnerable circumstances

"Does your country have any policies or programmes to enhance the outreach and responsiveness of support to the needs of people in vulnerable circumstances?"



Note: 35 countries responded.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023

Care coordination and case management are important parts of mental healthcare but their effects on inequalities are unknown

111. In order to reduce inequalities in the experiences and outcomes of care, there is a need for strong coordination of care within the health system and across other sectors, to ensure a comprehensive approach to the several psychosocial needs of people in disadvantage or in vulnerable circumstances. Coordination is particularly relevant at critical junctures of the pathway, such as the transition from inpatient to outpatient care. In the period of time following discharge from hospital, there is acute suicide risk and it is critically important that the transition to community-based care is managed carefully (OECD, 2022[248]). This requires not only strong community-based services, but also significant coordination between care providers to ensure the continuity of care (OECD, 2022[248]). There are several potential drivers of barriers to coordination between inpatient and outpatient providers, including funding and/or incentive challenges and workforce shortages. Where there are workforce shortages, finding time for communication and patient handover may be challenging (OECD, 2022[248]). There is also a need for collaboration between GPs and mental healthcare teams, and mental health services and social service providers (OECD, 2022[248]). This involves notifying social service providers when their patients are discharged from hospital, and building bridges between healthcare and social service providers so that the latter can consult mental health specialists when their user's mental health conditions worsen (OECD, 2022[248]).

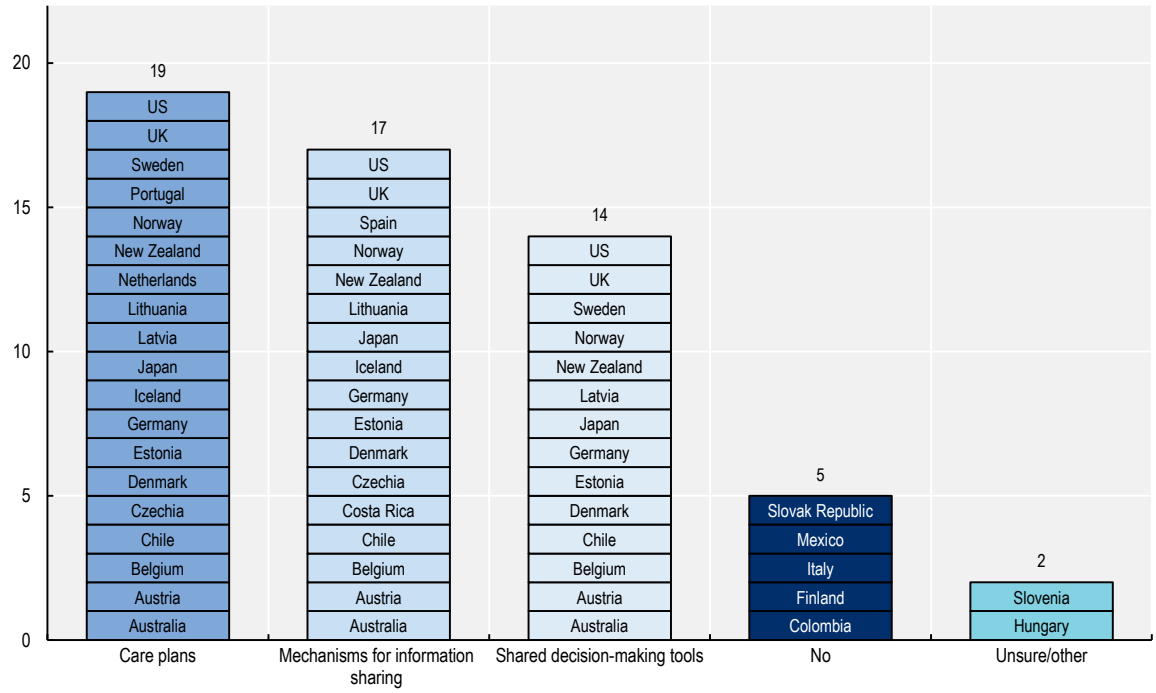
112. Measures to improve care coordination for mental health service users have been adopted by 24 out of 32 respondent countries, in efforts mostly aimed at patients with severe mental disorders (Estonia, Lithuania, Luxembourg, Portugal, and United Kingdom). Some countries focus on particular population

groups. Australia focuses on individuals who have experienced family, domestic, and sexual violence, as well as culturally and linguistically diverse communities with severe mental illness. Spain's initiatives cater to older people, while the United Kingdom also addresses young people. Luxembourg's efforts are directed at those dealing with alcohol dependence, and Iceland's programmes encompass children and families in need (OECD, 2023[180]).

113. Countries have adopted a variety of policies and programmes to improve care coordination for mental health service users: care coordinators, care plans, mechanisms for immediate information sharing or shared decision tools (Figure 5.7). In Sweden, a core legislation known as coordinated care planning (SIP) empowers individuals receiving services from multiple sectors to request a coordinated care plan. This plan is developed and regularly followed up by all engaged sectors, which often include healthcare, social care, education, employment, etc. In the United Kingdom, the *Community Mental Health Framework for Adults and Older Adults* asserts that every person requiring support, care and treatment in the community should have a co-produced and personalised care plan considering their needs and rights. In Australia, *Head to Health* services offer immediate and free, short- and medium- term support ("open door" approach), including assistance in service navigation, to connect people to further services if long-term care is required (OECD, 2023[180]).

Figure 5.7. Alternatives implemented by countries to improve care coordination for mental health service users

"Does your country have any policies or programmes to improve care coordination for mental health service users, either for the general population or targeted to key population groups? If yes, what type of policies or programmes have been implemented?"



Note: 31 countries responded. Greece and Luxembourg responded affirmatively but implement other type of policies. Countries that responded affirmatively might have selected several possible strategies and be represented more than once in the Figure.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023

114. Overall, care coordination has proven a valuable approach to deal with the needs of several patients (Olson et al., 2021[249]; Gulliver et al., 2018[250]). However, its effectiveness in addressing

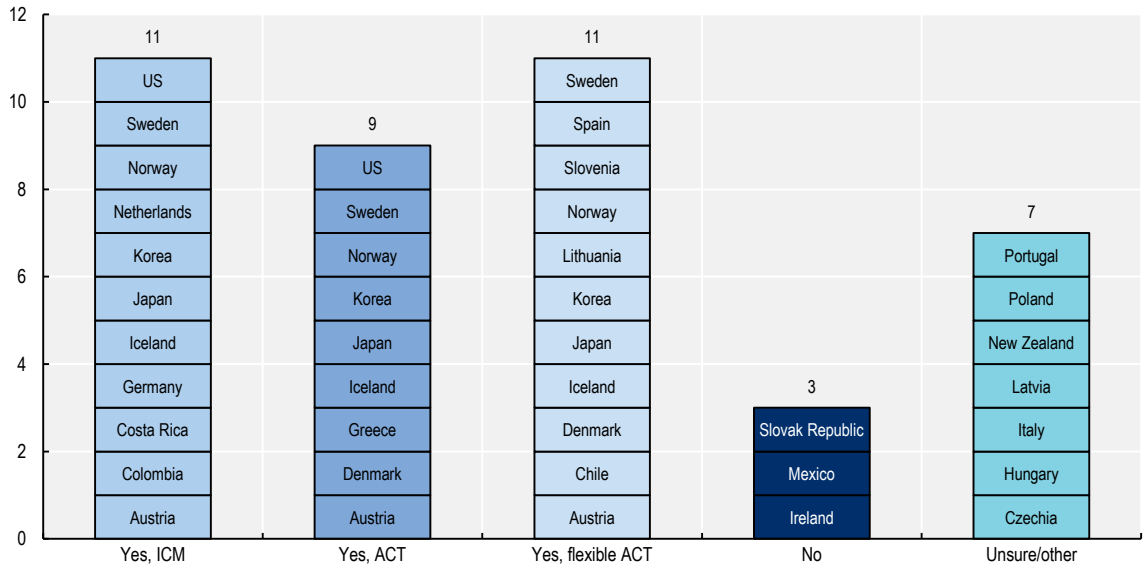
inequalities or serving key population groups has not been extensively studied. Few studies have demonstrated how care coordination management can effectively address the needs of key population groups. In the United States, “Wraparound” care coordination serves as an illustrative example. This comprehensive, family-driven model effectively addresses the needs of families and youths with emotional and behavioural challenges. With its personalised and culturally competent approach, the program has demonstrated effectiveness across various racial and ethnic groups (Stenersen et al., 2022[251]; Olson et al., 2021[249]). In Australia, *Partners in Recovery* stands as an effective care coordination program, as evidenced by its successful implementation in various regions across the country, effectively engaging vulnerable consumers, including Aboriginal people with severe and persistent mental illness (Isaacs et al., 2019[252]; Sutton, 2016[253]; Gulliver et al., 2018[250]).

115. Extensively studied in psychiatric research, different forms of case management have also shown benefits on experiences and outcomes of mental healthcare (Tyler, Wright and Waring, 2019[254]; Lee-Tauler et al., 2018[255]). Case management is defined as a healthcare process wherein a professional assists patients with complex needs by coordinating and integrating support services to optimize healthcare and psychosocial outcomes (Halcomb and Joyce-McCoach, 2023[256]). Twenty-four out of 34 respondent countries have one or more forms of case management, usually through intensive case management (ICM), Assertive Community Treatment (ACT) or flexible ACT teams (FACT) (Figure 5.8). A multidisciplinary team provides these approaches in various community settings, aiding with an array of services, such as medication supervision, housing assistance, financial guidance, and tackling daily life challenges. ICM evolved from ACT and case management, with ICM prioritizing limited caseload (less than 20 patients) and high intensity support (OECD, 2021[113]). While by default case management supports individuals in disadvantage or vulnerable circumstances, there is limited information about impact on key population groups defined by their demographic characteristics, socio-economic status or gender and sexual orientation and the associated inequalities.

116. In New Zealand, case management services are frequently delivered through the national health insurer but providers in other settings such as employability support and disability services also offer case management skills. For instance, support workers of the health and social care interagency approach *Whānau Ora* provide various forms of case management by Māori providers in Māori communities. In Denmark, ACT is applied in initiatives such as the homelessness strategy. Evidence from a systematic review on the effectiveness and costs of different case management interventions for homeless or vulnerably housed populations found that case management interventions, especially ACT, were cost-effective for individuals with complex needs, when the overall costs and benefits to patients, healthcare systems and society were taken into account (Ponka et al., 2020[257]).

Figure 5.8. Countries that have forms of case management to meet the needs of people with complex needs

“”Does your country have any form of case management to meet the care of people with complex needs?”



ICM: Intensive Case Management; ACT: Assertive Community Treatment.
Notes: 30 countries responded. Australia, Belgium, Estonia, Finland, Luxembourg, Switzerland, and the United Kingdom answered affirmatively without further details. Countries that responded affirmatively might have selected several possible strategies and be represented more than once in the Figure.
Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023

Being culturally and linguistically tailored is a key feature for interventions aimed at reducing inequalities in experiences and outcomes of care

117. Regardless of what care models are followed, improving experiences and outcomes requires that mental health workforce is responsive to the needs and specifics of groups at higher risk and where possible, representative of the diverse population it serves. In fact, being culturally and linguistically tailored is a key feature for interventions aimed at reducing inequalities beyond mental healthcare, also through impacting on and mental health literacy. Culturally and linguistically tailored interventions (e.g., psychoeducation material and group-based support) improve mental health literacy and reduce stigma across diverse ethnic and migration groups (Pérez-Flores and Cabassa, 2021[258]; Rusch, Walden and DeCarlo Santiago, 2020[259]; Na, Ryder and Kirmayer, 2016[260]; Misra et al., 2021[261]; Herati and Meyer, 2023[262]; Apers et al., 2023[263]). Studies show that culturally adapted interventions, including those designed through co-production, enhance the accessibility and acceptability of evidence-based treatment to people with different cultural needs (Degnan et al., 2018[264]; Arundell et al., 2021[265]; Lwembe et al., 2017[266]).

118. Culturally tailored mental health care has been recognised as essential for effective treatments outcomes across diverse population groups. Interventions adopted to a specific cultural group were roughly four times more effective than generic approaches, and that providing therapy in a client’s native language (when not English) doubled its effectiveness (Griner and Smith, 2006[267]). Complementing services with culturally familiar resources can further bridge treatment gaps: collaboration between traditional healers and biomedical practitioners has been shown to enhance clinical outcomes and build trust in communities that might otherwise underutilize care (Jilka et al., 2025[268]). Evidence suggests that traditional healers can

effectively relive distress and improve mild symptoms of common mental conditions such as depression and anxiety, highlighting their role as allies within generic services and systems (Nortje et al., 2016[269])

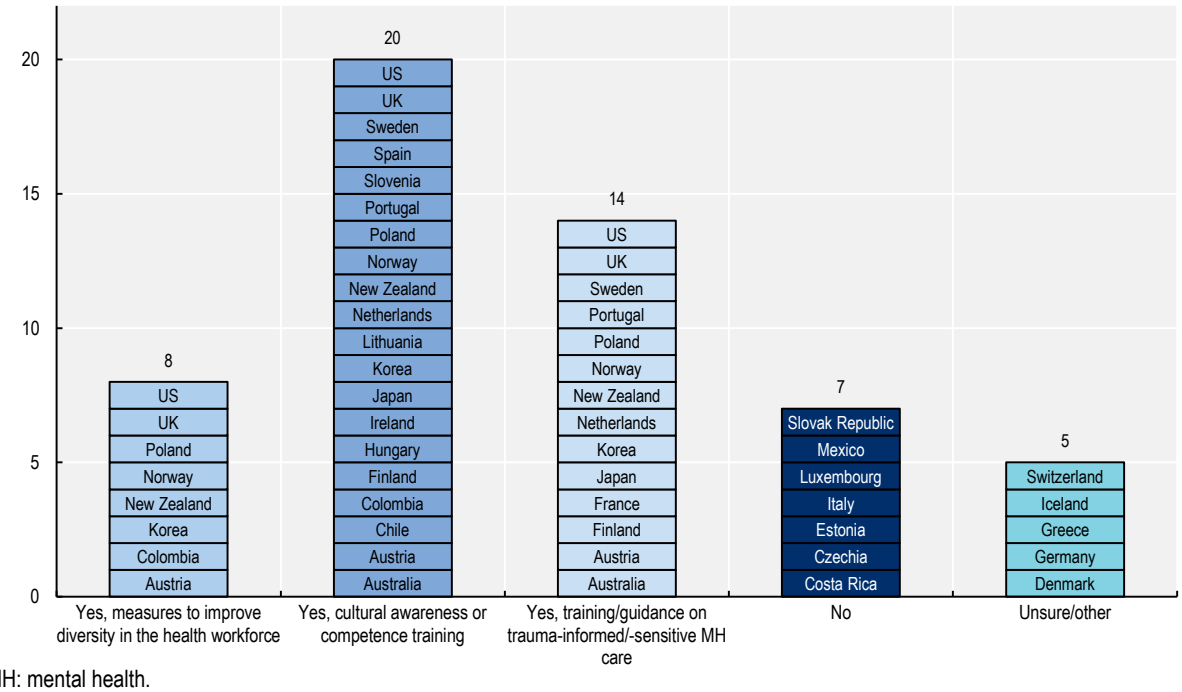
119. Community-based strategies that have proven successful in improving outcomes for minority ethnic groups in the United Kingdom include peer-to-peer support networks to address social isolation and interventions delivered by culturally congruent lay workers. These strategies facilitate more accessible mental health discussions within cultural networks and overcome barriers such as stigma, language, and cultural differences (Baskin et al., 2021[270]). For Latin American populations, United States literature reports strategies that incorporate culturally tailored approaches like narrative techniques and utilize Latino/a music and art as effective. Promising results were observed in enhancing mental health literacy, particularly on depression and psychosis knowledge, while mixed results were observed in stigma reduction (Pérez-Flores and Cabassa, 2021[258]). Nevertheless, the absence of tailored programmes can have negative consequences. For instance, an early evaluation of the *Nepean Blue Mountains Partners in Recovery Initiative* found service disparities for Aboriginal and Torres Strait Islander, homeless, and dual-diagnosis individuals, which were attributed to the lack of culturally and linguistic diverse, tailored programmes and lack of Indigenous staff facilitating access to services (Trankle and Reath, 2019[271]).

120. Among the heath workforce, measures intended to improve experiences and outcome of mental healthcare for key population groups were adopted by 65% of the responding countries, and cultural awareness or competence training was the most common (20 countries) (Figure 5.9). Australia provides a leading example of these efforts, with several initiatives and programmes ongoing and focusing on different groups. Resources for building cultural competency and trauma-informed practice when working with children and families are part of the *Emerging Minds* initiative promoting evidence-based online professional learning and support. The *Embrace Multicultural Mental Health Project* provides a national online platform for Australian mental health services and multicultural communities to access mental health resources, services and information in a culturally accessible format. Mental health scholarships are provided to support healthcare workers' training on culturally safe care towards Aboriginal and Torres Strait Islander people, also aiming at increasing greater representation of this group within the workforce (Department of Health and Aged Care, 2021[272]). Examples from other countries include Spain's *Mental Health Action Plan* (2022-2024) objective to develop training actions for healthcare professionals from a gender and mental health perspective, and training provided at the level of Autonomous Communities' on the same topics, emphasizing the importance of a gendered approach in eliminating biases in the assessment and healthcare for women (OECD, 2023[180]).

121. Training on trauma-informed mental healthcare was also a workforce measure commonly pursued, by 14 countries. Trauma-informed and trauma-responsive care is particularly relevant to reduce inequalities in experiences and outcomes for groups such as women, migrants and Indigenous populations, recognizing that trauma may be lifelong and the persons emotions and relationships with others and aiming at recovery from trauma as a key goal (New South Wales Health, 2022[273]; Department of Health & Social Care, 2018[145]). For women, experiences of trauma are common amongst those using mental health services and trauma often underpins many of the challenges women face. Trauma-informed services are complementary to gender-informed services, which take account of and respond to the particular lives and experiences of women (Department of Health & Social Care, 2018[145]).

Figure 5.9. Health workforce measures adopted by countries to improve experiences and outcomes of mental healthcare for key population groups.

"Does your country have any health workforce measures intended to improve experiences and outcomes of mental health care for key population groups?"



MH: mental health.

Notes: 35 respondent countries. Australia, Belgium, Chile, France and Latvia marked other type of policies. Countries that responded affirmatively might have selected several possible strategies and be represented more than once in the Figure.

Source: OECD calculations based on responses to OECD Country Questionnaire on Mental Health Inequalities 2023

122. Migrants and refugees may endure significant trauma pre-migration, during migration and in the resettlement process. There is evidence to suggest that culturally-responsive trauma-informed approaches can bridge gaps between mental healthcare and resettlement services and promote exchanges of knowledge to enhance collaboration across services (Im and Swan, 2020[274]; Im, Rodriguez and Grumbine, 2021[275]). In the Netherlands, the ARQ National Psychotrauma Centre provides specific training for healthcare professionals that work with groups such as refugees, asylum seekers, families and children, the police and veterans (ARQ National Psychotrauma Centre, n.d.[276]). Similarly, Norwegian Regional Centres for Violence, Traumatic Stress, and Suicide Prevention are mandated to increase knowledge among health workforce members on forced migration, refugee health, and the treatment of torture victims. Focusing on Indigenous populations workforce centres in New Zealand have resources on trauma-informed practice, including specific resource on cultural safety for Māori and Pacific people (OECD, 2023[180]).

123. Although to a smaller extent than strategies discussed above, some OECD countries have also been empowering patients in their efforts to improve experiences and outcomes. To improve the responsiveness of mental health services to the needs of key population groups, countries should look to increase co-production, where service users contribute significantly to the design and delivery of mental health services (OECD, 2021[3]). Supporting this, a systematic review found that interventions incorporating culturally informed organisation-specific adaptations were more effective for ethnic minority groups than non-adapted interventions (Arundell et al., 2021[277]). Furthermore, a pilot study in the United Kingdom utilizing co-production approaches for mental health services showed its effectiveness in addressing access barriers for racial and ethnic minority communities (Lwembe et al., 2017[266]). In line with these

findings, 15 out of 33 countries confirmed the existence of national or subnational policies and programmes facilitating co-design of mental health services, i.e., involving experts by experience in design and evaluation phases. Among countries with such initiatives, 50% targeted them at the general population of service users only, while 36% additionally included key population groups.

124. In Spain, the *National Mental Health Strategy* (2022-2026) aims at fostering collective participation through organised civil society groups, by establishing in each autonomous community mechanisms for the participation of associative movements, scientific societies, and professionals in the design, planning and evaluation of mental health services. Slovenia emphasizes active co-design through its Inter-ministerial working group on mental health, central to formulating guidelines and overseeing the *National Mental Health Programme* (2018−2028). In New Zealand, co-designing mental health services should ideally be done as part of honouring commitments under the Treaty of Waitangi with the Māori people. *The Access and Choice Program* is a good example of this commitment in practice with co-designed kaupapa Māori mental health and addiction services, highlighting the importance placed on collaborative service development.

Incorporating peers in providing mental health support contributes to positive outcomes among several groups in vulnerable circumstances

125. Provision of support beyond the traditional boundaries of the healthcare workforce has also been gaining traction with countries, namely through peer support, including people with lived experience of mental conditions. The numerous benefits of these approaches include the possibility to expand the support network towards low-threshold services and early identification without the need to training practitioners. The literature consistently demonstrates positive outcomes associated with the adoption of peer support to enhance mental health outcomes among various key population groups, including asylum seekers, homeless individuals, individuals of Black ethnicity, Indigenous populations, young mothers, single parents, and the LGBTIQ+ community (Gorse, 2022[278]; Ogbe et al., 2021[279]; Satinsky, Crepaz-Keay and Kousoulis, 2018[280]; Marshall et al., 2020[281]; Gillard et al., 2023[282]; Vujcich et al., 2018[283]). However, it is notable that peer support is often examined within the context of complementary interventions, and it is difficult to disaggregate the effects of peer-led interventions from simultaneous interventions (Vujcich et al., 2018[283]). One other important consideration is the broad spectrum of activities in which peer support can be incorporated. These range from peer support initiatives at the school level (Gorse, 2022[278]) through assistance in navigating the healthcare system (Corrigan et al., 2018[284]) to transition from hospital discharge to community care (OECD, 2021[113]), as well as peer-focused self-management programmes (Satinsky, Crepaz-Keay and Kousoulis, 2018[280]).

126. Seventy-six percent of the respondent countries have policies or programmes to promote mental health peer support. Among these countries, 44% target initiatives exclusively to the general population of service users, while 30% additionally include key population groups, and 26% only target key population groups. Australia demonstrated a strong commitment to developing the lived experience peer workforce, recognizing its crucial role in person-centred mental healthcare. The country funds up to 390 scholarships nationwide for individuals with lived experience to complete a *Certificate IV in Mental Health Peer Work*. Additionally, the Digital Mental Health Program allocates funds to organisations like Reachout Australia and LGBTIQ+ Health Australia, facilitating online peer support for various demographics, including young Australians and the LGBTQI+ community. In Canada, the federal government is currently funding a pilot peer support initiative in selected post-secondary institutions to bolster student mental health support. Psychological wellbeing services in Lithuania provide peer support group services for both the general population and priority groups, such as pregnant women and new mothers, relatives of dementia patients, and relatives of those who have died by suicide (OECD, 2023[180]).

6 Priorities to better understand and address mental heath inequalities

127. OECD countries have been making progress in understanding and addressing inequalities in mental health and mental health care for their populations. Still, there are several areas in which evidence supports more and better investment in the design, implementation and evaluation of policies and interventions to address the persistent mental health and care gaps.

Improve data on disparities for minority groups and people facing multiple disadvantages and better monitor and evaluate policies and programmes implemented

128. Although population groups at higher risk of poor mental-ill health have been identified by existing evidence, better data is needed to quantify the magnitude and trends of these inequalities to inform policy making. Lack of information particularly hinders action in what concerns minorities such as LGBTQI+, ethnic and Indigenous groups as well as people for which strong disadvantage arises from the intersection of different dimensions (e.g. ethnicity, gender and socio-economic status). To face challenges such as privacy concerns and reluctance in study participation, usually leading to these groups being underrepresented in the data, countries should consider alternative forms of data sampling, collection and reporting mechanisms in addition to dedicated study designs. Monitoring trends for people at higher risk and detecting new groups in disadvantage is essential in the context of crisis and emergencies, as proven during the COVID-19 pandemic. Countries should also consider embedding mental health indicators within broader national data systems linking health, social, and economic data to support more effective, equity-oriented policy responses.

129. Moving from understanding to addressing inequalities, the OECD country questionnaire shows that most countries have dedicated action to reduce inequalities in mental health and access to mental health care, and in to a lower extent in experiences and outcomes of mental health treatment. Still, countries need to better evaluate the policies and programmes implemented as only few OECD countries promote initiatives or resources aimed at systematically supporting evidence-based practice in this field.

Address social determinants of mental health and act early and across all sectors of society

130. The promotion of good mental health and prevention of mental-ill health has received more societal attention and governmental efforts in the last years, particularly since the COVID-19 pandemic. Countries should continue investing in cross-sectoral action to implement promotion and multilevel prevention efforts in schools, workplaces and social services, where mental health resilience can be boosted before the first signs of distress, and prevention and early identification can avoid mild symptoms to increase severity and evolve to conditions.

131. Addressing mental health inequalities requires action that goes largely beyond action on mental health, and focus on its social determinants: poverty, debt and financial insecurity, unemployment, low

education, homelessness, among others. Dedicated programmes to support people in these vulnerable circumstances will reduce the risk factors of poor mental health that disproportionally impact groups at the intersection of multiple forms of disadvantage. Countries should consider the burden of mental-ill health as an additional motivation to invest in welfare and social policy, as well as complement the programmes addressing social determinants with mental health interventions.

132. Furthermore, certain groups are more likely to be in vulnerable circumstances due to the stigma and discrimination by society, as well as violence and traumatic experiences they go through. Examples include gender and sexual orientation minorities, ethnic and Indigenous groups, women facing gender violence or refugees and immigrants. Efforts to reduce stigma, discrimination and violence are needed to fight the source of the problem, and countries should consider additional investment on these challenges as part of their strategy to tackle mental health inequalities.

Remove group-specific barriers in access to care and monitor inequalities in experiences and outcomes of treatment once access is gained

133. To address inequalities in mental health care, countries need to acknowledge and focus on both generic-barriers that impact some groups disproportionally (e.g. cost, travel distance) and group-specific barriers (e.g. discrimination). Most OECD countries have policies in place to reduce barriers in access to mental health services, namely financial ones. Such measures are not always sufficient to reduce the gaps in access between population groups. Countries should complement programs and policies aiming at improving availability of generic services with interventions to increase awareness and decrease stigma, improvements in the outreach and responsiveness of care for particular groups and phases of the life course. Efforts should also address group-specific needs, through the increase in the availability of cultural and linguistically appropriate services that best suit minorities and of trauma-informed care for people exposed to violence of other traumatic events.

134. Access to services is just one step towards reducing mental health care inequalities and does not ensure equal treatment experiences and outcomes to patients starting treatment. More evidence on how patient trajectories differ depending on their demographic or socio-economic characteristics is urgent to shed the light on the mechanisms behind poorer treatment experiences and outcomes for patients from low socio-economic status and particular minorities.

Implement culturally and linguistically adapted approaches, workforce diversity and peer-based support

135. Despite more data on disparities in treatment experiences and outcomes being needed, existing evidence supports the inclusion of certain components in countries' policy making to address these. First, countries should improve workforce diversity, by hiring practitioners that ensure the representativeness of all the ethnic, Indigenous, sexual orientation and gender groups in the patient population. Cultural awareness and competence training is can also qualify existing workforce to deliver culturally and linguistically adapted interventions. Second, countries can increase the participation of peers in the provision of mental health support. Peer-based support can improve the availability of low-threshold interventions, within or outside of the healthcare system, and has proven to enhance outcomes in several population groups. Last, involving people with lived experience and service users from the most disadvantage groups in co-design and co-production of programmes and interventions boosts the potential of these efforts to truly address the needs of patients in underserved populations.

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