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| SOURCE | NOTES | COMMENTS |
| [OECD iLibrary](https://www.oecd-ilibrary.org/sites/82129230-en/1/3/2/1/10/index.html?itemId=/content/publication/82129230-en&_csp_=e7f5d56a7f4dd03271a59acda6e2be1b&itemIGO=oecd&itemContentType=book) | * Impact of poor MH: worse **educational** outcomes, higher rates of **unemployment**, and poorer **physical health**. * 2018 **11%** of EU adults had psychological **distress** symptoms. * Without effective treatment and support, mental health problems can have a devastating effect on people’s lives, and significantly increase the risk of dying from suicide (OECD/EU, 2018). * In 2017, over 48 000 people died of **suicide** across EU countries. * The most frequent number of suicides were amongst **men** **aged** **45 and over** ([Figure 3.21](https://www.oecd-ilibrary.org/sites/82129230-en/1/3/2/1/10/index.html?itemId=/content/publication/82129230-en&_csp_=e7f5d56a7f4dd03271a59acda6e2be1b&itemIGO=oecd&itemContentType=book#figure-d1e20280)). * Effective approaches to reducing death by suicide include * good access to **support and mental health care**; * suicide **prevention training for gatekeepers** such as health workers and community leaders; * **reducing access to lethal means** such as firearms and pharmaceuticals; * **responsible media reporting** around suicide; * and **awareness** and **anti-stigma** campaigns. * Some EU countries include suicide prevention as part of their broader mental health policies, while others such as Ireland, Luxembourg, the Netherlands and Switzerland have specific suicide reduction plans. |  |
| [2022 OECD health report](https://www.oecd-ilibrary.org/docserver/507433b0-en.pdf?expires=1693669698&id=id&accname=guest&checksum=0552EF6EEAEC1B53924E733990ECE87D) | * Anxiety and depression have significantly increase in all EU countries * Especially affected: young women and people with financial difficulties   Relevant chapters:   * 1.2 1.3 1.4 1.6 annex 1.A * 2.3 * 3 pg 100   Chapter 1:   * The pandemic exacerbated many of the risk factors associated with poor mental health and weakened many of the protective factors * The prevalence of mental health issues is difficult to estimate as data obtained via population surveys often focus on a few specific mental health conditions or on the prevalence of conditions amongst specific age groups * **Estimates** of the share of people experiencing symptoms of mental health conditions are also affected by **self-reporting rates**, which can be influenced by different levels of **mental health literacy** or **stigma** within countries. * In European countries where broadly comparable pre-pandemic data are available, the share of young people (typically 18-29) with symptoms of depression more than doubled in several countries (Figure 1.1) * The share of young people with symptoms of anxiety also increased significantly in a number of European countries, in some cases doubling from pre-pandemic levels * Rates of **suicidal ideation** increased significantly, but there is not yet any indication of an increase in rates of death by suicide amongst **young** Europeans * **Population mental health was typically worst around pandemic “peaks”,** when infection and death rates were high, and uncertainty loomed large * *Graphs show MH worsening with peaks of pandemic (deaths + restrictions) 🡪 SHARE data: keep only countries with the worst pandemic in the first months?* * Many young people with pre-existing and severe mental health issues reported a worsening of their symptoms during the pandemic * While available data suggest some improvement in early 2022, mental distress remains very high * Young people’s mental health appears to have improved in early 2022, but symptoms of anxiety and depression are still double pre-pandemic levels in some countries * The pandemic has highlighted the **links between income, inequality and mental health**. * Data from Eurofound’s Living, working and COVID-19 e-survey found that young people aged 18-29 who ***perceived* their household to have financial difficulties** were significantly more likely to be at risk of depression over the course of the pandemic * The pandemic heavily **disrupted mental health care**, particularly during the first wave. * Following initial disruption, demand for mental health care appears to have increased in many European countries, challenging already-stretched mental health care systems   Annex 1.A: MEASURING MH AND WELL-BEING WITH SURVEY INSTRUMENTS   * Generalised Anxiety Disorder-7 (GAD-7) is a survey instrument commonly used to measure symptoms of anxiety. It is a seven-item questionnaire with a series of questions about the frequency with which respondents have experienced a range of negative symptoms over the past two weeks, such as “feeling nervous, anxious or on edge,” or “not being able to stop or control worrying.” Each response is assigned a score on a 4-point Likert scale, from 0 to 3 (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day). All items are added together to calculate a total score, with a score of 10 or above typically used to indicate anxiety (with 0-4 indicating minimal symptoms, 5-9 mild, 10-14 moderate, and 15-21 severe symptoms of anxiety). * Patient Health Questionaire-8 and 9 (PHQ-8 and PHQ-9) are shortened versions of the Patient Health Questionnaire (PHQ) and are used to measure the presence and severity of symptoms of depression. * The WHO-5 Well-being Index (WHO-5) is a questionnaire used to measure subjective well-being * The Hospital Anxiety and Depression Scale (HADS) is a 14-item survey with the first seven items on anxiety (HADSA) and the latter seven on depression (HADS-D). * The Mental Health Inventory-5 (MHI-5) contains five questions on the extent to which respondents experienced a range of positive and negative symptoms over the past four weeks, such as feeling nervous or feeling happy   CHAPTER 2.3: DISRUPTION IN MH CARE   * Unmet needs for mental health care have been on the rise during the pandemic with 23% of adults reporting some unmet needs for mental care in the EU in spring 2022, up from 20% in spring 2021 (Eurofound, 2022). * Many countries swiftly moved to remote mental health care services (online and by telephone) to ensure care continuity * Teleconsultations in mental health care also create new challenges, such as ensuring privacy, equity and efficiency of digital services   CHAPTER 3: ADULT MH   * The pandemic exacerbated many risk factors associated with poor mental health and weakened many protective factors, leading to an unprecedented worsening of mental health in the first two years. * **Early in the pandemic**, the prevalence of anxiety and depression doubled in some European countries (OECD, 2021[1]) |  |
| [2018 OECD fact sheet on mH](https://www.oecd.org/health/health-systems/OECD-Factsheet-Mental-Health-Health-at-a-Glance-Europe-2018.pdf) | * More than 1/6 people have MH problems in any given year in OECD * In order of importance: anxiety, depression, drug and alcohol disorders * People reporting depression less likely to work, more likely to be absent from work, less productive * Fewer MH programs target the unemployed and older population groups |  |
| [Promoting mental health in Europe: Why and how?](https://www.oecd-ilibrary.org/docserver/health_glance_eur-2018-4-en.pdf?expires=1693655604&id=id&accname=guest&checksum=D06EA2591EECA97807E8ED1A72CBE865) | * Mental ill-health, meanwhile, will affect everyone at some point in their lives – whether experiencing mental illness themselves, or as a family member, friend or colleague of someone living with a mental disorder * Children and adolescents with poor mental health have worse educational outcomes and job opportunities. Adults with mental health problems are less productive at work and more likely to be unemployed. Elderly people with mental problems are more likely to be isolated and be less active in their community. * Mental health problems cover a wide range of illnesses, including disorders such as mild or moderate **anxiety and depression, drug and alcohol use disorders, and severe disorders such as severe depression, bipolar disorders and schizophrenia**. * MH issues result from a complex interplay of many factors, including genetic, social and economic factors, and can be provoked or worsened by behavioral and environmental factors * “mental health is a state of well-being in which the individual realizes his or her own 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” (WHO, 2001) * Several mental illnesses are more common amongst women, including anxiety disorders, depressive disorders and bipolar disorders. Some of these gender gaps may be due to a greater propensity of women to report these problems. However, one exception is drug and alcohol use disorders, which are more than two times more likely to occur in men than women on average across EU countries (IHME, 2018) * The prevalence of chronic depression increases steadily with age among both women and men, and is particularly high in middle age (Figure 1.2) * This increase in older ages may be partly explained by the fact that depression is often associated with poor physical health, frailty, perceived financial strain and lower social support (Grundy, van den Broek and Keenan, 2017). * By level of education, people with at most lower secondary educational attainment are almost two-times more likely to report chronic depression compared to those with higher educational level. This is also the case for people in low-income groups * People with depression or other mental health problems often see improvement in their condition after finding work, as their labour-force status increases their self-esteem and sense of worth in society, and losing a job generally contributes to worsened mental health (OECD, 2018). 🡪 use recently lost job as an instrument? * **Suicide**: Many different factors may explain why some people are led to attempt or complete suicide, including major life events (such as the death of a loved one, a divorce or employment loss), social isolation, or socioeconomic or cultural context. * **Cost of mental health problems**: Besides the costs on health care systems, mental health problems also result in substantial costs in terms of social security benefits as well as negative labour market impacts in terms of reduced employment and productivity. * **Cross country differences in spending for MH**: By country, the estimated costs related to mental health problems range from 2% to 2.5% of GDP in Romania, Bulgaria and the Czech Republic, to over 5% of GDP in Denmark, Finland, the Netherlands and Belgium (Figure 1.6). These variations are mainly driven by the share of people reporting mental health problems (which may be under-estimated in countries where there is a strong stigma associated with mental health problems) as well as differences in the social security benefits provided to people with mental health problems (in terms of paid sick leave benefits, disability benefits and unemployment insurance benefits), and different levels of spending on mental health care services. * Mental health problems result in much higher sickness benefits, disability benefits and unemployment insurance benefits * Indirect costs of mental health problems on employment and productivity * Lost income and employment due to mortality from mental health problems and suicide is estimated at EUR 22 billion per year across EU countries * Lost income due to lower employment rate of people with depression is estimated at EUR 176 billion per year across EU countries * A range of **measures are recognized as effective in reducing suicide**, including restricting access to lethal means, raising awareness of suicide and suicide risk, improving access to mental health treatment, signposting to sources of help and protective measures in suicide “hotspots”, and tailored efforts to reduce suicide following hospitalization, for example psychosocial assessment and good follow-up care (Hawton et al., 2016; Zalsman et al., 2016) * Early life interventions to promote mental well-being: Efforts to ensure good mental health in the first few years of life are cost effective in terms of mental, physical, and social outcomes * Schools are an ideal setting for interventions to promote mental well-being. * Protecting and improving the **mental health of the working-age population**: The most economically effective interventions were found to be those targeting individuals rather than organisations (McDaid and Park, 2014; Hamberg-van Reenen, Proper and van den Berg, 2012). * Few initiatives, though, were found to focus on improving the mental health of the **unemployed**. * Promoting **good mental health among older people**: * There are key mental health risks linked to ageing, for instance around the sometimes-difficult transition from work to retirement, or related to physical illness and frailty. Social isolation, loneliness, and lower levels of contact with friends and family can also contribute to lower levels of mental well-being. * interventions have focused on tackling some of the risk factors for mental illness, for example loneliness, and promoting activities that foster mental well-being, for instance through promoting social participation. * participation in social activities, psychosocial educational interventions, intergenerational activities and volunteering, and some educational activities could help protect the mental well-being of older people (McDaid, 2015)   lots of [graphs here](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2018/promoting-mental-health-in-europe-why-and-how_health_glance_eur-2018-4-en;jsessionid=Y37ALPxs4Cdy6WBm-TOWx0_XurJgDcZOWJqq2WrI.ip-10-240-5-187). |  |
| [MH and related issues statistics EUROSTAT](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Mental_health_and_related_issues_statistics#Deaths_from_mental_and_behavioural_disorders.2C_Alzheimer.E2.80.99s_disease_and_intentional_self-harm) | * focuses on four aspects: * deaths from mental and behavioural disorders, Alzheimer’s disease and intentional self-harm; * the extent of depressive disorders; * healthcare for mental and behavioural disorders and Alzheimer’s disease; and * the availability of specialist healthcare resources (beds and personnel) for the treatment of mental and behavioural disorders. * Most data about 2019, some for 2020 * Deaths from mental and behavioural disorders, Alzheimer’s disease and intentional self-harm * Table 1: Causes of death – mental and behavioural disorders, residents, 2019: * A higher share of females (than males) in the EU died from mental and behavioral disorders: 4.8 % of all deaths among females in 2017 compared with 2.9 % among males. This pattern was repeated in 2019 across most of the EU Member States (2017 data for France) * Men more likely to die from suicide attempt (more lethal means) 🡪Males were 3.7 times as likely as females to die from intentional self-harm * The EU’s standardised death rate for mental and behavioural disorders was 38.8 deaths per 100 000 inhabitants in 2017; the death rate for males was only slightly higher than that for females   Depressive disorders:   * **Females** reported depressive disorders more often than males * In typical depressive episodes: the patient suffers from lowering of mood, reduction of energy, and decrease in activity; the patient’s capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common; sleep is usually disturbed and appetite diminished; self-esteem and self-confidence are almost always reduced and, even in a mild form, some ideas of guilt or worthlessness are often present. * **Older** people more affected by depression 🡪 Almost 1 in 10 people in the EU aged 75 years and over reported chronic depression * Table 4: Share of the population reporting that they had chronic depression, 2019: * Degree of **urbanization** 🡪 People living in EU cities were most likely to report chronic depression disorders * Figure 2: Share of the population aged 15 years and over reporting that they had chronic depression, by degree of urbanisation, 2019 * (%)   Mental healthcare:   * Use the number of hospital discharges for mental and behavioral disorders * In 2019, there were 3.7 million in-patients with mental and behavioural disorders who were discharged from hospitals in the EU * Figure 3: Hospital discharge rates for in-patients with mental and behavioural disorders, 2019 (per 100 000 inhabitants):   Healthcare beds and personnel   * Falling numbers of psychiatric **beds** in hospitals but increasing numbers of **psychiatrists** * Figure 4: Hospital beds – psychiatric care beds, 2019 (per 100 000 inhabitants): * Psychiatrists are medical doctors who specialise in the prevention, diagnosis and treatment of mental illness. They have post-graduate training in psychiatry and may also have additional training in a psychiatric speciality, such as neuropsychiatry or child psychiatry. In 2020, there were around 86 000 psychiatrists in the 26 EU Member States for which data are available * The number of psychiatrists rose in the vast majority of EU Member States between 2010 and 2020 when expressed relative to the size of the population. * By contrast, Italy, Latvia, Finland and Belgium were the only Member States to report a fall in their number of psychiatrists relative to population size; in each case the reduction was smaller than 1.0 per 100 000 inhabitants. * Psychologists study the mind and its functions, in particular in relation to individual and social behaviour. The third wave of the EHIS included questions asking respondents about their medical consultations with various specialists, including psychologists, psychotherapists or psychiatrists; the survey’s coverage was persons aged 15 years and over. * On average, the percentage of persons aged 15 years and over who reported having consulted a psychologist, psychotherapist, or psychiatrist in the 12 months prior to the 2019 EHIS survey was higher among females (7.7 %) than males (5.2 %). * Overall (males and females combined), the proportion of the population aged 15 years and over that had consulted a psychologist, psychotherapist or psychiatrist in the 12 months prior to the 2019 EHIS survey was between 3.5 % and 9.9 % in most EU Member States   LINK TO [DATA](https://ec.europa.eu/eurostat/statistics-explained/images/5/51/Mental_health_and_related_issues_Health2022.xlsx). |  |
| [WHO European framework for action on MH](C://Users/Jessica/Downloads/9789289057813-eng.pdf) | mental health in the context of the COVID-19 pandemic:   * Mental health and well-being are put at risk by a wide range of factors spanning individual, social and environmental levels, including poverty and deprivation; debt and unemployment; and violence and conflict. * Exposure to adverse experiences and situations in the formative periods of childhood and adolescence  – such as parental violence at home or bullying at school – can have damaging effects on the development of cognitive and emotional skills and affect mental well-being many years into the future. * The COVID-19 pandemic has greatly exacerbated the already substantial health and socioeconomic consequences of mental health conditions and has led to major changes in the need for and delivery of mental health services * Mental health services. * The pandemic has had major impacts on service provision. In-person contact was heavily restricted and replaced by remote modalities of support; staff and infrastructure were repurposed, and longer-term facilities were sealed off from the outside world, with residents becoming increasingly vulnerable to heightened infection risk and profound isolation.   Responding to mental health challenges in the WHO European Region: strategic objectives and actions:   * The EFAMH 2021–2025 sets out a  response to emergent and pre-existing challenges in light of the negative impact that the COVID-19 pandemic has had on mental health and well-being in the WHO European Region * core priorities of the EPW: * **moving towards universal health coverage: mental health service transformation;** * In some Member States, mental health service delivery is decentralized and represented by a  variety of community-based mental health services, including nongovernmental and charity organizations; in others, mental health service delivery is highly centralized and reliant on institutional and hospital-based models of care that often overlook the overall needs or even the basic rights and entitlements of service users * Transformation requires: * potential redesign or reconfiguration of services towards more accessible and person-centred * financial protection for individuals and families affected by mental health conditions * better access to the full range of existing evidence-informed technologies * reprofiling and training health and social care providers  * **protecting people better against health emergencies** * emergiencies: conflict, internal displacement, migration, economic recession or a disease outbreak such as COVID-19, renewed efforts are needed at the community level to build and maintain mental resilience * Both individual and community resilience can be fostered through shared learning and enhanced opportunities for active engagement in local arts, sport, leisure and civic activities, since these foster the formation of positive relationships as well as social capital or connectedness * healthy ageing programmes that encourage engagement in regular social and physical activity can be expected to lead to improvements in mental well-being and autonomy while also reducing cognitive decline * **ensuring healthy lives and well-being for all at all ages** * young people: * More than one year into the COVID-19 pandemic, the lowest level of reported mental well-being in spring 2021 was among women aged 18–24 years (together with women aged 35–44 years) and the largest reduction in mental well-being observed between summer 2020 and spring 2021 was among men aged 18– 24 years * Measures: * utilization of available guidance and existing networks, in particular the health promoting schools, to support capacity-building in, and implementation of, evidence- informed psychosocial interventions * delivery of social and emotional learning and mental health literacy, together with anti-bullying and self-harm prevention, through universal, school-based programmes * strengthened legal and social protection, clinical services, caregiver support and supportive environments to complement the above initiatives. * Adults * The pandemic has deeply affected the lives and safety nets of older adults, who were at the highest risk for severe disease and death and hence suffered to a  greater extent the documented disruption of routine health-care services * MH awareness and literacy * Compared with physical health literacy, the level of mental health literacy remains very low * MH in the workplace * Living with poor mental health can negatively affect work experience and performance; in turn occupational stress is a  major contributor to diminished mental well-being * Develop and support the implementation of programmes to promote mental well-being and prevent mental health conditions in the workplace, including adaptation to new working modalities, management of stress and prevention of substance abuse * Suicide prevention * Global health estimates show that close to 120 000 people take their own lives every year in the WHO European Region, equivalent to 12.8 deaths per 100 000 population or 1.3% of all deaths in 2019. * rates are markedly higher among males and it is a leading cause of death among those aged 15–29  years * bereavement, loneliness and social isolation are notable factors in suicide among older adults * Suicide is preventable; a global SDG target has been set to reduce the rate of suicide by a third by 2030 * Develop, implement and monitor comprehensive multisectoral plans for the prevention of self-harm and suicide among younger people, including enhanced surveillance and follow-up of individuals who harm themselves or attempt suicide, as well as capacity-building among general health-care and community workers * three priority initiatives: * **the creation of a mental health data platform aiming at routinely collected information on mental health systems’ performance and on mental health status of the population;** * **a focus on building resilience for the mental health and well-being of children and young people (includes adolescents aged 10–19 years and youth aged 15–24 years), especially following mounting evidence on the COVID-19 pandemic’s impact on the socioemotional functioning of younger people; and** * **provision of support for the mental health of older people**   Delivering for impact: support mechanisms for implementation:   * Making mental health visible through timely, relevant and comparable data * Mental health innovation and research * Develop a mental health data platform for routine data collection based on indicators jointly discussed and endorsed for a better understanding of the mental health status of a population and the performance of mental health systems, including measuring social functioning, financial protection and service responsiveness. * Explore and use digital technologies to create more opportunities for peer support through policy-makers, workforce, service users and carer |  |
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