

Mental Health Promotion and Prevention

Best Practices in Public Health



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BEST PRACTICES IN PUBLIC HEALTH

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Foreword

Mental health is fundamental to living a fulfilling and productive life, yet mental ill-health significantly affects a large part of the population in OECD countries. Depression and anxiety are the most prevalent conditions and have a large burden on population health, well-being and the economy at large – through increased demand for health and social services and reduced workforce productivity. Mild-to-moderate depressive symptoms, affecting one in five adults across OECD and EU27 countries, are of particular concern as they often go unrecognised and untreated, increasing the risk of progression to more severe conditions and contributing to raising overall societal costs.

This report provides OECD and EU27 countries with the means to identify, assess and transfer promising and best practice interventions aimed at promoting good mental health and preventing the deterioration of mental ill-health. It builds on the OECD's work on assessing Best Practices in public health. Interventions identified in this report are aligned with prevention priorities outlined in the *OECD Benchmark for mental health performance*, and have been proposed by OECD Member countries or identified through the European Union Best Practices portal. All interventions are assessed against validated best practice criteria from the *OECD Guidebook on Best Practices in Public Health*. Criteria include effectiveness, efficiency, equity, the quality of the evidence-base, and the extent of coverage, as well as an assessment of the intervention's potential to be transferred to another country.

This report presents 11 promising and best practice interventions that promote mental well-being and prevent symptom escalation. These interventions range from school-based resilience programmes and suicide prevention initiatives, to mental health literacy training for front-line professionals, and enhanced access to mental health care and psychological support services (e.g. such as free consultations with mental health professionals, youth walk-in centres, and online tools).

The report shows that these interventions can reduce symptom severity and duration by up to 87%, strengthen protective factors and mental resilience, and improve school attendance and reduce work absenteeism, with improvements ranging from 50% to 61%. OECD simulations also demonstrate that the studied interventions are cost-effective, generating measurable health and labour market savings while remaining within reach for many health systems. Finally, the report identifies common success factors and challenges related to evidence base, programme evaluation, and scale-up. It also distils key lessons for policymakers on how to improve access to mental health care and support, strengthen evidence base, and scale up effective mental health interventions.

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Table of contents

Foreword	3
Acknowledgements	4
Abbreviations and acronyms	11
Executive summary	12
1 Assessment and recommendations	15
Mental ill-health has a large burden on population health, well-being and the economy	19
Treating early symptoms of mental ill-health and screening postpartum depression will improve health and economic outcomes	25
Lowering the barriers of access to low-threshold and psychological treatments can enhance the effectiveness of interventions	30
Stronger evidence on the effectiveness and efficiency of interventions is needed for policy transfer and scaling-up	34
Scaling-up and transferability: Careful planning is crucial to successfully transfer or scale-up a best practice interventions on mental health given the complexities involved	36
References	40
Notes	42
2 The emergence of mental ill-health and its societal and economic impacts	43
Mental ill-health is widespread, has an early onset and is unequally distributed in the population	45
Particular phases of the life course, such as adolescence, maternity, and unexpected events, increase people's vulnerability to mental health problems	53
Mental ill-health has a heavy toll on both health, social and economic outcomes	55
Mental health issues are currently not receiving adequate support and several barriers hinder access to mental care	58
National policies and strategies to prevent and manage mental ill-health	62
The OECD has assessed 11 candidate best and promising practices	66
References	67
Notes	73
3 Prompt Mental Health Care	74
Intervention description	76
OECD Best Practices Framework assessment	77
Policy options to enhance performance	88
Transferability	91
Conclusion and next steps	98

References	99
Annex 3.A. Modelling assumptions for PMHC	103
Notes	104
4 iFightDepression® Tool	105
Intervention description	107
OECD Best Practices Framework assessment	108
Policy options to enhance performance	115
Transferability	118
Conclusion and next steps	125
References	125
Annex 4.A. Model parameters	128
5 Next Stop: Mum	130
Intervention description	132
OECD Best Practices Framework assessment	133
Policy options to enhance performance	142
Transferability	144
Conclusion and next steps	151
References	152
Annex 5.A. Modelling assumptions for NSM	156
6 Vigilans	158
Intervention description	159
OECD Best Practices Framework assessment	161
Policy options to enhance performance	171
Transferability	173
Conclusion and next steps	179
References	180
Annex 6.A. Modelling assumptions for Vigilans	183
Notes	184
7 Belgian Mental Health Reform	185
Intervention description	187
OECD Best Practices Framework assessment	188
Policy options to enhance performance	193
Transferability	195
Conclusion and next steps	202
References	203
Notes	204
8 SUPRA, Suicide Prevention Austria	205
Intervention description	207
OECD Best Practices Framework assessment	210
Policy options to enhance performance	213
Transferability	214
Conclusion and next steps	220
References	221
Notes	223

9 Mental Health First Aid	224
Intervention description	225
OECD Best Practices Framework assessment	227
Policy options to enhance performance	230
Transferability	231
Conclusion and next steps	237
References	237
Notes	239
10 @ease	240
Intervention description	242
OECD Best Practices Framework assessment	245
Policy options to enhance performance	250
Transferability	252
Conclusion and next steps	258
References	259
Notes	261
11 This is me (“To sem jaz”)	262
Intervention description	264
OECD Best Practices Framework assessment	266
Policy options to enhance performance	272
Transferability	275
Conclusion and next steps	282
References	283
12 Icehearts	286
Intervention description	287
OECD Best Practices Framework assessment	289
Policy options to enhance performance	294
Transferability	295
Conclusion and next steps	300
References	301
13 Zippy’s Friends	303
Intervention description	304
OECD Best Practices Framework assessment	306
Policy options to enhance performance	311
Transferability	313
Conclusion and next steps	319
References	320
Annex A. Methodology	322
References	329

FIGURES

Figure 1.1. Proportions of depressive symptoms, by severity, 25 OECD and EU27 countries, 2019	21
Figure 1.2. Share of people diagnosed with depression by a doctor, by symptom severity, 22 OECD countries	22
Figure 1.3. DALYs gained annually per 100 000 people, 2025-2050	28
Figure 1.4. Efficiency of interventions across OECD and EU27 countries	30
Figure 1.5. Two in five respondents find it “very difficult” or “difficult” to find information on how to deal with mental health problems, 16 OECD countries, 2019-2020	31
Figure 1.6. Psychological therapies covered in full or partly by basic healthcare coverage, 2020	33
Figure 1.7. Assessment of quality of evidence of the selected interventions	35
Figure 2.1. Proportions of depressive symptoms, by severity, 25 OECD and EU27 countries, 2019	48
Figure 2.2. Share of people reporting a diagnosis of depression by a doctor, by symptom severity, 22 OECD countries	49
Figure 2.3. Share of women and men at risk of depression, 25 OECD and EU27 countries, 2019	50
Figure 2.4. Suicide rates by gender in OECD countries, 2001 and 2021 (or nearest year)	52
Figure 2.5. Prevalence of anxiety and major depressive disorders over the life course in OECD countries, 2021	53
Figure 2.6. Share of people employed by mental distress, 31 OECD countries, mid-2010s	57
Figure 2.7. Proportion of respondents who agree that individuals with a history of mental health condition should be excluded from public office	57
Figure 2.8. Approximation of treatment coverage for mental ill-health across OECD and EU27 countries	58
Figure 2.9. Two in five respondents find it “very difficult” or “difficult” to find information on how to deal with mental health problems, 16 OECD countries, 2019-2021	62
Figure 3.1. Cumulative number of DALYs gained (2025-2050) – PMHC, Norway	80
Figure 3.2. Cumulative number of diseases avoided by 2050 – PMHC, Norway	81
Figure 3.3. DALYs gained annually per 100 000 people, 2025-2050 – PMHC, all countries	82
Figure 3.4. Total disease cases avoided, between 2025 and 2050 – PMHC, OECD and EU27 countries	82
Figure 3.5. Cumulative health expenditure savings per person, EUR, 2025-2050 – PMHC, Norway	83
Figure 3.6. Health expenditure (HE) savings per capita (EUR), average 2025-2050 – PMHC, all countries	84
Figure 3.7. Labour market workforce gains and savings, average per year, 2025-2050 – all countries	86
Figure 3.8. Transferability assessment using clustering	96
Figure 4.1. Cumulative number of DALYs gained (2025-2050) – iFD Tool, Germany	111
Figure 4.2. DALYs gained annually per 100 000 people, 2025-2050 – iFD Tool, all countries	112
Figure 4.3. Transferability assessment using clustering – <i>iFightDepression® Tool</i>	123
Figure 5.1. Cumulative number of DALYs gained (2025-2050) – NSM, Poland	137
Figure 5.2. DALYs gained annually per 100 000 people, 2025-2050 – NSM, OECD and EU27 countries	138
Figure 5.3. Labour market impacts, average per year, 2025-2050 – NSM, OECD and EU27 countries	140
Figure 5.4. Transferability assessment using clustering – Next Stop: Mum	149
Figure 6.1. Cumulative number of DALYs gained (2025-50) – Vigilans, France	164
Figure 6.2. DALYs gained annually per 100 000 people, 2025-50 – Vigilans, OECD and EU27 countries	165
Figure 6.3. Cumulative health expenditure savings per person, EUR, 2025-2050 – Vigilans, France	166
Figure 6.4. Cumulative health expenditure savings from self-harm alone, per person, EUR, 2025-2050 – Vigilans, France	167
Figure 6.5. Labour market impacts, average per year, 2025-2050 – Vigilans, OECD and EU27 countries	169
Figure 6.6. Transferability assessment using clustering – Vigilans	177
Figure 7.1. Transferability assessment using clustering	200
Figure 8.1. Suicide rates in Austria have been declining since the 1980s but stabilised since 2008	207
Figure 8.2. Transferability assessment using clustering	219
Figure 9.1. Transferability assessment using clustering	235
Figure 10.1. Transferability assessment using clustering	256
Figure 11.1. Transferability assessment using clustering	280
Figure 12.1. Transferability assessment using clustering	299
Figure 13.1. Transferability assessment using clustering	317

TABLES

Table 1.1. Screening tools and thresholds of severity	20
Table 1.2. Overview of the 11 selected candidate promising and best practices	24
Table 1.3. Summary of the effectiveness of the selected interventions	27
Table 1.4. Scale-up and transfer status of selected interventions	37
Table 1.5. Around half of all OECD and EU27 countries have conditions in place to implement mental health prevention programmes	39
Table 2.1. Screening tools and thresholds of severity	47
Table 2.2. The majority of national governments in OECD and EU27 support policies to promote mental health, 2023	65
Table 2.3. Overview of the 11 selected candidate best practices	66
Table 3.1. PHQ-9 and GAD-7 severity levels	79
Table 3.2. Cost effectiveness figures in local currency – PMHC, all countries	84
Table 3.3. Evidence Base assessment, Prompt Mental Health Care	87
Table 3.4. Indicators to assess the transferability of Prompt Mental Health Care	92
Table 3.5. Transferability assessment by country (OECD and non-OECD European countries)	94
Table 3.6. Countries by cluster	97
Table 4.1. Cost effectiveness figures in local currency – iFD Tool, all countries	113
Table 4.2. Evidence Base assessment, iFightDepression® Tool	114
Table 4.3. Indicators to assess the transferability of iFightDepression®	119
Table 4.4. Transferability assessment by country (OECD and non-OECD European countries) – <i>iFightDepression® Tool</i>	121
Table 4.5. Countries by cluster – <i>iFightDepression® Tool</i>	124
Table 5.1. Cost effectiveness figures in local currency – NSM, OECD and EU27 countries	139
Table 5.2. Indicators to assess the transferability of Next Stop: Mum	145
Table 5.3. Transferability assessment by country (OECD and non-OECD European countries) – Next Stop: Mum	147
Table 5.4. Countries by cluster – Next Stop: Mum	150
Table 6.1. Study group outcomes: Suicide attempts and mortality within a year	163
Table 6.2. Cost effectiveness figures in local currency – Vigilans, OECD and EU27 countries	167
Table 6.3. Evidence-based assessment, Vigilans	170
Table 6.4. Indicators to assess the transferability of Vigilans	173
Table 6.5. Transferability assessment by country (OECD and non-OECD European countries) – Vigilans	175
Table 6.6. Countries by cluster – Vigilans	178
Table 7.1. Evidence base assessment, The Belgian Reform	192
Table 7.2. Indicators to assess the transferability of The Belgian Reform	196
Table 7.3. Transferability assessment by country (OECD and non-OECD European countries)	198
Table 7.4. Countries by cluster	201
Table 8.1. SUPRA's starting package for suicide prevention proposes a wide range of measures	208
Table 8.2. Suicide prevention strategies target the whole population, individuals at risk, or people having showed signs of suicidal behaviour	209
Table 8.3. Indicators to assess the transferability of SUPRA	215
Table 8.4. Transferability assessment by country (OECD and non-OECD European countries)	217
Table 8.5. Countries by cluster	219
Table 9.1. Evidence base assessment, Mental Health First Aid	230
Table 9.2. Indicators to assess the transferability of Mental Health First Aid	232
Table 9.3. Transferability assessment by country (OECD and non-OECD European countries)	234
Table 9.4. Countries by cluster	236
Table 10.1. Information collected as part of @ease routine outcome monitoring	244
Table 10.2. Evidence Base assessment, @ease	249
Table 10.3. Indicators to assess the transferability of @ease	253
Table 10.4. Transferability assessment by country	255
Table 10.5. Countries by cluster	257
Table 11.1. 10-workshop programme of <i>This is me</i> (intervention 2)	266
Table 11.2. Evidence Base assessment, <i>This is Me</i>	270
Table 11.3. Indicators to assess the transferability of <i>This is me</i>	276
Table 11.4. Transferability assessment by country (OECD and non-OECD European countries)	278
Table 11.5. Countries by cluster	281
Table 12.1. Evidence Base assessment, Icehearts	292

Table 12.2. Indicators to assess the transferability of Icehearts	296
Table 12.3. Transferability assessment by country, Icehearts (OECD and non-OECD European countries)	297
Table 12.4. Countries by cluster	299
Table 13.1. Evidence base assessment, Zippy's Friends	310
Table 13.2. Indicators to assess the transferability of Zippy's Friends	314
Table 13.3. Transferability assessment by country (OECD and non-OECD European countries)	316
Table 13.4. Countries by cluster	318
 Annex Table 3.A.1. Parameters to model the impact of PMHC	 103
 Table A A.1. Overview of selected interventions	 322
Table A A.2. OECD's Best Practice Framework – the 5 E's	323
Table A A.3. Assessment limitations	329

Abbreviations and acronyms

CBT	Cognitive Behavioural Therapy
DALY	Disability-adjusted life years
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EAAD	European Alliance Against Depression
EHIS	European Health Interview Survey
EPDS	Edinburg Postnatal Depression Scale
EU	European Union
FTE	Full-time equivalent
GAD	Generalised Anxiety Disorder scale
GDP	Gross domestic product
GP	General Practitioner
HE	Health expenditure
IDS-SR	Inventory of Depressive Symptomatology-self-rating
iFD Tool	iFightDepression® Tool
MHFA	Mental Health First Aid
NAPHA	Norwegian Resource Centre for Community Mental Health
NEET	Not in employment, education or training
NSM	Next Stop: Mum
PHQ	Patient Health Questionnaire
PMHC	Prompt Mental Health Care
PPD	Postpartum depression
RCT	Randomised controlled trial
RR	Relative Risk
SF-12	Short-Form 12
SPHeP-NCD	Strategic Public Health Planning for Non-Communicable Diseases
SUPRA	Suicide Prevention Austria

Executive summary

Depression and anxiety pose a large burden on population health, well-being, and the economy

Mild-to-moderate depression and anxiety are the most common mental health conditions, affecting an estimated one in five adults across OECD and EU27 countries. These conditions often go undiagnosed – for example, about half of the individuals with moderate depressive symptoms do not receive a diagnosis. If left untreated, milder symptoms may progress into moderate functional impairments and even major depression. Mental health issues often emerge early in life and are exacerbated by vulnerabilities and socio-economic disadvantage, particularly among the unemployed, low-income and less-educated populations, resulting in substantive societal costs, including increased demand for health and social services, and reduced workforce productivity.

Eleven candidate best practices were assessed to be effective in promoting mental well-being, preventing symptom deterioration, and improving educational and occupational outcomes

The 2021 *OECD Benchmark for mental health performance*, set out six guiding principles, including promoting mental well-being and preventing mental illness. It identified key priorities such as school and workplace programmes, mental health literacy, early detection and support, facilitating help-seeking, and suicide prevention.

Aligned with these priorities, this report has identified 11 interventions with the help of OECD Member countries or through the European Union (EU) Best Practices portal. These interventions were assessed against validated best practice criteria – effectiveness, efficiency, equity, evidence quality, coverage, and transferability – outlined in the *OECD Guidebook on Best Practices in Public Health*. The interventions focus on:

- creating school environments that foster mental health well-being and resilience (e.g. *Icehearts* from Finland, *This is Me* from Slovenia, and *Zippy's Friends* implemented in multiple countries);
- enhancing mental health literacy and equipping front-line professionals to identify and help an individual with mental distress (e.g. *Mental Health First Aid* implemented in multiple countries);
- preventing suicide (e.g. *Suicide Prevention Austria*, and *VigilanS* from France);
- improving access to mental health care by providing prompt and free consultations with mental health professionals (e.g. *Belgian Mental Health Reform*, and Norway's *Prompt Mental Health Care*), youth walk-in centres (e.g. *@Ease* from the Netherlands), post-partum depression screening (e.g. Poland's *Next Stop: Mum*), and online tools (e.g. *iFightDepression® (iFD) Tool* from Germany).

Evidence shows that interventions that provide prompt access to mental health care and support reduce symptom severity and duration by up to 87%. Programmes such as *Mental Health First Aid* and *Zippy's Friends*, strengthen protective factors for mental well-being and mental resilience. Interventions, such as *@Ease*, *Icehearts* and the *Belgian mental health reform*, also demonstrated tangible improvements in school attendance and reduced work absenteeism, with reported gains ranging from 50% to 61%.

Scaling-up best practice interventions across OECD and EU27 would yield measurable health and labour market savings while remaining within reach for many health systems

OECD simulations show that implementing four interventions – *Prompt Mental Health Care*, *iFD Tool*, *Next Stop: Mum*, and *VigilanS* – across OECD countries could prevent 26.2 million cases of mental disorders over 2025-2050, which represents about 1.4% of the new cases of depression and anxiety across OECD countries per year.

These interventions also have the potential to deliver health benefits at costs within reach for many health systems, making them a cost-effective approach. For example, scaling up interventions like Norway's *Prompt Mental Health Care* could generate 35 Disability-Adjusted Life Years (DALYs) gained per 100 000 population per year on average across countries, compared with 56 DALYs lost per 100 000 population due to bullying-related depression in Canada. Estimated per capita annual savings could reach EUR 4.7 (USD 5.1) in health expenditure, and EUR 3.8 (USD 4.1) in labour market costs, with healthcare savings exceeding intervention costs in nearly one-fifth of countries studied.

The potential for transferring the studied interventions from the origin countries to other OECD and EU27 countries depends on organisational arrangements, political support, and economic conditions. An OECD analysis indicates that around half of OECD and EU27 countries report enabling conditions readily in place to implement the candidate best practices.

Three priorities for scaling up mental health initiatives

Despite differences in scale, target populations, and delivery models, common success factors and challenges emerge from the studied interventions. First, common characteristics have proven effective in improving access to mental health care and support among the interventions, suggesting that to improve access, policymakers can:

- Expand low-threshold and specialised mental health services, including multidisciplinary networks (e.g. the *Belgian mental health reform*), teleconsultations and online tools (e.g. *Prompt Mental Health Care* and *iFD Tool*).
- Reimburse psychotherapy (fully or partially) to reduce financial barriers, as done in the *Belgian reform* and *Prompt Mental Health Care*.
- Destigmatise mental ill-health and raise mental health literacy in the population, as illustrated by *Mental Health First Aid*.
- Roll out peer-based programmes to train students and front-line workers, such as teachers, to help individuals with mental distress (e.g. *@Ease* and *Mental Health First Aid*). While mental ill-health treatment relies on healthcare professionals, these programmes can reduce stigma, encourage people to talk and seek help, and prevent early symptoms from worsening.

Second, the limited evidence base for mental health interventions – due to gaps in data collection and inconsistent evaluation methodologies – act as a barrier to scaling up good practices. To address this, policymakers can:

- Encourage experts to adopt standard frameworks, such as the *OECD Benchmark for mental health performance*, to collect data and assess impact, including on subclinical conditions.
- Incentivise programme assessors to consistently apply these standards and ensure long-term monitoring to demonstrate effectiveness and sustainability, such as *Icehearts* in Finland.

Third, scaling up mental health interventions across different settings presents several challenges including contextual variability, cross-sector co-ordination, and limited workforce capacity. To facilitate transfer and implementation, policymakers can:

- Encourage implementers to share knowledge and apply established implementation strategies to support transfer across countries, as illustrated by the transfer of two practices (the *Belgian reform* and *Suicide Prevention Austria*) to other EU countries through the EU-Joint Action ImpleMENTAL.
- Foster cross-governmental co-ordination for coherent and sustained action.
- Invest in workforce planning and development, including by creating roles for existing professions, such as midwife-led post-partum depression diagnosis in *Next Stop: Mum*, or new professions, such as orthopaedagogues in the *Belgian reform*.

1 Assessment and recommendations

Mental ill-health imposes a significant burden on individuals and societies, with mild-to-moderate depressive symptoms affecting one in five adults in OECD and EU27 countries. If left untreated, these symptoms can escalate to mental illnesses, increasing societal costs. This chapter summarises key findings and policy recommendations following a review of 11 interventions aimed at promoting mental well-being and preventing symptom deterioration.

Key findings and recommendations

- Mental ill-health has a large burden on population health, well-being and the economy.** One in five adults across OECD and EU27 countries experience mild-to-moderate symptoms of depression and anxiety, conditions that affect more individuals than any other mental health disorder. If left untreated, milder symptoms may progress into moderate functional impairments and even major depression. Mental ill-health often emerges early in life and is exacerbated by vulnerabilities and socio-economic disadvantage, particularly among the unemployed, low-income and less-educated populations, resulting in substantive societal costs, including increased demand for health and social services, and reduced workforce productivity.
- As part of the work on OECD Best Practices in Public Health, this report identifies and assesses proven best practice interventions designed to prevent and manage mental ill-health. The selected interventions focus on **promoting good mental health and preventing mild-to-moderate symptoms of depression and anxiety from deteriorating into more serious disorders, as well as preventing suicide.** Informed by submissions from countries and the EU Best Practices portal, 11 promising and best practices were identified, aligning with the prevention priorities outlined in the OECD Benchmark for mental health performance (OECD, 2021^[1]).
- The selected best practice interventions cover the following priorities: making schools mental health-friendly environments that build resilience (e.g. *Icehearts*, *This is Me* and *Zippy's Friends*); improving mental health literacy and enabling front-line professionals to recognise and help an individual with mental distress (e.g. *Mental Health First Aid*); preventing suicide (e.g. *Suicide Prevention Austria* and *VigilanS*); and making mental health care system easy for individuals to seek help (e.g. *Belgium's Mental Health Reform*, *@Ease*, *iFightDepression® Tool*, *Prompt Mental health care* and *Next Stop: Mum*).
- Preventing and treating early symptoms of depression and anxiety improve people's health, educational and labour market outcomes.** Evidence shows that interventions that provide prompt access to mental health care and support reduce symptom severity and duration by up to 87%. Programmes such as *Mental Health First Aid* and *Zippy's Friends*, strengthen protective factors for mental well-being and mental resilience. Interventions, such as *@Ease*, *Icehearts* and the *Belgian mental health reform*, also demonstrated tangible improvements in school attendance and reduced work absenteeism, with reported gains ranging from 50% to 61%.
- This report uses OECD modelling analysis, based on the Strategic Public Health Planning for Non-Communicable Disease model, to assess the effectiveness and cost-effectiveness of scaling-up promising and best practices in OECD and EU27 countries. The analysis shows that implementing four key interventions – *Prompt Mental health care*, *iFightDepression® Tool*, *Next Stop: Mum* and *VigilanS* – could prevent 26.2 million cases of mental disorders in OECD countries and 9.1 million in EU27 countries, over the 2025-2050 period (1.4% of the new annual cases of depression and anxiety in OECD countries). **These interventions have the potential to deliver health benefits at affordable costs, making them cost-effective.** For example, scaling up interventions like *Prompt Mental health care* could generate 35 Disability-Adjusted Life Years (DALYs) gained per 100 000 population per year on average across countries, compared with 56 DALYs lost per 100 000 population due to bullying-related depression in Canada. Estimated per capita annual savings could reach EUR 4.7 in health expenditure, and EUR 3.8 in labour market costs, with healthcare savings exceeding intervention costs in nearly one-fifth of countries studied.

- **The assessment of the transferability of the interventions** from the origin country to other countries indicates that 47% of OECD and EU27 countries have organisational arrangements, political support, and economic conditions in place to implement the selected promising and best practice interventions. In the remaining countries, key gaps include, among others, a limited number of psychologists per capita and lower spending on prevention and health promotion.
- Analyses of the 11 interventions have also identified **three key areas that deserve a special attention** in the design, scaling up and transferring best practices promoting good mental health.
- First, **individuals with mental health care needs face both health system-related and stigma-related barriers to access treatment**. The cost of treatment, long travel distances and waiting times to see a mental health professional are major barriers for people from seeking help for mental ill-health. On average, two-thirds of individuals who need mental health care are estimated to lack access to treatment in OECD and EU27 countries. Taboo and stigma surrounding mental health care cause additional personal barriers, discouraging people from talking and seeking help. Among those with mental health needs, one in five young people and one in seven adults fear to be judged by their peers if they seek mental health support. To address access barriers, it is crucial to:
 - **Increase the availability of and facilitate access to low-threshold and specialised mental health care** across regions and local settings, including online tools. For instance, the *Belgian reform* establishes networks of mental health professionals across schools, workplace, and social services. Additional measures include teleconsultations and online tools that improve access for individuals with mild-to-moderate symptoms (e.g. *Prompt Mental health care* and *iFightDepression® Tool*).
 - **Reduce access barriers by reimbursing the cost of psychological therapies either in part or in full**, as illustrated in *Prompt Mental health care* and Belgium's reform. For instance, in Belgium, where people were recently entitled to reimbursement for a specified number of consultations with a psychologist, nearly 40% of patients using the service reported that they had to forgo care when the cost was not reimbursed.
 - **Support programmes to communicate** on mental health to normalise mental ill-health, remove stigma-related barriers and to enhance mental health literacy in the population (e.g. *Mental Health First Aid*, *Zippy's Friends*).
 - **Roll out peer-based programmes to train students and front-line professionals** (such as teacher) to help individuals with mental distress (e.g. *@Ease* and *Mental Health First Aid*). While the treatment of mental illnesses relies on healthcare professionals, these programmes can reduce stigma, encourage people to talk and seek help, and prevent early symptoms from worsening.
- Second, **the evidence base of interventions is generally of moderate or weak quality and requires strengthening**. While 80% of the interventions have strong-quality data collection methods and 40% have strong-quality study design, several selected interventions have a lack of relevant data and proven effectiveness. The indicators used to assess intervention effectiveness are heterogeneous. The evidence-base of mental health interventions can be strengthened by implementing actions to:
 - **Encourage experts and professionals to agree on and use standard frameworks for data collection and programme evaluation**, such as the OECD Benchmark for mental health performance (OECD, 2021^[1]). For example, in England, the National Health Service Talking Therapies has implemented an outcome monitoring system that collects symptom scores from 98% of users.

- **Incentivise programme leaders and assessors to consistently apply these standards** across programme evaluations and ensure sufficient long-term monitoring of patients. For instance, in Finland, the *Icehearts* programme has its own follow-up tool that systematically collects data, including mentors' assessment of child's progress twice a year and parents' and children's self-assessment once a year.
- Third, **transferring interventions needs to be thoroughly planned and resourced**. The OECD's transferability analysis has identified several countries with strong potential to adopt and implement the 11 selected interventions. However, practical attempts to transfer these interventions have encountered difficulties related to differences in national and local contexts, integrating mental health programmes in various sectors of the government, and gaps in mental health workforce capacity. Policy options to facilitate the transfer of policies include:
 - **Encourage implementers to share knowledge and experience and apply established implementation strategies** to support the transfer of best practices across countries, as illustrated by the transfer of the *Belgium's mental health reform* and *Suicide Prevention Austria* to other EU countries through the EU Joint Action ImPeMENTAL.
 - **Foster cross-governmental co-ordination for coherent and sustained action**. For example, seven Norwegian ministries have collaborated on the National Mental Health Strategy; the Ministries of Health, Culture, Children and Equality, Labour and Social Affairs, Education, Local Government and Modernisation, and Justice.
 - **Ensure that there is sufficient capacity in the mental health workforce**, by planning for the future, and by creating roles for existing professions, such as midwife-led postpartum depression diagnosis in *Next Stop: Mum*, or new professions, such as orthopaedagogues in the *Belgian reform*.

Mental ill-health has a large burden on population health, well-being and the economy

Major depression and generalised anxiety disorders are the most diagnosed mental disorders in OECD countries. On average across OECD countries, around 3% of the population lived with major depression and 5% with generalised anxiety disorders in 2019 (IHME, 2020^[2]). The prevalence of major depression was higher in women (3.9%) than in men (2.1%), and it varied with age. The highest rates were found among individuals aged 20-24 followed by those aged 35-44. Individuals suffering from major depression experience depressed mood or a loss of pleasure or interest in activities for most of the day, while individuals with anxiety disorders experience excessive fear and worry. The symptoms of both conditions result in significant distress or significant impairment in social and occupational functioning. The severity and the duration of symptoms are key factors of the clinical diagnosis of mental disorders (Box 1.1).

Box 1.1. Diagnostic and screening tools for mental ill-health

Different instruments are used to identify and diagnose mental ill-health.¹ This box provides an overview of the two most common alternatives: structured interviews, that allow the diagnosis of mental disorders as per internationally recognised psychiatric classification systems; and screening tools, designed to identify individuals at risk of conditions which should then be clinically assessed. In line with the remaining of the report, examples focus on depression and anxiety related mental-ill health, responsible for a large burden worldwide.

Structured interviews for clinical diagnosis of major depression

The Diagnostic and Statistical Manual (DSM) is used by medical doctors to establish diagnostic criteria for mental disorders, such as major depression. Patients are diagnosed with major depression if they report five or more depressive symptoms, including at least one of the symptoms “depressed mood” and/or “loss of interest or pleasure”. The list of symptoms include:

- Depressed mood most of the day
- Loss of interest or pleasure in activities most of the day
- Significant weight loss or weight gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings worthless or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of suicide.

Comparable diagnostic criteria are also defined for generalised anxiety disorder.

Patients reporting less than five symptoms do not fulfil the diagnosis of major depression but may be considered in the “subclinical depression” category. While there is significant heterogeneity in the conceptualisation of subclinical depression, a systematic review found that most studies define subclinical depression as having two to four symptoms including depressed mood or loss of interest (Rodríguez et al., 2012^[3]).

Screening tools for depressive and anxious symptoms

Screening tools are designed to capture a continuum of mental ill-health and to identify symptoms of different severity. Among the most used tools:

- The Patient Health Questionnaires (PHQ) are scales validated by research to assess the severity of depressive symptoms (OECD, 2023^[4]; Kroenke et al., 2009^[5]). The PHQ-9 is composed of nine questions referring to the previous two weeks. In each question, the frequency of the symptom is associated with a number of points: not at all (0 point), several days (1), more than half the days (2), nearly every day (3). The total score ranges from 0 to 27, with higher score indicating greater severity of symptoms. The score cut-offs used to define the severity of symptoms are shown in Table 1.1. A shorter version of the questionnaire, the PHQ-8, removes the final question of PHQ-9, which focusses on suicidal ideation, and scores 0-24 points. A positive screening result is considered when scoring 10 or more, in both PHQ-8/9.
- The Generalised Anxiety Disorder scale (GAD-7) is a tool to assess anxiety symptom severity (Spitzer et al., 2006^[6]). The GAD-7 is composed of seven items capturing the presence of anxiety symptomatology, each with four categories of response (similarly to the PHQ). The sum of the seven items ranges between 0 and 21 points and allows for the identification of one of the four categories of symptom severity (Table 1.1). A positive screening result is considered when scoring 10 or more in GAD-7.

Table 1.1. Screening tools and thresholds of severity

PHQ-9	GAD-7
0-4: Minimal depression	0-4: Minimal anxiety
5-9: Mild depression	5-9: Mild anxiety
10-14: Moderate depression	10-14: Moderate anxiety
15-19: Moderately severe depression	15-21: Severe anxiety
20-27: Severe depression	

Source: Kroenke et al. (2001^[7]), "The PHQ-9: Validity of a brief depression severity measure", <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>; Spitzer et al. (2006^[6]), "A brief measure for assessing generalised anxiety disorder", <https://doi.org/10.1001/archinte.166.10.1092>.

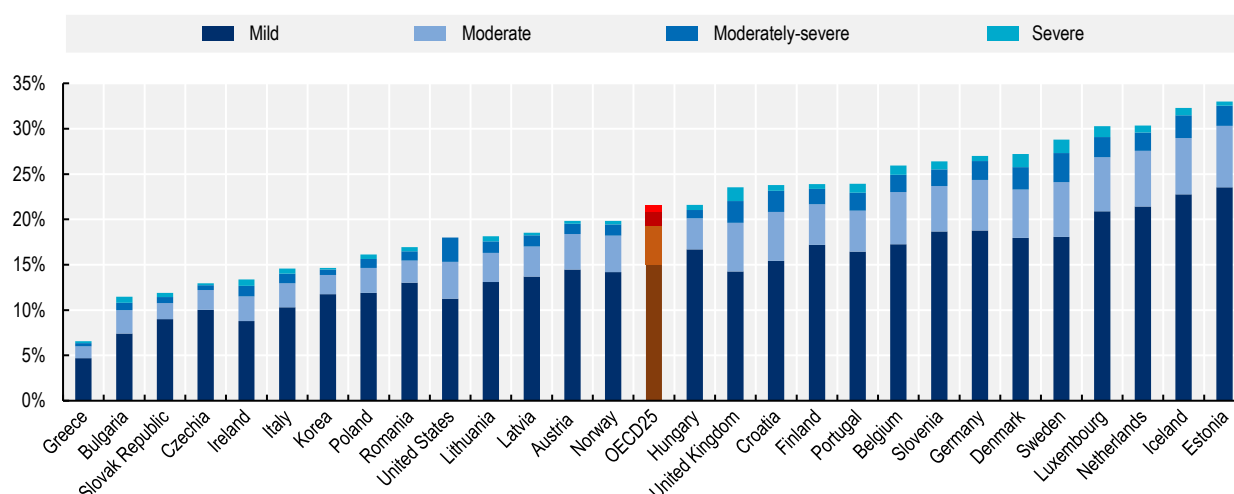
Symptom screening tools have been increasingly incorporated into national health surveys to measure population mental health. PHQ-8 is applied in more than 60% of OECD countries (OECD, 2023^[4]), for example through the European Health Interview Survey (EHIS), the Korea Community Health Survey, and the United States National Health Interview Survey. Estimates of mental disorders prevalence in the population are likely to differ depending on the type of instrument used to measure them. Compared with diagnostic interviews, screening tools are likely to overestimate population level prevalence, as these tools were designed to identify individuals at risk for conditions – some of whom may not meet the criteria for a confirmed diagnosis.

1. Mental ill-health is used as an umbrella term encompassing both subclinical experiences (e.g. distress, subclinical symptoms) and diagnosed conditions (e.g. major depression, anxiety disorders).

Mild-to-moderate depressive symptoms affect one in five adults across OECD and EU27 countries and, too often, remain undiagnosed and untreated

The proportion of people experiencing mild-to-moderate symptoms is large. OECD analysis of survey data from OECD and EU27 countries found that **nearly one in five people aged 15 and above reported having mild-to-moderate symptoms of depression in 2019**. Specifically, 15% of respondents reported having mild symptoms of depression, 4% had moderate symptoms, while 2% had moderately-severe and severe symptoms (Figure 1.1). More than 25% of the population aged 15 and above report mild-to-moderate symptoms in Luxembourg, the Netherlands, Iceland and Estonia, compared to less than 15% in Poland, Korea, Italy, Ireland, Czechia, the Slovak Republic, Bulgaria and Greece. In all the studied countries, **the mild and moderate symptoms represent the bulk of depressive symptoms: 90% of individuals with mental health symptoms had reported mild-to-moderate symptoms**. Individuals with mild-to-moderate symptoms, not fulfilling the diagnostic of major depression, have lower quality of life, poor health perception, higher level of disability and well-being, impairment in physical functioning (Rodríguez et al., 2012^[3]).

Figure 1.1. Proportions of depressive symptoms, by severity, 25 OECD and EU27 countries, 2019

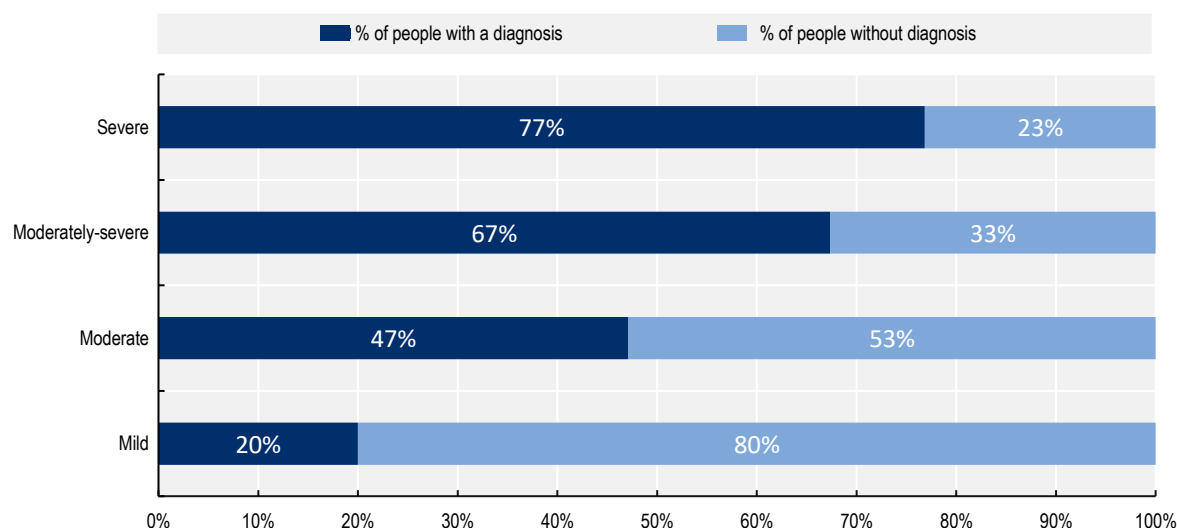


Note: Age 15+. In the United States, the moderately-severe and severe are grouped.

Source: OECD analysis based on EHIS, 2019, and national survey data for Korea (Korea Community Health Survey 2019), the United Kingdom (European health interview survey 2019) and the United States (National Health Interview Survey 2019).

Mild and, often, moderate depressive symptoms are less likely to be diagnosed because they do not meet the clinical criteria. If symptoms are milder or less persistent, patients are more likely to remain undiagnosed. OECD analysis based on survey data from 22 OECD countries, confirms that the likelihood of receiving a diagnosis of depression increases with the severity of symptoms (Figure 1.2). Specifically, about 8% of the surveyed population reported to have been diagnosed with depression in the last 12 months. This proportion increases with the severity of symptoms: the share of those with a diagnosis is 20% in those with mild symptoms, 47% in those with moderate symptoms, 67% in those with moderately-severe symptoms, and 77% in those with severe symptoms. As more than half of individuals with mild and moderate symptoms are undiagnosed, there is a potential for prevention and early interventions targeting those with mild and moderate symptoms.

Figure 1.2. Share of people diagnosed with depression by a doctor, by symptom severity, 22 OECD countries



Note: Age 15+.

Source: OECD analysis based on EHIS, 2019, including data for the United Kingdom.

If left untreated, mild symptoms can turn into mental illnesses. People with mild and moderate symptoms are significantly less likely to receive a mental health therapy or treatment compared to those with severe symptoms (Evans-Lacko et al., 2018^[8]). However, if milder symptoms are left untreated, they can deteriorate to mental disorders. Evidence shows there is a 10% to 20% risk that subclinical depression deteriorates to major depression (Teepe et al., 2023^[9]). In addition, subclinical depression poses a 33% to 50% risk of patients developing moderate functional impairments.

The burden of mental ill-health is possibly increasing, although more data are needed to confirm this trend. Previous OECD analysis showed that population mental health fluctuated during the COVID-19 pandemic, typically worsening during periods of infection and movement restriction (OECD, 2023^[10]). As the pandemic receded, population mental health has improved, although level of mental ill-health has remained elevated. In about half of the OECD countries with available data, the proportion of people reporting depressive symptoms decreased in 2022 compared to 2020 levels, but this proportion remains at least 20% higher than pre-pandemic levels. Several factors can explain the persistent high level of mental distress, such as the cost-of-living crisis, climate crisis, conflicts, as well as increased awareness and changing language around mental health that reduced the stigma of this health issues making it easier to speak and seek support.

As the prevalence of mental ill-health has increased, **rates of suicidal ideation (suicide thoughts) have increased too, especially among young people.** In the three OECD and EU27 countries for which data is available, up to a quarter of young people reported having had suicidal ideation during the COVID-19 crisis, which was five times higher than pre-pandemic levels (OECD/European Union, 2022^[11]). However, in most countries, this trend did not translate into an increase in deaths by suicide. In 2020 and 2021, death by suicide represented 11.2 deaths in 100 000 people, compared to 11.3 in 2018 and 11.1 in 2019, on average across OECD countries. Between 2001 and 2021 suicide rates across OECD countries reduced by 34% for males and 24% for females.

The burden of mental ill-health varies across population groups. Women experience 62% higher rates of depression than men, while men face much higher suicide rates. Mental ill-health often begins at early ages, with 75% of adult disorders starting before adulthood. Vulnerability increases during life transitions,

such as adolescence, pregnancy and postpartum, or migration, and is heightened by negative events such as unemployment or death of a relative or friend. The uneven distribution of mental health conditions has a particularly detrimental impact on people in low income and/or with low education. Socio-economic disadvantages such as unemployment and income loss, exacerbate mental health issues.

Mental ill-health carries a significant economic burden, including spending on healthcare and social services, and lost labour productivity

Mental ill-health carries a significant cost to the society. The cost of mental ill-health was estimated at **4% of gross domestic product (GDP)** across the 28 EU countries in 2015 (OECD/European Union, 2018^[12]). This equates to more than EUR 600 billion, equivalent to twice the health budget of France. This cost includes 1.3% of GDP in direct spending on health systems, 1.2% of GDP on social security programmes, and a further 1.6% of GDP in indirect costs related to lower employment and work productivity. It has been suggested that this cost may be under-estimated because several additional costs could not be included due to data limitations. For instance, it does not account for social spending related to mental health problems, such as higher social assistance benefits and higher work-injury benefits, costs within the criminal justice system, and the higher cost of treating a physical illness if the patient also has a mental illness.

The cost of mental illness varies according to the severity of symptoms and treating symptoms in their early stages would prevent more costly healthcare later. Medical cost of treating mental illnesses may vary up to 20-fold by level of severity. A German study found that in 2019, the 6-month treatment cost of mental disorders was estimated at EUR 511 for mild symptoms, EUR 2417 for moderate symptoms, EUR 7 624 for moderately-severe symptoms and EUR 10 485 for severe symptoms (König et al., 2023^[13]). This finding suggests that interventions at an early stage of the disease are likely to prevent higher costs when mental health symptoms deteriorate to more severe conditions.

Mental health symptoms, even milder forms, have negative labour market outcomes, suggesting that preventing a deterioration of the disease can increase employment and productivity. Mental ill-health is associated with lower employment and higher absenteeism from work. The strength of the association varies by the severity of symptoms. Previous OECD analysis based on 31 countries found that individuals with moderate mental distress were 15% less likely to be employed compared to those with no mental distress, while the risk increases to 36% for individual with severe mental distress (OECD, 2021^[14]). An Australian study found a significant and positive association between the level of depressive symptoms and the number of mental health-related work absence in the previous four weeks (Johnston et al., 2019^[15]). Individuals with mild depression symptoms had about 0.5 absence day whereas those with moderate symptoms had around 1 absence day, and those with severe symptoms had more than 3 absence days.

Eleven candidate promising and best practices were examined

OECD and EU27 countries have various policy interventions at their disposal to prevent mental ill-health and promote good mental health. The OECD Framework for Mental Health Performance recommended six policy areas for addressing mental ill-health prevention and promoting good mental health (OECD, 2021^[1]). Policy areas include strengthening suicide prevention, improving mental health awareness and literacy, making schools mental health-friendly environments, ensuring that workplaces foster good mental health, enabling front-line professionals to recognise and respond to mental health symptoms, and improving access to care and support by making it easy for individuals to seek help.

Eleven candidate promising and best practices were identified and assessed. Interventions were identified with the help of member countries of the OECD Expert Group on the Economics of Public Health and through the European Commission Best Practice portal (European Commission, n.d.^[16]). Six of the

selected interventions aim to facilitate access to mental health care and support for individuals with mild-to-moderate symptoms by expanding low-threshold services (e.g. supportive material and talking groups) and specialised care services. Three case studies relate to education-based programmes developing children's skills enabling good mental health. Two case studies focus on suicide prevention, and three case studies focus on training for front-line professionals such as midwives and teachers to help individuals with mental distress or in a crisis (Table 1.2). Some of the interventions can cover multiple policy areas at the same time. The population target of the selected interventions is diverse, including children, adolescents, adults, perinatal women, and individuals with mild-to-moderate mental health symptoms, and those with more severe symptoms and suicidal ideation. The geographic representation covers more than 11 countries since some interventions were implemented in several countries. The selected case studies include various ways of delivering the intervention, such as healthcare settings, web-based tools, peer-to-peer programme, and school settings.

Table 1.2. Overview of the 11 selected candidate promising and best practices

Name	Policy areas	Description	Country
Prompt mental health care (PMHC)	Facilitate access	Improved access to mental health support via PMHC centres for individuals with mild-to-moderate symptoms	Norway
iFightDepression® (iFD Tool)	Facilitate access	Web-based, guided self-help programme	Germany
Next Stop: Mum	Front-line actors; Facilitate access	Early diagnosis of postpartum depression	Poland
VigilanS	Prevent suicide	Prevention of reiteration of suicide attempts	France
Belgium's mental health reform	Facilitate access	Improved access to mental health support via a network of psychologists	Belgium
Suicide Prevention Austria (SUPRA)	Prevent suicide; Front-line actors	Suicide prevention with multiple components	Austria
Mental Health First Aid (MHFA)	Front-line actors; Mental health literacy	Training individuals to listen to people with mental distress and provide first aid	Multiple
@Ease	Facilitate access	Peer-to-peer programme for mental health support for adolescents with mild-to-moderate symptoms	Netherlands
This is Me	Facilitate access; School	Online platform for adolescent and school-based programme	Slovenia
Icehearts	School	Programme to accompany children and adolescents with mental health issues	Finland
Zippy's Friends	School	Enhancing social and coping skills in children	Multiple

Each intervention was assessed against a standard methodology common to all the analyses part of the OECD series on best practices in public health. The approach was co-developed by delegates to the OECD Expert Group on the Economics of Public Health and assesses interventions against five best practice criteria including effectiveness, efficiency, equity, quality of evidence base and extend of coverage, as well as an assessment of the intervention's transferability potential. For further methodological details, see Annex A.

While this report focusses on early intervention and prompt access to care for highly prevalent mental disorders, such as depression and anxiety, this focus is not intended to diminish the importance of addressing other disorders, including psychotic disorders, bipolar disorder, and substance use disorders. Instead, the report supports the view that improving access to care and support across the spectrum of mental health conditions must be an overarching policy priority.

Scaling-up early interventions for mild and moderate symptoms of depression and anxiety can have broad public health benefits, including reducing stigma and strengthening mental health literacy, which may indirectly benefit those with other severe mental disorders. For instance, a population trained in mental

health support and exposed to destigmatising conversations around mental ill-health (e.g. *Mental Health First Aid*) may also acquire skills to better support individuals with complex conditions, encouraging them to seek help earlier.

However, there is a risk that disproportionate focus on mild and moderate symptoms could lead to resource shifts or a lack of policy attention to services addressing other mental health needs. For example, if workforce and funding are primarily channelled into prevention and early intervention programmes, specialised services such as intensive case management could face shortages, reducing the quality and accessibility of care.

To mitigate this risk, it is essential that policy efforts to promote good mental health also include measures for people with severe mental disorders. This may include tailored health promotion and prevention measures as well as specific resources to specialised care. For instance, interventions improving access to mental health support for individuals with mild-to-moderate depressive symptoms (e.g. *Prompt Mental health care*, *@Ease*) also serve as a gateway to secondary healthcare services or to general practices for individuals with more severe mental health conditions.

Treating early symptoms of mental ill-health and screening postpartum depression will improve health and economic outcomes

Most interventions facilitate access to people with mild-to-moderate symptoms, such as free consultations with mental health professionals, walk-in centres for youngsters, and guided self-help online tools

Six of the 11 case studies were designed to provide individuals with mild-to-moderate symptoms with **easy and prompt access** to low-threshold and psychological care. Evaluation studies show that these interventions are effective in facilitating access to care and improving individuals' mental health status. The following case studies fall in the category of interventions facilitating access to care:

- **Prompt Mental Health Care (PMHC)** provides individuals with mild-to-moderate symptoms of depression and anxiety with a facilitated and prompt access to diagnosis and talking therapy. Evidence from a randomised controlled trial (RCT) study shows that 59% of the individuals who received *PMHC* treatment had recovered from the symptoms of mild-to-moderate depression or anxiety after six months, compared to 32% of those who received treatment as usual. In addition, *PMHC* increases recovery by 83% at six-month follow-up compared to treatment as usual.
- **iFightDepression® (iFD Tool)** is a web-based, self-management tool for people with mild-to-moderate depressive symptoms, that uses the principle of cognitive behavioural therapy and is guided by a health professional. *iFD Tool* offers free-of-charge training and exercises to do at home. It complements psychological therapy, rather than replacing it. The intervention is effective in shortening the time a person lives with the symptoms of depression and anxiety. Evidence from a RCT study shows that the intervention reduces the symptoms by 40% on an 84-point scale after six weeks and three months, and it increases remission after eight weeks.
- **@Ease** are walk-in centres where young people who experience mental distress can come, seek help and talk with a young adult. The intervention reduces psychological distress and improves social and occupational functioning among adolescents. It also reduces school absence. Among the youngsters who received the intervention, the proportion of those who were absent from school at least once in the last three months decreased from 44% to 17% between the first and third visit to the walk-in centre.
- **This is Me** consists of two different interventions. It offers an online information and counselling service (*#Tosemjaz*) available at any time and at no cost for adolescents with mental distress, as

well as a school-based workshop programme, that systematically addresses the development of social and emotional competencies and realistic self-evaluation of students in primary and lower secondary education. The *#Tosemjaz* website offers a repository of questions-answers by theme (e.g. self-image; love and obsession; drugs and addiction, etc.) and has a chat function that adolescents can use anonymously to exchange with psychologists and other health professionals. The website receives about 180 000 unique visitors, more than 260 000 visits and 1 000 000 page views each year. The school-based workshops are complemented by a self-help manual for adolescents aged 15 and over, widely made available to students as well as to education and health professionals in Slovenia.

- **Belgium's mental health reform** has created a network based on multidisciplinary and intersectionality to enable prompt and free-of-charge access to psychologists. Specifically, the reform entails the creation of networks of mental health professionals (e.g. psychologists and "orthopedagogues") at the regional and local levels, and the reimbursement of both low-threshold and specialised psychological care, covering up to eight and 20 psychological sessions per patient per year, respectively, among others. An evaluation study shows that in the group of individuals who got access to a psychologist through the network, the prevalence of mental health disorders has decreased by 10% on average, six months after their enrolment.
- **Next stop: Mum** is a postpartum depression screening programme with targeted support for women at high risk. The programme aims to inform women on postpartum depression, train midwives to screen postpartum depression in perinatal women and refer those with higher risk to psychological consultations. The programme expanded the potential for screening postpartum depression, reaching about 10% of the target population. A higher likelihood of screening then increases the likelihood of treatment and recovery.

Four interventions specifically target children and young people, three being school-based programmes (*Icehearts*, *Zippy's Friends* and *This is Me*) and one being a peer-based programme (*@Ease*). *This is Me* and *@Ease* are described just above.

- **Icehearts** uses team sports to provide long-term mentoring support to socially vulnerable children and adolescents. Support is provided both in and outside of schools. An evaluation study found that at 4-year follow-up, 49% of *Icehearts* participants showed improved prosocial behaviour, whereas 34% showed a worsening. No evidence is found for emotional and conduct problems. *Icehearts* also reduces school dropouts with a 50% reduction in the number of children being not in employment, education, or training (NEET).
- **Zippy's Friends** is a social and emotional learning programme for school-based children aged 5-7 years. The programme improves social-emotional skills and coping strategies, providing children valuable tools to navigate challenges through adolescence and into adulthood. Negative attitudes such as opposition and withdrawal were reduced by 9% and 15% (respectively) compared to the control group.

Two interventions aim to support suicide prevention. Each intervention has a different focus and breadth. One is a nationwide strategy, while the other is a programme dedicated to individuals who had a first suicide attempt.

- **Suicide Prevention Austria (SUPRA)** is national strategy for suicide prevention, including a gatekeeper programme (e.g. front-line professionals trained to listen to people at risk of suicide and provide essential support), safeguarding hotspots for suicide attempts (e.g. bridges, railways), and reducing access to means of suicide (e.g. firearms, substances). The global effectiveness of SUPRA has not been evaluated, although its components have shown to be effective in reducing suicides.
- **VigilanS** is a prevention programme for individuals who were hospitalised after a suicide attempt. The intervention aims to provide information and involves follow-up phone calls and postcards six

month after hospital discharge. The programme reduces the risk of suicide attempt repetition by 24% within one year.

Three interventions aim to train front-line professionals such as teachers and midwives, in order to provide recognise and support to a person experiencing mental distress or in a crisis. *Next Stop: Mum* and *SUPRA* are described above. The third intervention is described below.

- **Mental Health First Aid (MHFA)** is a training programme that teaches front-line professionals how to recognise, understand and help someone experiencing mental distress or a crisis. MHFA increases mental health literacy, helping-behaviour and confidence in helping people with mental health problems.

Early interventions of mental ill-health prevent the development of more severe mental disorders and improve health and economic outcomes. The selected case studies show positive effects on three key domains: enabling factors for good mental health, health outcomes, and educational and occupational outcomes (Table 1.3), with some interventions reporting evidence on multiple dimensions. Five of the selected interventions show to improve factors supporting mental well-being such as social-emotional skills, coping strategies, interpersonal relationships, and health literacy. Five of the selected interventions also improve clinical outcomes, such as reduced symptoms, faster recovery, less time spent with mental distress, and increased screening of postpartum depression. Finally, four interventions show positive effects on educational and occupational outcomes, including improved school attendance and reduced absenteeism from work.

Table 1.3. Summary of the effectiveness of the selected interventions

	Improvement in enabling factors for good mental health	Improvement in mental health outcomes	Improvement in educational and occupational outcomes
Prompt mental health care (PMHC)		Reduces symptoms by 87% more than controls on a 27-level scale; increases recovery by 83% compared to control	
iFightDepression® (IFD Tool)		Reduces symptoms by 40% more than controls, on an 84-level scale, after 6 weeks and 3 months; improves remission after 8 weeks	
Next Stop: Mum		Extends screening of postpartum depression, reaching 10% of the target group	
VigilanS		Reduces reiteration of suicide attempts by 24% within one year	
Belgium's mental health reform		Reduces prevalence of mental health disorders by 10% after 6 months	Decreases by 60% the number of absence days after 6 months
Suicide Prevention Austria (SUPRA)			
Mental Health First Aid (MHFA)	Increases knowledge on mental health (effect size 0.63), increased helping behaviour (effect size 0.56)		
@Ease	Reduces distress score by 19% on a 40-point scale between the first and third visit, improves functioning score by 6% on a 100-point scale		Reduces school dropout by 61% between the first and third visit
This is Me (including #Tosemjaz website and school-based programme)	#Tosemjaz increases knowledge, with 180 000 unique visitors per year; School programme reduces interpersonal difficulties by 4% on a 144-point scale		School-based programme improves classroom climate after 10 workshops

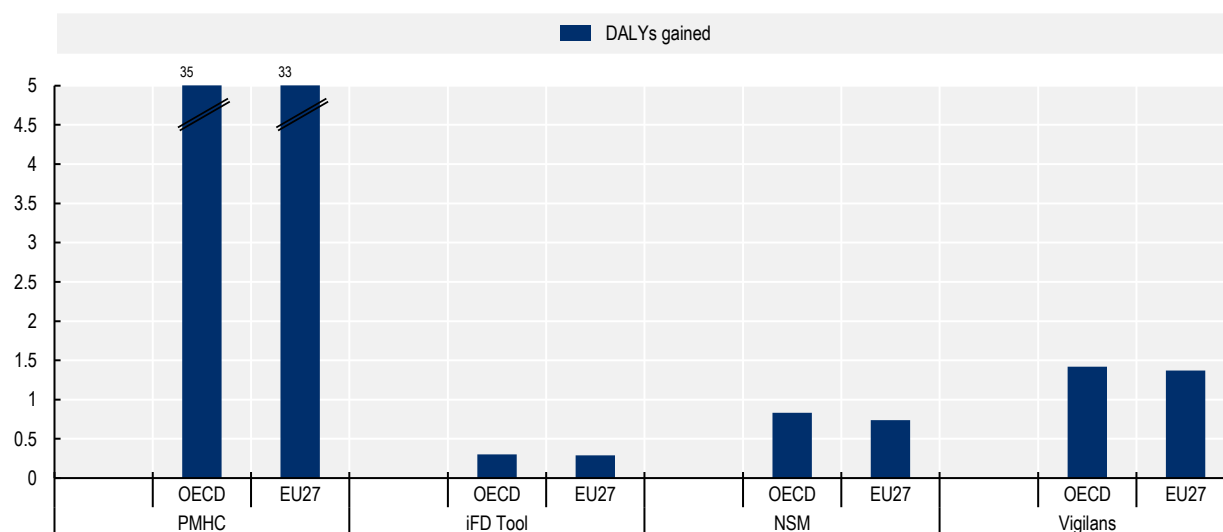
	Improvement in enabling factors for good mental health	Improvement in mental health outcomes	Improvement in educational and occupational outcomes
Icehearts	Improves prosocial behaviour in 49% of participants after 4 years		Reduces by 50% the number of children being not in employment, education, or training (NEET)
Zippy's Friends	Reduces oppositional behaviour by 9% and withdrawal by 15%		

Note: The effectiveness of Suicide Prevention Austria (SUPRA) has not been assessed.

OECD simulations indicate selected interventions would yield significant health and labour market savings while being affordable for many health systems

The OECD Strategic Public Health Planning for Non-Communicable Diseases (SPHeP-NCD) model was used to assess the effectiveness and cost-effectiveness of scaling-up selected promising and best practices in OECD and EU27 countries. This analysis focusses on four of the 11 interventions (*PMHC*, *iFD Tool*, *Next Stop: Mum*, and *VigilanS*), based on data availability and quality. Results from the model show that implementing all interventions would yield a significant health impact – preventing 26.2 million and 8.1 million cases of mental health disorders in OECD and EU27 countries, respectively, between 2025 and 2050. This represents about 1.4% of the annual cases of depression and anxiety in OECD countries. Furthermore, across the four interventions, between 0.3 and 35 disability-adjusted life years (DALYs) per 100 000 population would be gained in OECD countries over the period 2025-2050 (0.3 and 33 DALYs gained in EU27 countries, respectively) (Figure 1.3). For comparison, depression attributable to bullying in Canada results in a loss of 56 DALYs per 100 000 population (IHME, 2020^[2]).

Figure 1.3. DALYs gained annually per 100 000 people, 2025-2050



Note: PMHC = Prompt Mental health care, iFD = iFightDepression®, NSM = Next Stop: Mum.
Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

Interventions can generate both health expenditure savings and improvements in workforce productivity, although the magnitude of benefits varies across countries. OECD simulations show that transferring *PMHC* – an intervention that provides timely access to effective mental health care – to OECD and EU27 countries would lead to significant savings in health expenditure, due to reduction in symptoms severity and shorter disease duration. Specifically:

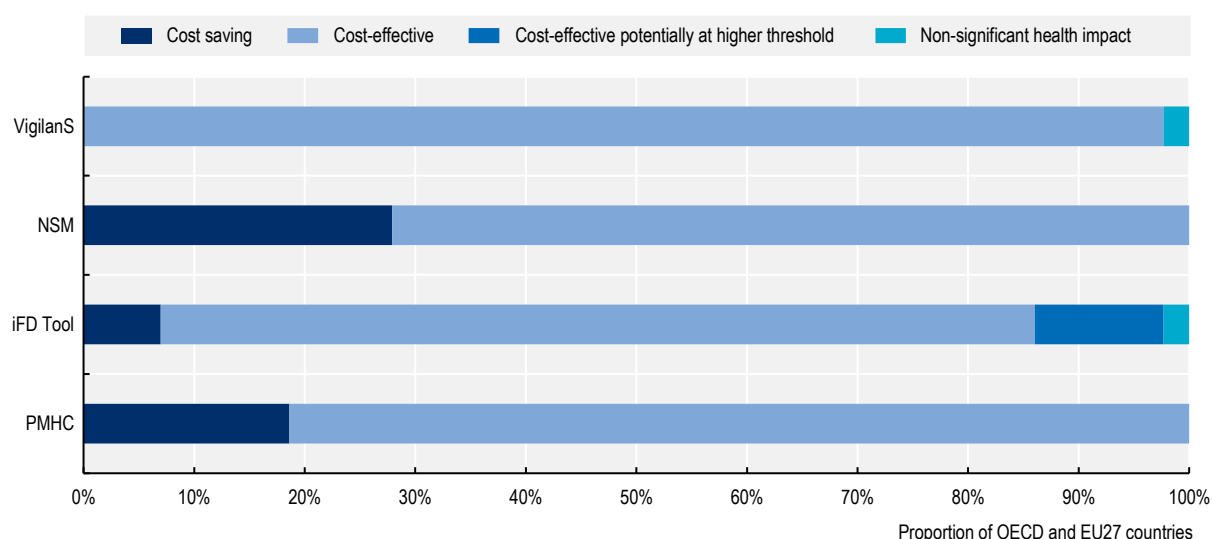
- Scaling up *PMHC* would result in average annual savings of EUR 4.7 per person in OECD countries and EUR 3.57 across EU27 countries.
- Scaling-up a postpartum depression screening programme such as *Next Stop: Mum* improves early detection and diagnosis and supports timely access for psychological care, thereby reducing time spent with the disease and preventing symptom deterioration. This leads to better health outcomes alongside reduced healthcare costs on the long term in all studied countries.
- The transfer of *iFD Tool* and *VigilanS* would also yield health expenditure savings in 19 and 17 countries, respectively, although with no cost reductions in remaining countries. For *VigilanS* – a suicide reiteration prevention programme – health expenditure savings are offset by the cost of treating future chronic diseases. As suicide-related deaths are avoided, the cost of treating certain diseases is expected to increase over the years, as captured by the model's dynamics. However, *VigilanS* produces significant gains in workforce participation and productivity.

Across all the four interventions studied, the reduction of mental health symptoms increases both labour force participation and work productivity. For example, the *PMHC* intervention would save OECD countries up to EUR 3.8 per person per year in labour market costs (EUR 3.5 in EU countries).

Interventions are cost-effective in all countries studied, and even cost saving in some countries.

Analysis of cost per DALY gained over the period 2025-2050 shows that scaling-up *PMHC* would be cost saving in 19% of countries studied and cost-effective¹ in the remaining countries (Figure 1.4). Expanding the *Next Stop: Mum* screening programme – assuming that the programme covers up to three psychological support consultations- would be cost saving in 28% of countries studied and cost-effective in remaining countries. Scaling-up *iFD Tool* would be cost saving in 7% of countries, cost-effective in 79% and potentially cost-effective at higher threshold² in 12% of countries. The scale-up of *VigilanS* is consistently found cost-effective in all countries except one country where the health impact is non-significant.

Figure 1.4. Efficiency of interventions across OECD and EU27 countries



Note: Cost per DALY gained is measured using total intervention costs less total health expenditure savings divided by total DALYs gained over the period 2021-2050. An intervention is considered cost-effectiveness when the cost per DALY is below the average cost-effectiveness threshold applied in European countries (i.e. EUR 50 000 based on (Vallejo-Torres et al., 2016^[17]). For *iFD Tool*, the average cost per DALY is below EUR 50 000, but in a few countries, the confidence interval for the cost-effectiveness ratio crosses the threshold of EUR 50 000 per DALY. Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

Lowering the barriers of access to low-threshold and psychological treatments can enhance the effectiveness of interventions

Analyses of the 11 case studies have identified three main challenges and several solutions to guide policymakers in designing, scaling up or transferring interventions to prevent mental ill-health and promote good mental health. These three challenges are discussed in the reminder of this Chapter, and are summarised as follows:

- Barriers to access and use mental health care and support services can be addressed by increased availability and affordability of mental health care and support services, investments to increase the level of mental health literacy in the population and by developing peer-based support programmes.
- Moderate or poor quality evidence on the effectiveness of interventions can be addressed by using standard frameworks and validated clinical tools to build the evidence base and by incentivising programme assessors to consistently apply these standards.
- Difficulties in previous transfers due to contextual variability, suboptimal cross-sector co-ordination, and limited capacity of the mental health workforce highlight the need to share knowledge, apply established implementation strategies, involve different parts of the government and invest in workforce planning and development.

People in needs of mental health care face financial, organisational, geographical barriers as well as knowledge and stigma-related barriers to access treatment

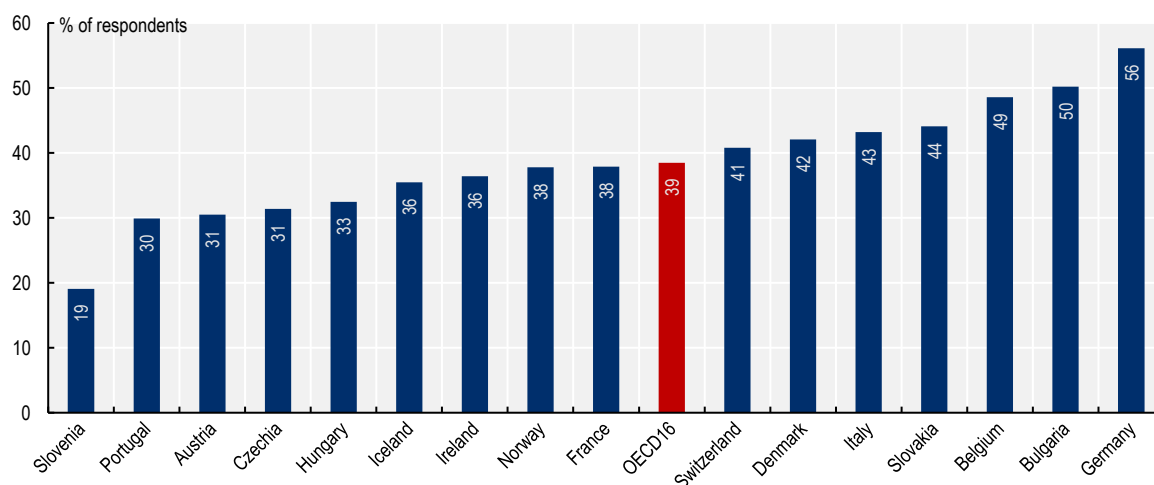
The levels of unmet needs for mental health care are high in OECD countries. On average, two-thirds of individuals in OECD and EU27 countries who need mental health care are estimated to lack access to treatment, based on OECD analysis (see Chapter 2). The gap in mental health support and treatment

varies with the severity of mental ill-health: individuals with mild and moderate symptoms are significantly less likely to receive a mental health therapy or treatment than those with severe symptoms (Evans-Lacko et al., 2018^[8]).

There are various reasons explaining high level of unmet needs for mental health care. These include, but are not limited to, financial, organisational and geographical barriers, such as out-of-pocket payments for psychological therapies, long waiting times to access psychological therapy, shortage of providers, and long distance to travel. Health system characteristics, such as the availability of healthcare services and the health benefit basket covered by national health insurance, are key determinants of healthcare access (Paris et al., 2016^[18]).

Cultural, social and knowledge barriers, such as the lack of mental health literacy and stigma around mental illness, are other important determinants of access to mental health services. **Mental health literacy** is the capacity to find, understand and use information and services to inform decisions and take actions related to mental health problems. Low levels of mental health literacy result in people not having sufficient resource to deal with mental health problems and not seeking care. Four in 10 people reported difficulties to find information on how to handle mental health problems, on average across 16 OECD countries, in 2019-2021 (Figure 1.5). This proportion varies from 19% in Slovenia to 50% or more in Bulgaria and Germany.

Figure 1.5. Two in five respondents find it “very difficult” or “difficult” to find information on how to deal with mental health problems, 16 OECD countries, 2019-2020



Note: Due to the wide variety of sampling and data collection procedures across countries, country differences should be interpreted with caution. Source: The HLS19 Consortium of the WHO Action Network M-POHL (2021^[19]), International Report on the Methodology, Results, and Recommendations of the European Health Literacy Population Survey 2019-2021 (HLS19) of M-POHL, <https://m-pohl.net/sites/mpohl.net/files/inline-files/HLS19%20International%20Report.pdf>.

Stigma around mental illness, and in particular stigma about seeking help for mental ill-health, creates additional barriers to access mental health care. Perceived stigma (or self-stigma) is an individual's perception that they will be treated differently by other people if they seek mental health treatment. A US study focussing on college students found that self-stigma was a major barrier to seek care for one in five students with unmet needs for mental health (Eisenberg, Golberstein and Gollust, 2007^[19]). In another US study, one in seven adults with mental health needs did not seek treatment because they feared to be judged by their neighbours (Mason et al., 2013^[20]). Interestingly, personal stigma (i.e. the perception that one has about someone seeking mental health treatment) is less of a problem. When asked about stigma

around mental health care, college students generally reported greater perceived stigma than personal stigma (Pedersen and Paves, 2014^[21]). This result suggests that communication around mental health interventions can help change perception and reduce self-stigma, which may have a positive impact on care-seeking for mental health problems.

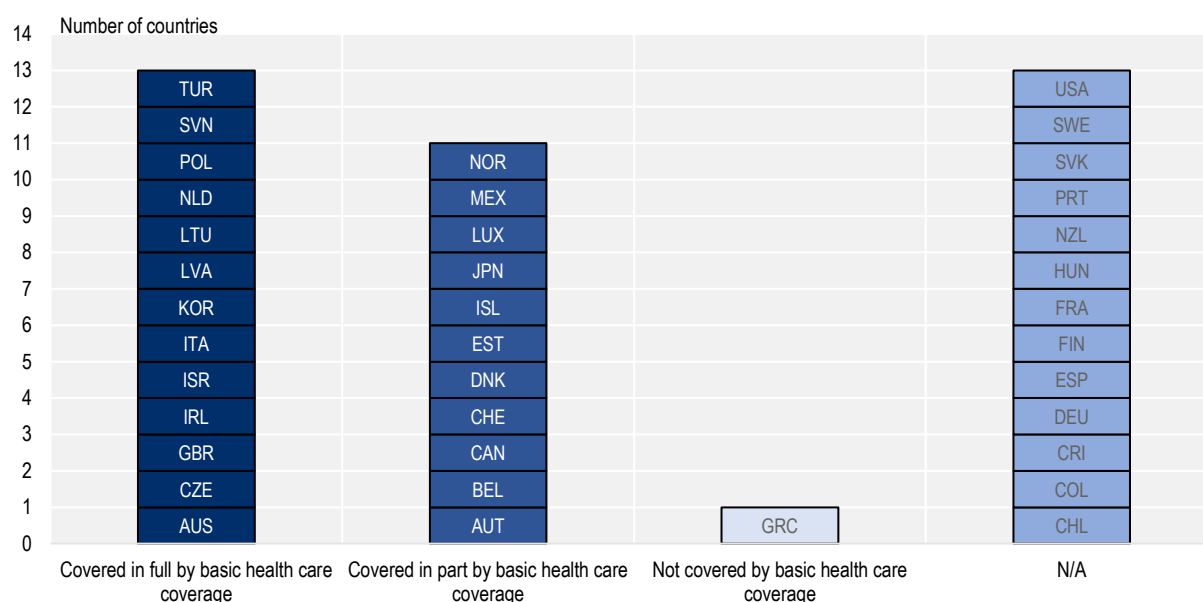
Policy recommendations

In response to high levels of unmet needs in mental ill-health, the following section outlines policy recommendations to remove barriers to access low-threshold and psychological treatment.

Increasing the availability of mental health care services is a top priority to facilitate timely management of mental ill-health. For example, this would **include policies to ensure prompt mental health care services**, with mental health professionals delivering both low-intensity mental health care (e.g. support group) and specialised care such as psychological therapy, across regions and local settings. Increasing provision of low-threshold and specialised treatment would have implications on the mental health workforce. For example, both *PMHC* and the *Belgian reform* are best practices to improve access to care for people with mild-to moderate symptoms. Besides, the Belgian network of mental health professionals spreads across various settings (such as schools, workplace, and social services) to reach a wider group of individuals who might not seek care on their own and to ensure integration of mental health care with other services. When such services cannot be deployed across the entire territory, tele-consultation and online tools should be used to facilitate access for individuals with mild-to-moderate symptoms. In an experimentation of *PMHC* video teleconsultations, users reported that video treatment was more accessible, as they did not have to travel to and from the service, or as they appreciated being able to sit at home in a safe environment and talk about difficult issues. Online services have the potential to increase the programme coverage and reduce waiting times. Evidence from *Next Stop: Mum* – a screening programme of postpartum depression in perinatal women- show that in the regions in which the intervention was deployed, the programme covered 5% of the target population in its in-person version, while the coverage was doubled (10%) when using both in-person and virtual screening versions. The online *iFD Tool* – a guided self-help tool- is a best practice to reduce the time on waiting list, as it provides the patient with information and exercises to address mental health challenges, while waiting for an appointment with a mental health professional.

Enhancing the affordability of mental health care by removing financial barriers can also substantially improve access to services. Cost of psychological therapies should be reimbursed, either partially or in full. In 2020, 24 of 25 countries responding to the survey had psychological therapies delivered by a psychologist covered in full or in part by basic health coverage (OECD, 2021^[1]). Among countries reimbursing the service, more than half (13) covered it in full by basic health coverage (Figure 1.6). While having significant costs for governments, removing the financial barriers is a key lever for seeking mental health care. For instance, both *PMHC* and the *Belgian reform* removed the cost barrier, partly or in full. *PMHC* is totally free-of-charge for patients, and the *Belgian reform* entitles patients to reimbursement for a specified number of free consultations with a psychologist. In Belgium, nearly 40% of users of the new scheme reported that they previously had to forgo care when cost was not reimbursed. This suggests that 40% of the users of the new scheme would have forgone psychological treatment if the cost was not covered.

Figure 1.6. Psychological therapies covered in full or partly by basic healthcare coverage, 2020



Note: N/A not available.

Source: OECD, (2021^[1]), *A New Benchmark for Mental Health Systems*, <https://doi.org/10.1787/4ed890f6-en>.

Effective communication should contribute to normalise mental health symptoms and promote care seeking. For example, interventions such as *MHFA* and *This is Me* promote discussion about mental health problems and the identification of solutions. In addition, school-based interventions, such as *Zippy's friends*, *Icehearts* and *This is me*, teach basic essential skills to deal with emotional and mental issues, providing solutions to mental health problems in children and adolescents.

Efforts should be made to enhance mental health literacy among the population, including young people, workers, and the whole community. Interventions such as *MHFA* that train front-line professionals can raise the level of mental health literacy in various settings, such as schools, higher education institutions, workplaces, and communities. In the workplace, *MHFA* training is crucial for creating mentally healthy environments where employees feel supported, valued, and confident in talking openly about mental health. In Australia, a specialised *MHFA* course trains adults to deliver an intervention specifically designed for Aboriginal and Torres Strait Islander communities, taking into consideration cultural sensitivities.

Peer-based programmes may be implemented to train students and front-line workers (such as teachers) to provide support to a person with mental distress or in a crisis. While treatment of mental illnesses should remain with healthcare professionals, these programmes can help lift the taboo off mental illnesses and can encourage people to discuss their problems and seek help. These interventions can also avoid that early symptoms worsen to more severe conditions. Interventions such as *@Ease* and *MHFA* rely on individuals (peers) who are trained to listen and guide a person experiencing mental distress or crisis.

Stronger evidence on the effectiveness and efficiency of interventions is needed for policy transfer and scaling-up

There are gaps in the evidence base of mental health promising and best practices

Only half of the case studies present proven effectiveness on mental health outcomes and/or enabling factors for good mental health. The OECD Benchmark report identified that it is extremely difficult to assess the efficiency and the evidence-base of the mental health systems because of their loose conceptualisation of efficiency, an heterogeneity in service design and a lack of data (OECD, 2021^[11]). The lack of relevant data and proven effectiveness is also one of the main limitations identified during the analysis of the case studies. Although the evidence base is one of the criteria used to select the candidate interventions, just about half of the analyses present proven effectiveness on mental health outcomes and/or enabling factors for good mental health. Three interventions found mixed or no proven effectiveness of the programme. Two interventions did not – or only partially – evaluate the programme effectiveness on the key indicators described in Table 1.3.

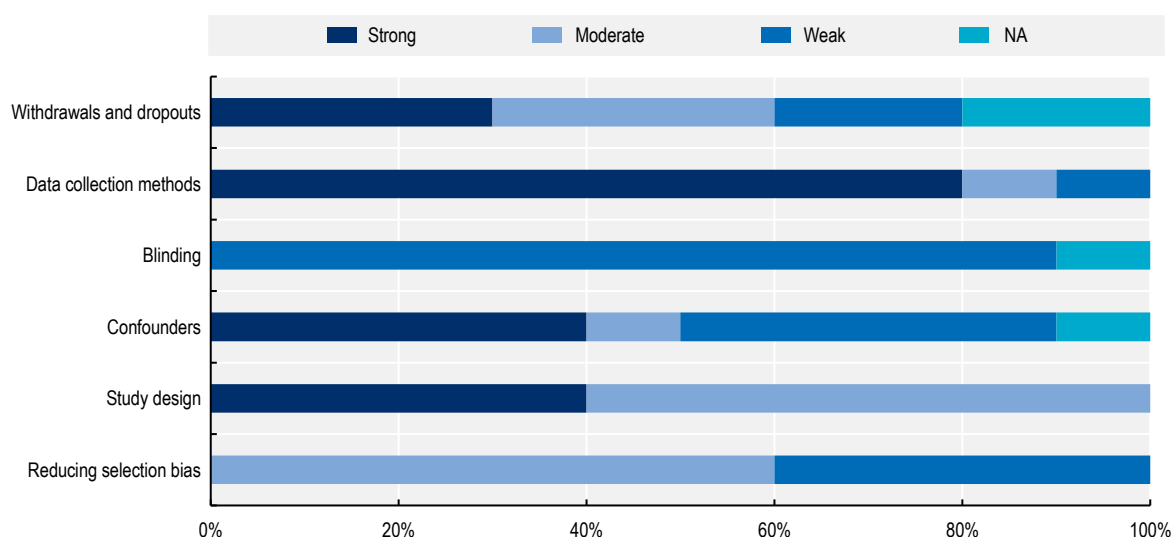
There is a large heterogeneity in the indicators used to measure the interventions' effectiveness. The original studies evaluating the intervention effectiveness use a large variety of indicators, with low level of consistency across the case studies. These indicators can be classified into three groups of outcomes as mentioned above (i.e. enabling factors for good mental health, mental health outcomes, and educational and occupational outcomes). Yet, there is a large heterogeneity in the indicators used within each group of outcomes.

- Enabling factors for good mental health include a variety of measures of social-emotional skills, coping and resilience skills, and social isolation. At least eight different scales were used to measure children's social-emotional skills, such as Strengths and difficulties questionnaire, Kidcope checklist, Social skills improvement system rating scale, among the others.
- Health outcomes include symptom severity and duration, incidence and remission of mental disorders, suicide attempts, and screening of postpartum depression. The two studies evaluating symptoms relied on different instruments: one used PHQ-9 and the other one the Inventory of Depressive Symptomatology self-rating scale. Other studies used indicators about patient satisfaction, quality of life, and general mental well-being, with no consistency in the selected indicators.
- Educational and occupational outcomes are also heterogenous: they include school attendance, school dropout, classroom climate, and work absenteeism. Each original study uses a different indicator from the other original studies.

The evidence base of the selected interventions is generally of moderate or poor quality, with the exception of the data collection methods which are of strong quality. The quality of the evidence supporting the selected interventions was assessed against the Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998^[22]). This tool evaluates the internal validity of studies using six criteria: selection bias; study design; controlling for confounders; blinding; data collection methods; and withdrawals and dropouts. For each criterion, a study is awarded either a “strong”, “moderate” or “weak” score. Figure 1.7 presents a summary of the evidence quality assessment of the selected interventions. Most selected interventions (i.e. 90% of the interventions) have weak assessments regarding “blinding”, while “reducing selection bias” was rated as moderate in 60% of cases and weak in 40% of cases. The quality of the “study design” is relatively more balanced, with 60% of the case studies showing a moderate quality study design and 40% with a strong study design (e.g. random controlled trial). The evidence base of the interventions is often calculated on observational studies that compare the evolution of outcomes before and after the intervention. Although informative, this type of studies may not be sufficiently reliable to assess the intervention effectiveness. Higher quality evidence is obtained when

the intervention effectiveness is assessed by comparing the group that received the intervention with a control group that received treatment as usual (as for example, *PMHC* and *iFD Tool*). Finally, strong quality assessment is granted for 40% of the interventions regarding “controlling for cofounders” and for 30% of interventions regarding “reducing withdrawals and dropout”. Most interventions have strong quality “data collection methods”, with 80% of the interventions using both valid and reliable methods.

Figure 1.7. Assessment of quality of evidence of the selected interventions



Note: Results reflect findings from the selected interventions. “NA” = not applicable.

Source: OECD analyses based on the methodology in: Effective Public Health Practice Project (1998^[22]), “Quality assessment tool for quantitative studies”, <https://www.nccmt.ca/knowledge-repositories/search/14>.

Policy recommendations

The key findings summarised above on the quality of the evidence base highlight gaps in data collection and quality that may hinder transferring and scaling-up mental health interventions. Recommendations to strengthen the evidence base of mental health interventions include the following ones.

Experts and professionals should be encouraged to agree and use standard frameworks for data collection, such as the OECD framework for mental health system (OECD, 2021^[1]). The OECD Framework outlines a set of indicators for continuous mental health surveillance, including those related to prevention and promotion, which countries can collect to advance the mental health policy agenda, **Experts and professionals should also be encouraged to establish standards for programme evaluations**, such as requesting that programme assessors systematically include the measurement of mental health symptoms. In England, the outcome monitoring system of the National Health Service Talking Therapies collects symptom scores from 98% of users, which serves to assess the programme performance. In addition, **experts and professionals should be encouraged to agree on validated clinical tools** to measure symptom severity and the enabling factors for good mental health. These recommendations help prioritise mental health preventive actions and focus on subclinical conditions.

Programme leaders and assessors should be incentivised to consistently apply these standards across programme evaluations. For example, funding for programmes can be linked to the standards and tools used in evaluations. It is also important to **ensure sufficient long-term monitoring** of patients to assess programme effectiveness and sustainability, particularly when the programme targets children and young people. For instance, for interventions such as *Icehearts* and *@Ease*, programmes and outcomes

are repeatedly measured and monitored. Specifically, *Icehearts* in Finland has its own follow-up tool that systematically collects data, including mentors' assessment of each child's progress twice a year, parents' and children's assessment once a year. It is essential to conduct follow-up studies until participants reach adulthood to evaluate the long-term effects of the programme. Finally, it is crucial to carefully monitor the impact of mental health interventions, not only to assess their effectiveness but also to guard against potential unintended consequences such as overdiagnosis or shift attention away from patients with more complex needs. This will help ensure that scaling-up interventions leads to equitable and effective improvements in mental health.

Scaling-up and transferability: Careful planning is crucial to successfully transfer or scale-up a best practice interventions on mental health given the complexities involved

Transferring interventions is a complex task that requires a well-designed implementation strategy

Transferring promising and best practices from one country to another is generally a difficult task, as highlighted in previous OECD analyses (OECD, 2022^[23]). Transferring practices on mental health also presents complexities. Specifically, at least three specific issues were identified in the transferring of promising and best practices on mental health.

Attempts to transfer the best practices have encountered difficulties due to cross-national differences in contexts and needs. Countries have different characteristics, and their mental health care system differs, which may facilitate or hinder the transfer. For instance, adopting walk-in centres for young people is relevant in areas with good public transport so that young people in need can go to the centres on their own. In countries where a significant share of the population lives in rural and remote areas, online support and teleconsultation may be more suitable. Another example is the implementation of prompt mental health care services and networks of mental health workers in local settings such as social services, schools, and hospitals. These interventions are particularly relevant in countries where psychological therapies can be obtained without a referral from a general practitioner as direct access to a psychologist removes one of the key barriers to care access.

The second specificity of the mental health practice transfer is the need for the integration of mental health promotion and prevention programmes into other related domains such as schools, unemployment and social services. Most selected interventions require interprofessional and intersectoral collaboration, and effort to engage multiple stakeholders. For instance, the transfer of school-based interventions requires to involve education actors such as teachers and school directors, as well as pupils and their parents. The delivery of these interventions is facilitated by small class size and teacher motivation relating to their perception on their ability to influence the development of children. Another example is a suicide prevention programme, such as *Suicide Prevention Austria*, that requires the collaboration with the Ministry of Transport to safeguard hotspots for suicide such as bridges, highways or railways.

The third difficulty that can hinder successful transfer of mental health interventions is the country's mental health workforce capacity. Interventions that aim to facilitate access to mental health care rely on mental health care workers, such as psychologists and mental health nurses. In most selected interventions, psychologists play a prominent role. Countries with shortages in mental health professionals may experience difficulties in adapting these interventions in their local context. A number of OECD countries report shortages in mental health professionals, although data is not systematically collected, and when it is collected it is specific to some professions (OECD, 2021^[11]). For instance, the number of

psychologists per 1000 population varies hugely across countries, from 0.02 in Hungary and Korea to 1.40 or above in Norway and Denmark (WHO, 2024^[24]).

Despite the difficulties outlined above, the evidence shows the case studies can be successfully scaled-up and transferred if adapted to the local context. Six of the promising and best practices were, or are being, scaled up nationally, and eight practices were, or are being, transferred from the “owner” country to another “target” country (Table 1.4). In many cases, the promising and best practices are transferred to multiple “target” countries. For instance, *MHFA* was, or is being, transferred to 29 countries, while *Zippy’s Friends* to 18 OECD and EU countries. The European Union financially supports the transfer of promising and best practices related to mental health across EU/EEA countries. For example, the EU-funded EAAD-Best project supported the transfer of *iFightDepression®* Tool to 8 EU countries. Another example is the EU-funded Joint Action ImplementAL that helps countries to transfer and implement two selected best practices: *Suicide Prevention Austria* transferred to 17 EU/EEA countries, and the *Belgian mental health reform* transferred to 14 EU/EEA countries (Box 1.2).

Table 1.4. Scale-up and transfer status of selected interventions

Case study	Scaled-up nation-wide, achieved or underway	Transferred to another country	No scale-up, no transfer
Prompt mental health care (PMHC)		✓	
iFightDepression® (iFD Tool)	✓	✓	
Next Stop: Mum			✓
VigilanS	✓		
Belgian reform	✓	✓	
Suicide Prevention Austria (SUPRA)	✓	✓	
Mental Health First Aid (MHFA)		✓	
@Ease		✓	
This is Me	✓		
Icehearts		✓	
Zippy’s Friends	✓	✓	

Source: OECD analyses.

Box 1.2. The EU-funded Joint Action ImpleMENTAL

The EU-funded Joint Action ImpleMENTAL was a 3-year project, ending in 2024. The work of the Joint Action aimed to support countries in transferring and implementing two selected best practices: *Suicide Prevention Austria* transferred to 17 EU/EEA countries, and the *Belgian mental health reform* transferred to 14 EU/EEA countries.

The Joint Action ImpleMENTAL supported participating countries in the implementation process, such as assessing the situation and needs in the target countries, establishing local networks for mental health, sharing knowledge, setting achievable goals, fostering stakeholder engagement and advocacy, and building capacity for mental health care services.

The Joint Action has used the CHRODIS Plus implementation strategy, which consists in three phases. The pre-implementation phase is crucial to analyse the context of the target countries, assess the feasibility of the implementation and set action plans for the pilots testing the intervention. The implementation phase aims to monitor progress of implementation and collect data, while the post-implementation aims to evaluate the success of the intervention and report lessons learnt. A similar three-step strategy is also recommended in the OECD Guidebook on best practices in public health. Based on the Plan-Do-Study-Act framework, the OECD recommends identifying and assess the transfer feasibility to a different context (Step 1), prepare and implement (Step 2); and monitor and evaluate (Step 3) (OECD, 2022^[25]).

Source: JA-ImpleMENTAL website, <https://ja-implemental.eu/>.

Nearly half of OECD and EU27 countries have already in place many of the elements needed to transfer the identified best practices to their own country. OECD developed a methodology to cluster countries based on their potential to transfer selected case studies to their own countries. High-level methodological details are in Annex A, with further details available in (Wiper et al., 2022^[26]). The section below summarises key findings from the analyses assessing the potential for countries to transfer and implement the interventions described in the case studies in this report:

- Countries in cluster one comprise 20 OECD and EU27 countries – representing 47% of the studied countries- that have organisational, political, and economic conditions in place at the national level to support the implementation of the mental health interventions (Table 1.5). For example, these countries typically have good level of accessibility to healthcare services and a higher number of psychologists. These countries also have national policies to prevent suicide, improve mental health awareness and literacy, and a strategy or an action plan that guides the implementation of the mental health policy.
- Countries in cluster two – 14 OECD and EU27 countries – have national policies in place supporting the implementation of mental health interventions. However, they may not have the arrangements in place to provide access to mental health services, and they have a lower budget available to implement the interventions. In addition, the number of psychologists per capita is relatively smaller than in countries part of cluster one, and they also tend to show lower score for the healthcare accessibility index suggesting the presence of barriers to access healthcare services. Spending on prevention is relatively lower than in cluster one.
- Countries in cluster three – 9 OECD and EU27 countries – are less likely to have organisational, political, and economic conditions supporting the implementation of mental health interventions, although all countries have the opportunity to tailor the promising and best practices according to their specific needs, resources and contexts. Countries in this cluster on average score lower on

the healthcare accessibility index than countries in cluster one, and the number of psychologists per capita is smaller than countries in clusters one and two. In addition, countries in cluster three may not have an action plan to guide the implementation of their mental health policy, a suicide prevention strategy or programmes to increase mental health literacy. The average spending on prevention is also relatively lower than for countries in cluster one.

Table 1.5. Around half of all OECD and EU27 countries have conditions in place to implement mental health prevention programmes

Cluster 1: Countries with high potential to transfer and implement mental health interventions	Cluster 2: Countries that should ensure accessibility to mental health services.	Cluster 3: Countries that should ensure accessibility and political feasibility of the interventions.
Australia	Colombia	Bulgaria
Austria	Czechia	Chile
Belgium	Estonia	Costa Rica
Canada	Japan	Croatia
Cyprus	Korea	Greece
Denmark	Latvia	Hungary
Finland	Lithuania	Italy
France	Malta	Romania
Germany	Mexico	Slovak Republic
Iceland	Netherlands	
Ireland	Poland	
Israel	Portugal	
Luxembourg	Switzerland	
New Zealand	Türkiye	
Norway		
Slovenia		
Spain		
Sweden		
United Kingdom		
United States		

Source: OECD analyses.

It is important to note that there are limitations with this analysis, most importantly:

- It should not be assumed that the transfer of the mental health interventions will fail in countries where it is recommended to consider challenges related to population, political and/or economic feasibility (e.g. clusters 2 and 3). Rather, the results indicate areas to which countries should pay particular attention, but which are not necessarily pre-requisites for transferral.
- The analysis relied on publicly available data that covered many OECD and EU27 countries. Therefore, the analysis is high level and may rely on simplifications and not capture all the relevant indicators and factors to assess the potential for transferability.
- The data used for the analysis is collected at the national level and therefore does not consider regional differences within countries.

Policy recommendations

The key findings summarised above on scaling-up and transferability highlight the barriers associated with transferring and scaling-up best practices on mental health prevention. Based on the analysis of the case studies, the following policies were identified to assist policymakers in scaling-up interventions within countries as well as transferring them to other countries.

Implementers should be encouraged to share knowledge and experiences from previous transfers.

Building on previous transfers is essential to learn from past experiences and improve future transfer. It is also crucial that implementers have at their disposal guidelines and standards to facilitate the transfer and implementation process. For instance, the Joint Action ImpleMENTAL uses the established implementation strategy developed by the Joint Action CHRODIS Plus (Box 1.2). Lessons learnt from CHRODIS Plus have supported the development of ImpleMENTAL, for instance in carrying out of a country's situation analysis and an assessment in the early phases of the implementation. In turn, lessons learnt from ImpleMENTAL may help future transfers. For instance, ImpleMENTAL identified that along with achievable and sustainable goals, it is motivating to have "quick wins" producing positive results soon after the implementation of the intervention.

A cross-governmental approach should be used to implement mental health interventions. Mental health prevention and promotion activities span across many different sectors such as health, school, work, social services and justice. It is essential that governments co-ordinate mental health strategies and that collaboration between multiple ministries is improved in order to effectively implement policies. In 2021, 19 OECD countries reported that multiple ministries, in addition to the Ministry of Health, were in charge for implementing mental health interventions (OECD, 2021^[1]). Ten countries also reported that ministries other than the Ministry of Health (e.g. ministries of social affairs, families, employment) had a dedicated mental health budget. For example, Norway has developed the National Mental Health Strategy with seven ministries, including the Ministries of Health, Culture, Children and Equality, Labour and Social Affairs, Education, Local Government and Modernisation, and Justice.

Careful planning and, when necessary, increasing the capacity of the mental health workforce are crucial to support an effective implementation of the identified best practices. Efforts to collect data on the workforce capacity should be made, reflecting the diversity of the professions including psychologists, mental health nurses, general practitioners, psychiatrists, social workers and occupational therapists. Where necessary, policymakers can also increase the workforce capacity by creating new roles for existing professions, such as midwife-led postpartum depression diagnosis in *Next Stop: Mum*, or new professions such as orthopaedagogues in the *Belgian reform*. At the same time, it is important to ensure integrating these new roles with established, traditional roles across healthcare and other sectors, such as the social sector. Finally, mental health workforce projections should also be carried out and used to plan for future mental health needs of the population. For instance, England's 2020/21 mental health workforce plan emphasised expanding the diversity of staff roles and established a significant number of new professions. These included "traditional" staff such as nurses, occupational therapists or doctors, and new roles such as peer support workers, personal well-being practitioners, or call handlers (Health Education England, 2017^[27]). As of 2025, the UK Government recruited more than 6 700 additional mental health workers and developed mental health support teams in schools and colleges, now being accessible to more than half of pupils in England.

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Notes

¹ An intervention is considered cost-effectiveness when the cost per DALY is below the average cost-effectiveness threshold applied in European countries (i.e. EUR 50 000 based on Vallejo-Torres et al. (2016^[17])).

² The average cost-effectiveness ratio falls below the cost-effectiveness threshold, but the confidence interval for the ratio crosses the threshold.

2 The emergence of mental ill-health and its societal and economic impacts

Mental health is crucial for a fulfilling life, yet mental ill-health significantly affects a large part of the population in OECD countries. Major depression and anxiety disorders are the most prevalent conditions, with a considerable burden of their subclinical forms: approximately one-fifth of people in OECD and EU27 countries experience mild-to-moderate depressive symptoms. This chapter examines the prevalence and uneven distribution of mental health conditions and discusses their societal and economic impacts. Additionally, it explores both systemic and personal barriers to mental health care contributing to the high unmet care need and large treatment gap. Finally, it provides a state of play of the mental health policies in OECD countries and introduces country examples of 11 candidate best practices aimed at mitigating the substantial burden of mental ill-health.

Key findings

Mental ill-health imposes high burden – including mild and moderate forms – and is unequally distributed in the population and over the life course

- Around 2% of the population in OECD and EU27 countries has moderately-severe and severe depressive symptoms, while approximatively 19% report mild-to-moderate symptoms. While severe symptoms are associated with significant impairment in social and occupational functioning, individuals with mild-to-moderate symptoms of depression and anxiety may also experience lower quality of life and functioning. Yet, more than two-third of these remain undiagnosed. If left untreated, mild symptoms of depression and anxiety can deteriorate into mental illnesses: addressing these symptoms early offers substantial potential for prevention and improved mental health outcomes.
- High levels of mental distress persist, particularly post-COVID-19, possibly leading to increased burden of mental ill-health. This burden is unequally distributed, with women experiencing 62% higher rates of moderate to severe depressive symptoms than men. In contrast, men have higher suicide rates, which are up to seven times greater than those experienced by women. Suicidal thoughts have increased among young people, with up to a quarter of young people reporting such thoughts during the pandemic, despite no significant change in suicide deaths across OECD countries.
- Mental ill-health often begins early in life, with 75% of adult mental disorders starting before adulthood. Vulnerability increases during life transitions, such as adolescence, pregnancy and postpartum, or migration, and is heightened by negative events such as unemployment or death of a relative or friend. The uneven distribution of mental health conditions has a particularly detrimental impact on people in low income and/or with low education. Socio-economic disadvantages such as unemployment and income loss, exacerbate mental health issues.

Mental ill-health has a heavy toll on both health, social and economic outcomes

- Mental ill-health has substantial economic costs to the society, including considerable costs from reduced employment and productivity. Existing estimates of mental ill-health costs exceeded 4% of the GDP for 28 EU countries in 2015. Costs go beyond mental health services and include costs of treating comorbidities and suicide attempts, as well as social considerable spending primarily through disability benefits. The mental ill-health employment gap is stark, with people experiencing severe mental distress having employment rates over 25 percentage points (p.p.) lower than those without mental distress. Education and employment outcomes are closely linked, with mental health conditions leading to lower educational attainment which hampers labour market participation. Other reasons for the employment gap include stigma and discrimination.

Health system and personal barriers in access mental health care drive high unmet need and a large treatment gap

- Support for people with mental health issues remains limited across OECD countries. While different measures exist, they tend to conclude that around two-thirds of people in OECD countries do not receive the support they would need, or they seek. Those with severe symptoms are 2.4 times more likely to receive treatment than those with mild symptoms and only one fifth of those with major depressive disorder in high-income countries received adequate care.

- Several barriers to accessing mental health care are related to structural challenges of health systems. These include financial constraints – such as limited coverage and out-of-pocket payments – which deter individuals from seeking care, organisational issues – such as long waiting times-, and geographical challenges – such as long travel distances- that particularly affect rural areas. Underlying these systemic barriers is the limited capacity of mental health professionals.
- In addition, barriers to care are often also personal. Examples include low perceived need, limited mental health literacy, and various forms of stigma that significantly hinder access to mental health care. Low perceived need is the most common reason for not seeking treatment, particularly among those with mild-to-moderate symptoms. Stigma – whether perceived, external, or self-imposed – deters many from seeking help. Additionally, two in five individuals in OECD countries struggle to find mental health information.

OECD and EU27 countries have been implementing policies to address barriers in access to quality care, reduce stigma and discrimination and promote good mental health and prevent mental ill-health

- Following the increase in attention to mental health globally, especially post-COVID-19, many countries have implemented comprehensive policies addressing multiple domains: stigma reduction, promotion of good mental health and prevention of mental ill-health and improving access to quality mental health care. For instance, in 2023, 83% of OECD and EU27 countries with available responses reported having introduced initiatives to combat stigma and discrimination, and 88% focussed on improving mental health awareness and literacy. In terms of care, 96% reported allowing access to some form of mental health services without a referral (although this might be by phone or online or include out-of-pocket payments), and 78% have integrated mental health promotion and treatment into primary care. Further, 73% reported the use of talking therapy, an evidence-based treatment that is effective particularly for mild-to-moderate symptoms of depression and anxiety.

Mental ill-health is widespread, has an early onset and is unequally distributed in the population

Mental health is pivotal for living a meaningful life and encompasses more than just the absence of mental illnesses or of mental ill-health, including multiple aspects of psychosocial functioning (OECD, 2023^[1]) (Box 2.1). Theoretical frameworks conceiving mental health have been evolving over the past decades and currently agree on the existence of a continuum of functioning and symptoms that can appear and disappear and evolve over time (OECD, 2023^[1]). Mental ill-health can result from diagnosable mental health conditions (defined according to psychiatric classification systems), but also from subclinical manifestations of these conditions or from non-disorder-specific psychological distress (Box 2.2). Without prejudice of several other categories of mental health conditions – such as bipolar and psychotic disorders – this chapter focusses on major depression, anxiety disorders and related symptoms which are of very high prevalence in the population and are targeted by most best practices studied in this report.

Box 2.1. Terminology and definitions

This report addresses both subclinical symptoms and diagnosed mental health conditions. Terminology related to mental health varies across countries and contexts, with different preferences shaping the language used. For consistency, this report applies the following terms:

- Mental health issues/problems/challenges, mental distress, and subclinical symptoms – used to describe experiences that do not meet diagnostic thresholds.
- Mental health conditions, mental disorders, and mental illnesses – used to refer to diagnosed conditions.
- Mental ill-health – used as an umbrella term encompassing both subclinical experiences (e.g. distress, subclinical symptoms) and diagnosed conditions (e.g. major depression, anxiety disorders).

Box 2.2. Diagnostic and screening tools for mental ill-health

Different instruments are used to measure mental ill-health. This box provides an overview of the two most common alternatives: structured interviews, that allow the diagnosis of mental disorders as per internationally recognised psychiatric classification systems; and screening tools, designed to identify individuals at risk of conditions which should then be clinically assessed. In line with the remaining of the report, examples focus on depression and anxiety related mental ill-health, responsible for a large burden worldwide.

Structured interviews for clinical diagnosis of major depression

The Diagnostic and Statistical Manual (DSM) is used by medical doctors to establish diagnostic criteria for mental disorders, such as major depression. DSM-5 is the latest version of the manual, published in 2015 by the American Psychiatric Association. According to these criteria, applied through structured interviews, patients are diagnosed with major depression if they report five or more depressive symptoms, including at least one of the symptoms “depressed mood” and/or “loss of interest or pleasure”. The list of symptoms include:

- Depressed mood most of the day
- Loss of interest or pleasure in activities most of the day
- Significant weight loss or weight gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings worthless or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of suicide.

Comparable diagnostic criteria are also defined for generalised anxiety disorder.

Patients reporting less than five symptoms do not fulfil the diagnosis of major depression but may be considered in the “subclinical depression” category. While there is significant heterogeneity in the

conceptualisation of subclinical depression, a systematic review found that most studies define subclinical depression as having two to four symptoms including depressed mood or loss of interest (Rodríguez et al., 2012^[2]).

Screening tools for depressive and anxious symptoms

Screening tools are designed to capture a continuum of mental ill-health and to identify symptoms of different severity. Among the most used tools:

- The Patient Health Questionnaires (PHQ) are scales validated by research to assess the severity of depressive symptoms (OECD, 2023^[1]; Kroenke et al., 2009^[3]). The PHQ-9 is composed of nine questions referring to the previous two weeks. In each question, the frequency of the symptom is associated with a number of points: not at all (0 point), several days (1), more than half the days (2), nearly every day (3). The total score ranges from 0 to 27, with higher score indicating greater severity of symptoms. The score cut-offs used to define the severity of symptoms are shown in Table 1.1. A shorter version of the questionnaire, the PHQ-8, removes the final question of PHQ-9, which focusses on suicidal ideation, and scores 0-24 points. A positive screening result is considered when scoring 10 or more, in both PHQ-8/9.
- The Generalised Anxiety Disorder scale (GAD-7) is a tool to assess anxiety symptom severity (Spitzer et al., 2006^[4]). The GAD-7 is composed of seven items capturing the presence of anxiety symptomatology, each with four categories of response (similarly to the PHQ). The sum of the seven items ranges between 0 and 21 points and allows for the identification of one of the four categories of symptom severity (Table 1.1). A positive screening result is considered when scoring 10 or more in GAD-7.

Table 2.1. Screening tools and thresholds of severity

PHQ-9	GAD-7
0-4: Minimal depression	0-4: Minimal anxiety
5-9: Mild depression	5-9: Mild anxiety
10-14: Moderate depression	10-14: Moderate anxiety
15-19: Moderately-severe depression	15-21: Severe anxiety
20-27: Severe depression	

Source: Kroenke et al. (2001^[5]), "The PHQ-9: Validity of a brief depression severity measure", <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>; Spitzer et al. (2006^[4]), "A brief measure for assessing generalized anxiety disorder: the GAD-7". <https://doi.org/10.1001/ARCHINTE.166.10.1092>.

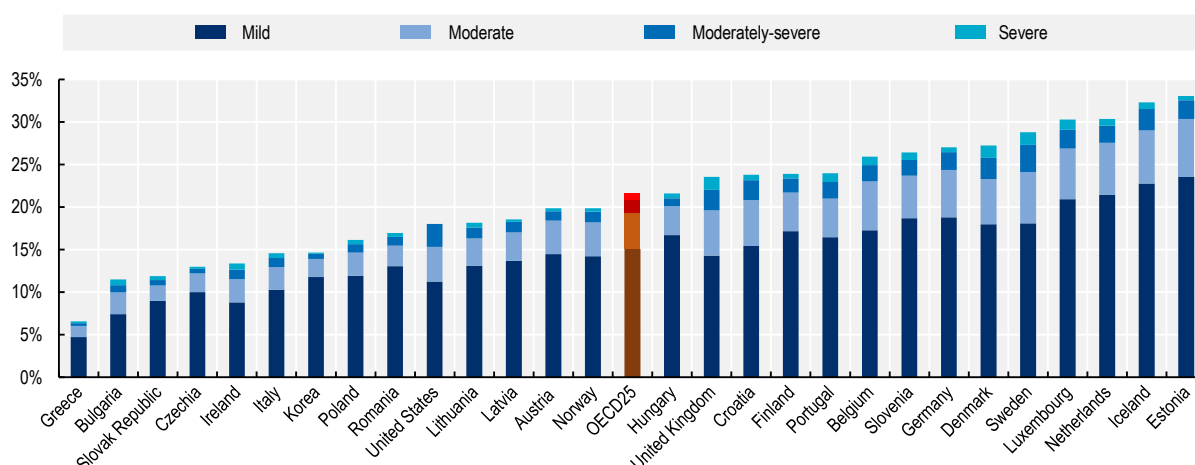
Symptom screening tools have been increasingly incorporated into national health surveys to measure population mental health. PHQ-8 is applied in more than 60% of OECD countries (OECD, 2023^[1]), for example through the European Health Interview Survey (EHIS), the Korea Community Health Survey, and the United States National Health Interview Survey. Estimates of mental disorders prevalence in the population are likely to differ depending on the type of instrument used to measure them. Compared with diagnostic interviews, screening tools are likely to overestimate population level prevalence, as these tools were designed to identify individuals at risk – some of whom may not meet the criteria for a confirmed diagnosis.

Major depression and generalised anxiety disorder are the most diagnosed mental health conditions in OECD countries. On average across OECD countries, estimates suggest that around 3.4% of the population lived with major depression and 5.8% with generalised anxiety disorder in 2022 (IHME, 2024^[6]). Individuals suffering from major depression experience depressed mood or a loss of pleasure or

interest in activities for most of the day, while individuals with anxiety disorders experience excessive fear and worry. The symptoms of both conditions result in significant distress or significant impairment in social and occupational functioning. The severity and the duration of symptoms are key factors of the clinical diagnosis of mental disorders.

On average, around 19% of people in OECD and EU27 countries experience mild-to-moderate depressive symptoms. OECD analysis of survey data from OECD and EU27 countries found that nearly one in five people aged 15 and above reported having mild-to-moderate symptoms of depression in 2019, based on the screening tool PHQ-8 (Box 2.2). Specifically, 15% of respondents reported having mild symptoms of depression, 4% had moderate symptoms, while 2% had moderately-severe and severe symptoms (Figure 2.1). More than 25% of the population aged 15 and above report mild-to-moderate symptoms in Luxembourg, the Netherlands, Iceland and Estonia, compared to less than 15% in Poland, Korea, Italy, Ireland, Czechia, the Slovak Republic, Bulgaria, and Greece. In all the studied countries, **the mild and moderate symptoms represent the bulk of mental ill-health**: 90% of individuals with mental health symptoms had reported mild-to-moderate symptoms. Individuals with mild-to-moderate symptoms, not fulfilling the diagnostic of major depression, have lower quality of life, poor health perception, higher level of disability and impairment in physical functioning (Rodríguez et al., 2012^[2]).

Figure 2.1. Proportions of depressive symptoms, by severity, 25 OECD and EU27 countries, 2019

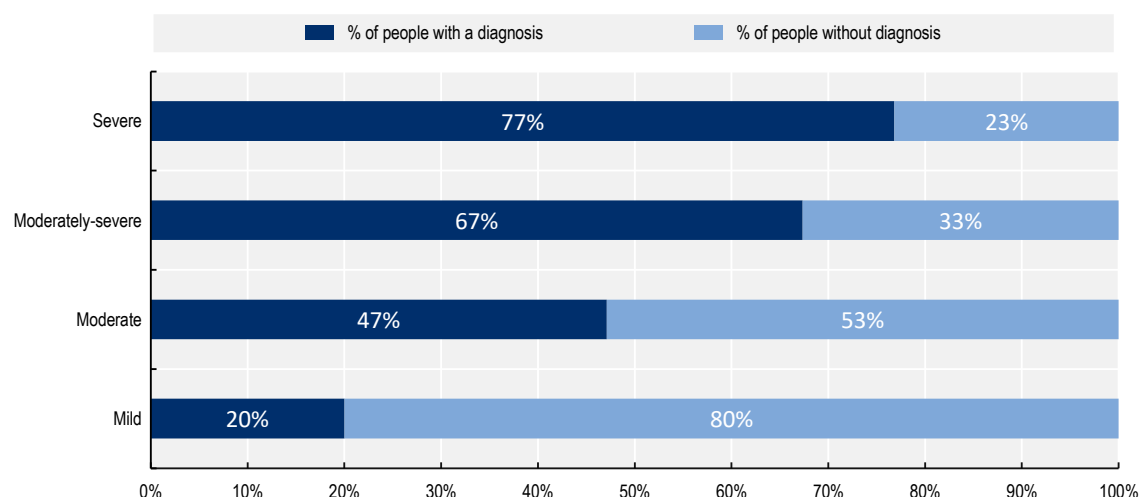


Note: Age 15+. In the United States, the moderately-severe and severe are grouped.

Source: OECD analysis based on EHIS, 2019, and national survey data for Korea (Korea Community Health Survey 2019), the United Kingdom (European health interview survey 2019) and the United States (National Health Interview Survey 2019).

People with mild and, often, moderate depressive symptoms are less likely to be identified because they do not meet existing clinical criteria. OECD analysis based on survey data from 22 OECD countries confirms that the likelihood of reporting a diagnosis of depression increases with the severity of symptoms (Figure 2.2). Specifically, about 8% of the surveyed population reported to have been diagnosed with depression in the last 12 months. This proportion increases with the severity of symptoms: the share of those with a diagnosis is 20% in those with mild symptoms, 47% in those with moderate symptoms, 67% in those with moderately-severe symptoms, and 77% in those with severe symptoms. As more than half of individuals with mild and moderate symptoms are undiagnosed, they represent a large potential for prevention and early intervention that might prevent the deterioration of their mental health.

Figure 2.2. Share of people reporting a diagnosis of depression by a doctor, by symptom severity, 22 OECD countries



Note: Age 15+.

Source: OECD analysis based on EHIS, 2019.

If left untreated, mild symptoms can turn into mental illnesses. People with mild and moderate symptoms are significantly less likely to receive a mental health therapy or treatment compared to those with severe symptoms (Evans-Lacko et al., 2018^[7]). However, if milder symptoms are left untreated, they can deteriorate to mental disorders. Evidence shows there is a 10% to 20% risk that subclinical depression deteriorates to major depression. In addition, subclinical depression poses a 33% to 50% risk of patients developing moderate functional impairments (Teepe et al., 2023^[8]), in domains such as physical or social functioning.

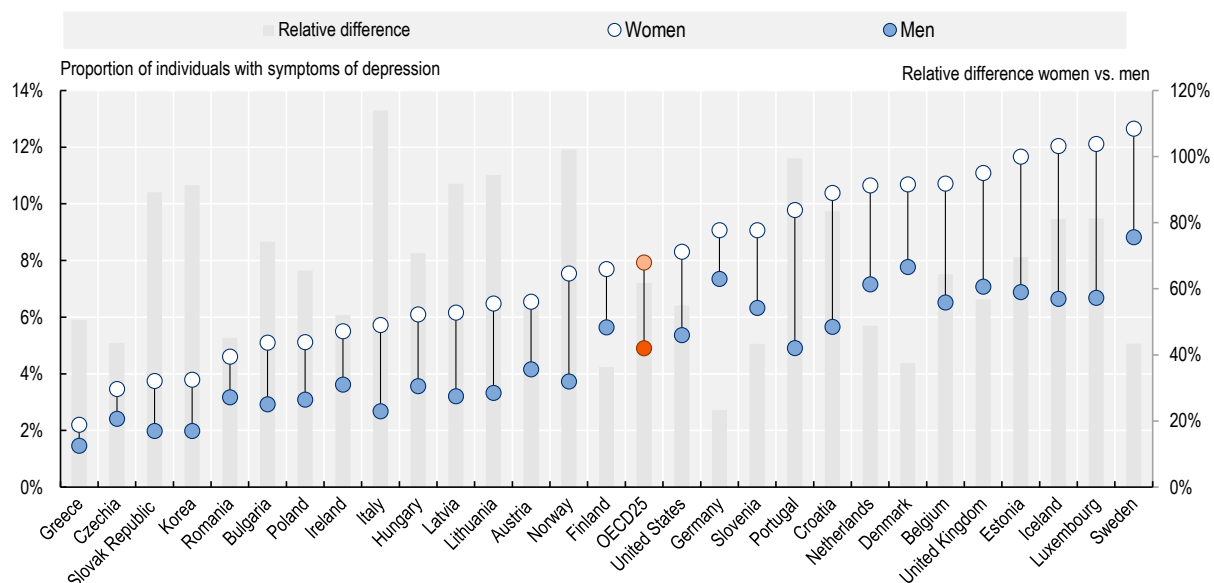
The burden of mental ill-health is possibly increasing, although more data are needed to confirm this trend. Previous OECD analysis showed that population mental health fluctuated during the COVID-19 pandemic, typically worsening during periods of infection and movement restriction and lock-down (OECD, 2023^[9]). As the pandemic receded, population mental health has improved, although level of mental ill-health has remained elevated. In about half of the OECD countries with available data, the proportion of people reporting depressive symptoms decreased in 2022 compared to 2020 levels, but this proportion remains at least 20% higher than pre-pandemic levels. Several factors can explain the persistent high level of mental distress, such as the cost-of-living crisis, climate crisis, conflicts, as well as increased awareness and changing language around mental health, that reduce stigma and make it easier to speak and seek support.

The prevalence of different mental disorders is distributed differently by gender. Studies consistently show higher prevalence of internalising disorders amongst women (e.g. depression, anxiety and eating disorders) while men have higher prevalence of externalising conditions (e.g. conduct disorders, attention deficit/hyperactivity disorders, among others) and substance use disorders (Farhane-Medina et al., 2022^[10]; Needham and Hill, 2010^[11]; Herrmann et al., 2023^[12]; Otten et al., 2021^[13]; Mental Health Foundation United Kingdom, 2017^[14]). Figure 2.3 shows the shares of men and women with depressive symptoms of moderate or higher severity (i.e. PHQ-8 $\geq$ 10), by country. It also presents the relative differences (in percentage) calculated as the difference in shares between women and men divided by the share in men. Where the proportions of women reporting symptoms is more than twice that of men the relative difference exceeds 100%. Across all 28 countries studied, the prevalence of depressive symptoms of moderate or higher severity is higher in women by 62% (average relative difference). The relative

difference varies from 23% in Germany to 100% and above in Norway and Italy, where women are more than twice likely to screen positive for depression. Evidence from some countries also suggests that the trends for the past decades might differ by gender. For example, in England from 2000 to 2014, rates of depression and anxiety steadily increased in women and remained largely stable in men (McManus et al., 2016^[15]).

Figure 2.3. Share of women and men at risk of depression, 25 OECD and EU27 countries, 2019

Respondents with moderate or severe depressive symptoms (PHQ-8 $\geq$ 10)



Note: Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe symptoms based on a PHQ-8 score equal or higher than 10, which is also the cut-off for a positive screening on being at risk of a (clinical) diagnosis of depression. Countries are ranked by increasing prevalence for women. The grey bars represent the level of relative difference (on the secondary Y-axis). The OECD25 average excludes Bulgaria, Croatia and Romania.

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 the Korea Community Health Survey 2019 for Korea.

In line with the potential increase in the burden of mental ill-health, rates of suicide thoughts, have also increased, especially among young people. In the OECD and EU27 countries for which data was available, up to a quarter of young people reported having had suicidal ideation during the COVID-19 crisis, which was five times higher than pre-pandemic levels (OECD/EU, 2022^[16]). However, in most countries, this trend did not translate into an increase in deaths by suicide (Box 2.3). In 2021 and 2020, death by suicide represented 11.2 deaths in 100 000 people, compared to 11.1 in 2019 and 11.3 in 2018, on average across OECD countries. Over the last two decades, historical data show declining trends in suicide rates, with an average reduction across OECD countries of 34% for males and 24% for females, between 2001 and 2021.

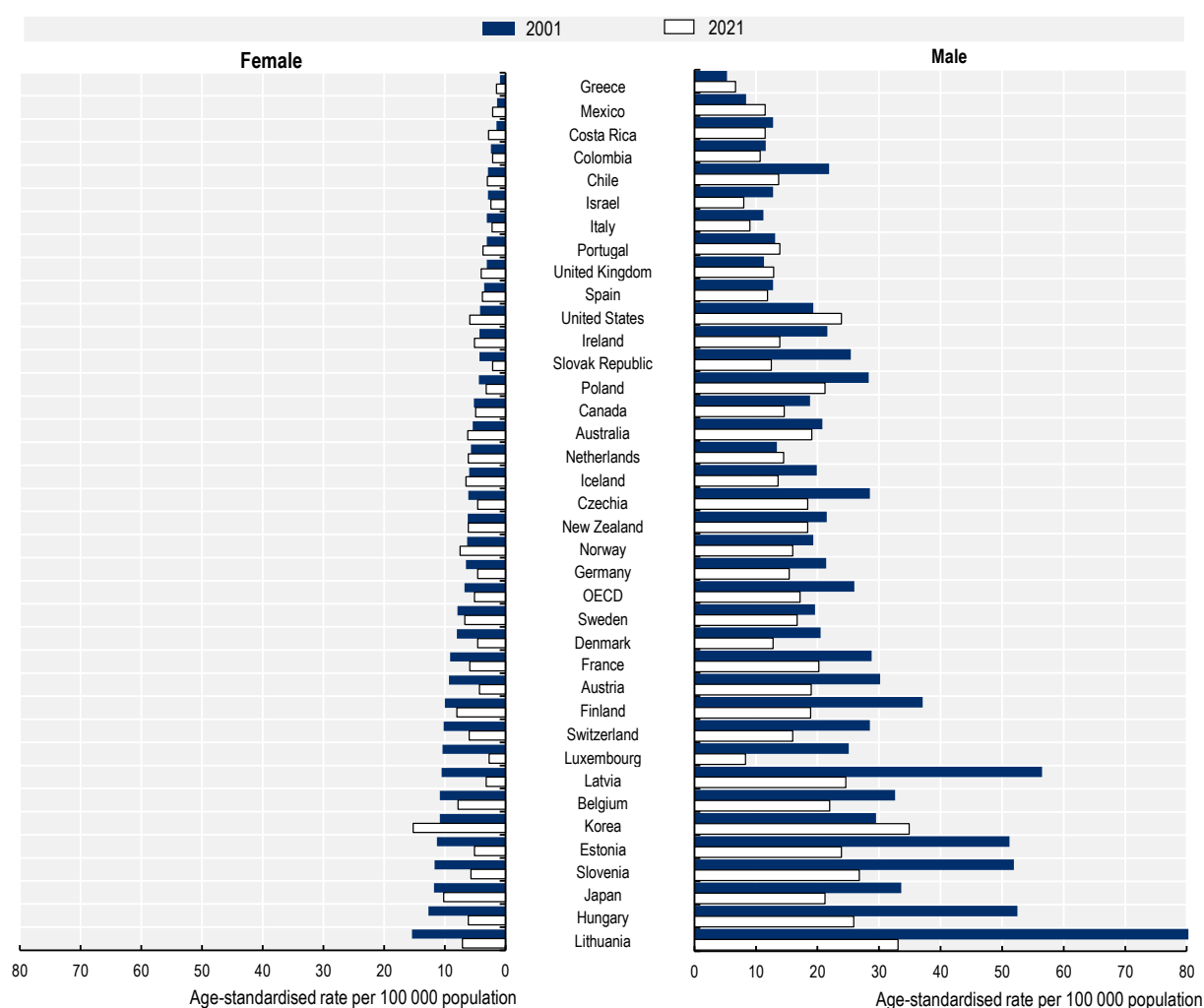
Box 2.3. Suicide and suicidal behaviours

Suicide is defined as the act of deliberately killing oneself (WHO EMRO, 2024^[17]) or when people harm themselves with the goal of ending their life, and die as a result (National Institute of Mental Health, 2023^[18]). Suicidal behaviours – often referred to as suicidality – includes suicidal thoughts, suicide attempts, plans, and preparatory acts for suicide (Nock et al., 2008^[19]).

Self-harm episodes may occur with or without suicide intention. Determining if an episode of self-harm constitutes or not suicidal behavioural poses methodological challenges, because of existing stigma around suicide and difficulties for ascertaining the intentions of the person. Moreover, some suicide attempts might not require medical care and thus might go unregistered, leading to an underestimation of the prevalence of suicidal behaviours in the population.

Men have higher suicide rates than women. This pattern could be seen in all OECD and EU27 countries studied, both in 2001 and 2021, with rates of death by suicide in men being two to seven-fold higher than in women (Figure 2.4). Between 2001 and 2021, deaths by suicide decreased by one-third in men in 30 countries and in women in 24 countries. In the countries where suicide rates have increased, the relative percentage change was higher in women than in men, except for the Netherlands.

Figure 2.4. Suicide rates by gender in OECD countries, 2001 and 2021 (or nearest year)



Notes: Annual deaths per 100 000 inhabitants, cause of death intentional self-harm. Latest available data for Norway and New Zealand is from 2016.

Source: OECD Health Statistics 2024.

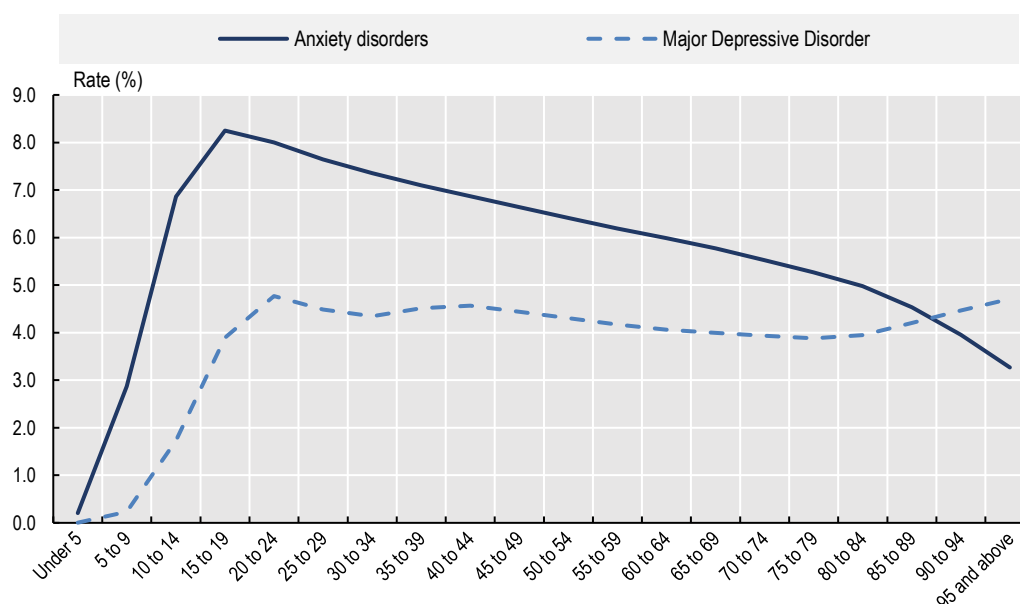
While cross-country comparisons in suicide attempts should take in consideration different practices in reporting and consequent data limitations, studies seem to consistently report a **reverse gender pattern in suicide behaviour, in what has been named as the suicide behaviour gender paradox**. While men have higher rates of death by suicide, women are more likely to report suicide intention and, in some countries, suicide attempts too. Differences in the lethality of suicide attempts (e.g. means of suicide) seem to explain at least part of the higher suicide fatality among men (Schrijvers, Bollen and Sabbe, 2012^[20]; Freeman et al., 2017^[21]). For instance, French data from 2012 to 2023 show consistently higher rates of hospital stays due to self-harm and suicide attempts in women than in men. In addition, the same data also suggests that while self-harm hospitalisations have decreased in adults aged 25 to 65 years old, a sharp and worrying increase is observed since 2020 for girls and young women aged 10 to 24 years old (Drees, 2024^[22]).

Particular phases of the life course, such as adolescence, maternity, and unexpected events, increase people's vulnerability to mental health problems

Over their life course, people face several periods of increased vulnerability to mental ill-health. Life stages at increased vulnerability can include specific periods, such as childhood and adolescence, but also transition periods (e.g. transitioning into adulthood or parenthood). Higher vulnerability to the onset of mental health conditions can also be a consequence of negative events and unexpected shocks in someone's life. For instance, becoming unemployed, the death of someone close, being forced to migrate are all negative events that can lead to a deterioration of mental health. Last, there are population groups that are consistently more vulnerable and at higher risk of mental ill-health, such as people in low socio-economic status or groups minoritised due to their ethnicity, indigeneity, gender or sexual orientation. Importantly, this disadvantage tends to persist over the life course and for some groups, such as people living in precarious situations, extend intergenerationally (Vargas Lopes and Llena-Nozal, 2025^[23]).

Mental disorders with an early onset in childhood and adolescence tend to persist throughout the life course. Approximately 75% of adult mental disorders have their onset during adolescence, and this early onset increases the risk of recurrence and disabling physical conditions in adulthood (Erskine et al., 2015^[24]; Kessler et al., 2005^[25]). In high-income countries, mental disorders are the main cause of disability among adolescents and young adults (Gore et al., 2011^[26]; Erskine et al., 2015^[24]). Figure 2.5 shows the sharp increase in prevalence of anxiety disorders and major depressive disorder from early ages, peaking at 15 to 19 years old (anxiety disorders) and 20 to 24 (major depression) and persisting into adulthood. The prevalence of anxiety disorders tends to decrease over lifetime and particularly for old people, while the prevalence of major depressive disorder is sustained and increases again from 80 years onwards.

Figure 2.5. Prevalence of anxiety and major depressive disorders over the life course in OECD countries, 2021



Source: IHME (2024^[6]), *GBD Results*, <https://ghdx.healthdata.org/gbd-results-tool/result/fe3810d88cf54f085e5b2883ff865925>.

Life course transition periods and turning points, such as pregnancy and postpartum, make women vulnerable to mental ill-health. Women face higher risk of onset and recurrence of mental ill-health conditions during pregnancy and in the postpartum period (Howard and Khalifeh, 2020^[27]). Large

registry-based cohort studies identified the first five months postpartum as a time of vulnerability for all mental disorders, including major depression, bipolar disorders, schizophrenia and adjustment disorders. Women with previous history of these conditions are at higher risk. Depression is the most prevalent mental health condition during the perinatal period. The likelihood of depressive episodes postpartum can be twice higher than during other periods of woman's life course, with detrimental effects that often go beyond the individual and impact both the infants and the family (Leight et al., 2010^[28]). Historically, the prevalence of major depression in high-income countries has been reported to around 10% and 15% during the first year postpartum. These estimates are likely to vary more across countries and often increase in the context of low and lower-middle income countries (Faisal-Cury et al., 2013^[29]). Based on a recent meta-analysis, the prevalence of postpartum depression was estimated as 17.0% for Northern America, 16.6% for Central-Eastern Europe, 16.3% for Southern Europe and 13.8% for Northern Europe. The same analysis reports twice the prevalence of postpartum depression among women with financial problems compared to those without. Likewise, women without family or partner support are twice as likely to have postpartum depression as those with support, and non-married women are 71% more likely to have postpartum depression than married or cohabiting women (Wang et al., 2021^[30]).

Mental disorders are consistently more prevalent among individuals with low socio-economic status. The association between low socio-economic status and mental ill-health is well-documented, particularly for depressive and anxiety disorders, and regardless of what defines the socio-economic status: low income, low educational status or unemployment at the individual level (Muntaner, 2004^[31]; Blas and Kurup, 2010^[32]; Yu and Williams, 1999^[33]; Sareen et al., 2011^[34]) or, at the area-level, living in a neighbourhood with low socio-economic conditions or low social capital, among other indicators (Silva, Loureiro and Cardoso, 2016^[35]; Rehkopf and Buka, 2005^[36]). For example, in the United States, the risk of developing major depression was 44% higher for individuals with lower income, and 13% higher for those with second-lower income, compared to those with higher income (Sareen et al., 2011^[34]).

The effects of socio-economic status on mental health becomes evident when people experience events that abruptly change their income or their employment towards a disadvantaged situation. Becoming unemployed or having a substantial reduction in household income increases the risk of mental disorders, especially depression and other mood disorders (Barbaglia et al., 2015^[37]). In the United States, decreasing income category in a three-year period was associated with an increased risk of developing depressive/bipolar, anxiety or substance use disorders (adjusted odds ratio, 1.30; 99% confidence interval, 1.06-1.60), compared to no income change (Sareen et al., 2011^[34]). The experience of unemployment is associated with higher risk of mental ill-health, including suicide, through mechanisms such as stress, lower life satisfaction and lower self-esteem (Amin, Korhonen and Huikari, 2023^[38]; Escudero-Castillo, Mato Diaz and Rodriguez-Alvarez, 2022^[39]; Milner et al., 2013^[40]). Longer time in unemployment is associated with higher burden of mental ill-health, and unemployment can have lasting detrimental mental health effects, which may outlast the duration of the unemployment spell (OECD, 2021^[41]). Greater exposure to unemployment is associated with higher risk of suicide (Milner, Page and Lamontagne, 2014^[42]). Other adverse life shocks, such as personal injury, jail or separation from a spouse also result in greater risk of mental disorders for socio-economic groups already in disadvantage, but to a lesser extent than those related to income losses, deprivation or poverty. For example, Australian longitudinal data suggests that between 22% to 35% of mental health inequalities in favour of higher-income groups are explained by life events related to financial hardship and 2% to 5% by negative life shocks such as personal injury, separation from a spouse, death of a relative or friend, or being detained in jail (Hashmi, Alam and Gow, 2020^[43]).

Evidence about differences in mental health based on migration status is mixed. Some studies suggest that foreign-born people experience a slightly higher rate of mental health conditions compared to those who were born in the country, while other studies point to no significant differences or even reversed pattern of better mental health among migrants (Vargas Lopes and Llena-Nozal, 2025^[23]). Several factors, which are challenging to account for in empirical analysis, might explain these mixed results: the

reason(s) behind the decision to migrate (e.g. avoid conflict and violence vs. seek better educational opportunities or financial situation), the socio-economic status of the migrants, or the countries of origin and destination (WHO, 2023^[44]; Füller, Vieth and Otto, 2023^[45]). OECD analysis of 25 countries showed that eight countries registered a higher prevalence of symptoms of depression of moderate or higher severity among native-born individuals (Czechia, Hungary, Ireland, Italy, Luxembourg, Portugal, the United Kingdom, the United States) while the remaining 17 countries had a higher prevalence among foreign-born (Vargas Lopes and Llana-Nozal, 2025^[23]). Where there is heightened risk of mental illness amongst immigrant communities, these may be driven by various social and structural factors such as 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^[46]; Salami et al., 2017^[47]).

For refugees, both pre and post-migration stressors drive poor mental health, and post-migration factors may moderate the ability to recover from pre-migration trauma (Hynie, 2018^[48]). The experience of displacement and refugee typically includes loss of material property such as homes and possessions, as well as disruption of family, personal and professional projects and plans. Further traumatic situations might be related with war and violence, injury and witnessing death (Barbui et al., 2022^[49]). Post-migration stressors include complexity in the asylum and resettlement processes, discrimination, poor social integration or loneliness, worrying about family and friends overseas, and economic stressors (Chen et al., 2017^[50]; Goodkind et al., 2021^[51]). A meta-analysis focussing on studies of Syrian refugees resettled in high-income western countries found a prevalence of 40% for anxiety, 31% for depression and 31% for post-traumatic stress disorder and a pooled prevalence of having any of the three disorders of 33%, all significantly higher than in the general population.

Mental ill-health has a heavy toll on both health, social and economic outcomes

Besides high population burden, mental ill-health translates into substantial economic consequences. The high costs result from the healthcare needed to treat mental disorders, social security support required by people with lived experience of mental health conditions but also the adverse labour market consequences faced by these people (OECD/European Union, 2018^[52]; OECD, 2021^[41]).

Overall costs related to mental ill-health are estimated to have exceeded 4% of GDP across 28 EU countries in 2015, representing EUR 600 billion. This total cost is broken down into approximately 1.3% of GDP (or 190 billion euros) in spending on healthcare systems, 1.2% of GDP (170 billion euros) on social security programmes, and a further 1.6% of GDP (240 billion euros) in other costs related to lower employment and lower productivity. Other estimates of the economic value associated with mental disorders suggest losses of USD 4.7 trillion globally in 2019 (EUR 4.1 trillion), reaching the equivalent of 6.5% of GDP in Western Europe and 8% of GDP in high-income North America (Arias, Saxena and Verguet, 2022^[53]). Estimates for the United States in the same year attribute USD 334 billion (EUR 295 billion) to the societal cost of major depression disorder (MDD), of which 38% was related healthcare costs, 34% to reduced employment and productivity (e.g. absenteeism and presenteeism), and 24% to household-related cost (annual income loss by an adult without MDD living with an adult with MDD) (Greenberg et al., 2023^[54]). In Germany, the proportion of direct medical and social care costs amounted to 30% of the economic burden of mental disorders, with the rest being attributed to sick leave, unemployment and early retirement (König et al., 2023^[55]).

Previous OECD work suggests that mental health care accounted for about 13% of health spending across EU countries in 2015, being similar to spending on cancer care in several countries (OECD/European Union, 2018^[52]). Health expenditure data from 2018 covering additional countries suggests that there was considerable **variation in the proportion of total health spending allocated to mental health care**: from 4% in Estonia, Greece and Poland to 10% or above in England, Canada, Germany, Norway and

France. On average, OECD countries with available data spent 6.7% of their health budget on mental health (OECD, 2021^[56]). Spending on mental health services increased during the pandemic in countries such as the United Kingdom, Australia and the United States, including public funding and private health insurance, but also out-of-pocket costs (Cantor et al., 2023^[57]; Welfare, 2024^[58]; Helen Giulburt, 2024^[59]).

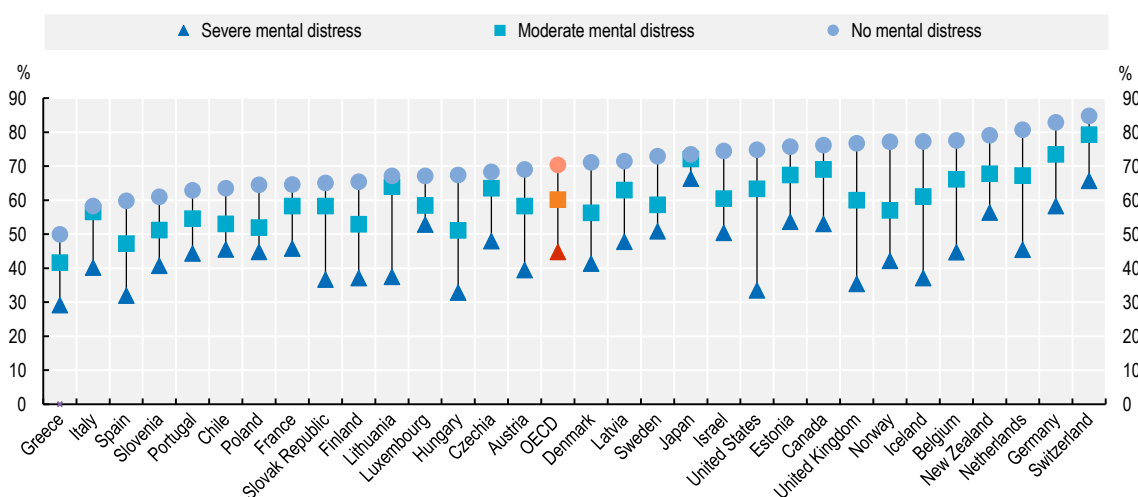
Health and social care costs resulting from mental ill-health go beyond the expenditure on mental health services only. Healthcare costs also result from treating comorbidities and suicide attempts. For example, a Canadian study shows that comorbidities, intentional self-harm, suicide and all-cause mortality were higher in patients with depression, who had healthcare utilisation costs 3.5 times higher and social services costs three times higher than those of peers without depression (Tanner et al., 2020^[60]). In addition, the costs of mental health conditions increase with severity. Compared with average healthcare costs of the German population, the excess direct medical and social care costs of treating severe mental health conditions in Germany is up to 20 times higher than the cost of mild disease severity (EUR 10 485 vs. EUR 511 excess cost¹ by person for a 6-month period), and five times higher than treating moderate disease severity (EUR 2 417). The main cost driver, and explanation to the large differences in costs by severity, are hospital stays (König et al., 2023^[55]).

Due to limitations to their labour participation, people with lived experience of mental disorders often require welfare support in the form of sick leave benefits, disability benefits, unemployment insurance or early retirement. OECD estimates from EU countries suggest that the bulk (66%) of mental-health-related social spending is attributable to disability benefits (EUR 112 billion out of EUR 170 billion spent on social security programmes on average, in 2015) (OECD/European Union, 2018^[52]). This proportion may vary on a country basis, depending on the generosity and organisation of welfare programmes (e.g. if disability assessment does not appropriately recognise mental-health-related disability, unemployment benefits might be more often used). Other social spending attributable to mental ill-health includes social assistance benefits or lone-parent benefits (OECD/European Union, 2018^[52]).

The direct costs with social programmes are not the only economic consequence of mental health-related disability. **Costs due to productivity losses are large, potentially the biggest contributor to the economic burden of mental disorders** (OECD/European Union, 2018^[52]). There is variation in the literature regarding the phenomena captured in estimating productivity losses, whether not only absenteeism but also presenteeism of those employed is captured, as well as exiting from the labour market through several pathways – unemployment, disability or early retirement, or due to premature death. Furthermore, productivity losses increase with disorder severity. Based on German data, productivity losses range from around EUR 5 612 per 6 months per person for mild disease severity to EUR 21 399 for severe disease severity (König et al., 2023^[55]).

In line with high-cost estimates of negative labour market impacts, previous work has described the **mental ill-health employment gap observed in OECD countries** based on data from mid-2010s. On average in 31 OECD countries, the employment rate for people with moderate mental distress was 10 p.p. lower than for those without distress (Figure 2.6). For those with severe distress, the difference was even larger (26 p.p. difference compared to those without distress). In 22 out of the 31 countries studied, employment rates for people with severe mental distress were less than 50%. Employment gaps were of similar magnitude in countries with overall high employment rates (such as Switzerland) or in countries with low employment rates (such as Italy).

Figure 2.6. Share of people employed by mental distress, 31 OECD countries, mid-2010s

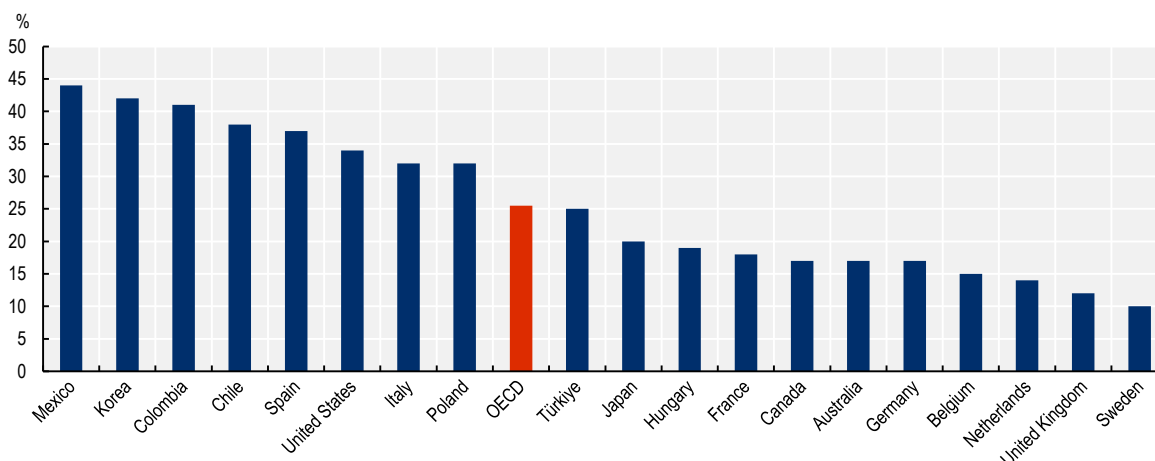


Note: The figure presents data between 2012 and 2016. Individuals with mental distress have provided survey responses to a series of mental health questions that place them in the bottom quintile of respondents. Ireland data are excluded due to data quality concerns.

Source: OECD (2021^[41]), *Fitter Minds, Fitter Jobs: From Awareness to Change in Integrated Mental Health, Skills and Work Policies*, <https://doi.org/10.1787/22257985>.

Work-based discrimination against people with mental health conditions remains high. Many people reporting a mental health condition would like to work but cannot find a suitable job (OECD, 2021^[41]). Despite increased awareness around mental health in the recent years, discrimination remains widespread. In a survey from 2019, a quarter of respondents in OECD countries agreed that anyone with a history of mental health condition should be excluded from public office (Figure 2.7). This proportion reached more than 40% of respondents in countries such as Colombia, Korea and Mexico (OECD, 2021^[41]).

Figure 2.7. Proportion of respondents who agree that individuals with a history of mental health condition should be excluded from public office



Note: Data from 2019.

Source: OECD (2021^[41]), *Fitter Minds, Fitter Jobs: From Awareness to Change in Integrated Mental Health, Skills and Work Policies*, <https://doi.org/10.1787/22257985>. Adapted from Ipsos MORI / King's College London (2019), World Mental Health Day 2019, https://www.ipsos.com/sites/default/files/ct/news/documents/2019-10/world-mental-health-day-2019_0.pdf.

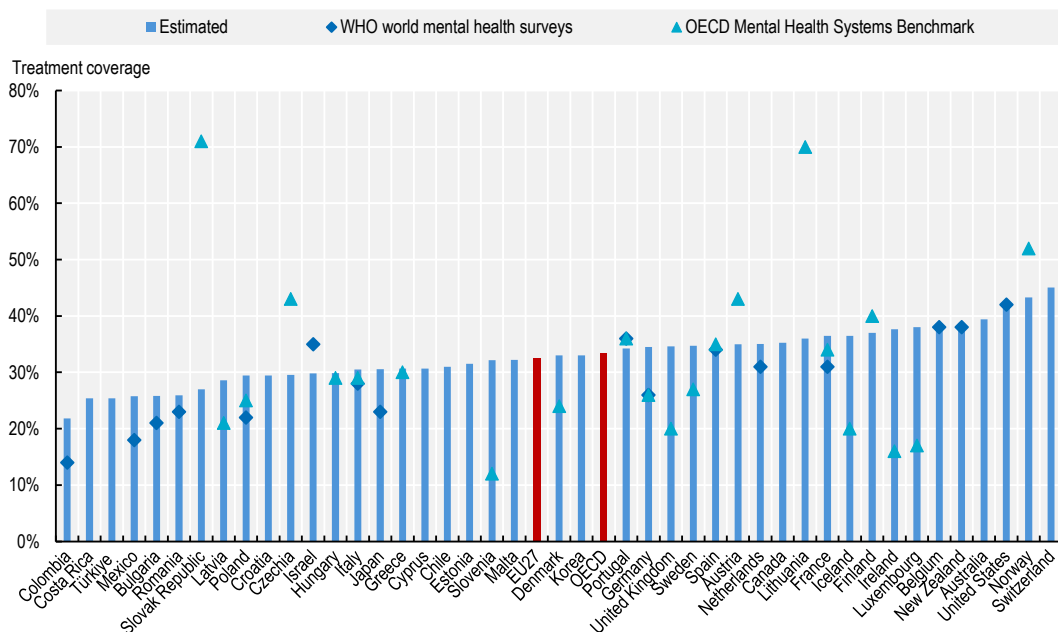
The impacts of mental ill-health on educational outcomes and transitions from school to the labour market are key determinants for labour participation in adulthood. Mental health condition onset is associated with decreased school performance (Owens et al., 2012^[61]; Fröjd et al., 2008^[62]). OECD data show that students reporting mental distress are 35% more likely to have repeated a grade, on average in OECD countries. In adulthood, the education-related disparities persist. Among OECD countries, the share of working-age people who have completed high-level education is consistently lower for people with mental distress compared to those without (28% vs. 35% on average across OECD countries) (OECD, 2021^[41]).

Mental health issues are currently not receiving adequate support and several barriers hinder access to mental care

Two-thirds of people with mental ill-health do not access to the care needed

About two-thirds of individuals in OECD and EU27 countries who need mental health care are estimated to lack access to treatment. Without a standardised and uniformly adopted definition, this report approximates the treatment gap using two complementary sources (see Box 2.4). According to estimated data from the OECD, an average of 33% of people in OECD countries and 32% in EU27 countries who require mental health care receive it, leaving around two-thirds without adequate access to treatment. Proportions of treatment coverage range from 22% in Colombia to 45% in Switzerland (Figure 2.8).

Figure 2.8. Approximation of treatment coverage for mental ill-health across OECD and EU27 countries



Note: Any type of treatment ranges from specialty mental health services, general medicine, human services (e.g. social worker) or complementary alternative medicine (such as chiropractors or self-help groups).

Source: OECD analysis based on data from Evans-Lacko et al. (2018^[71]), "Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys", <https://doi.org/10.1017/S0033291717003336> and OECD (2021^[56]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>.

Box 2.4. Approximation of treatment gap for mental ill-health

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

- Data from previous OECD work (OECD, 2021^[56]) investigating the unmet needs for mental ill-health due to financial reasons, wait times or transport. Based on this analysis, access to mental health services was identified as the complementary figure to the proportion of individuals with unmet needs.
- The treatment coverage identified by the WHO World Mental Health Survey (Evans-Lacko et al., 2018^[7]), which asked respondents if they had sought professional help for emotional, mental health, nerve, or substance use disorders, and if they received treatment within the past 12 months.

Although the two surveys examine slightly different issues and cover marginally different mental health conditions, comparing data from both sources for countries included in both analyses suggests very similar conclusions, as showed in the figure (Figure 2.8). At the net of a few countries with outlying results (e.g. Slovak Republic and Lithuania) in one of the two datasets, the analysis supports a broad comparability of data. Extrapolation for countries lacking data was performed using an ensemble model based on a lasso regressor, incorporating the following country-specific indicators: suicide rates, depression rates, World Happiness Index, number of mental health professionals, universal healthcare service coverage index and gross domestic product (GDP). Extrapolated data should only be considered as a high-level indicator of the possible coverage of services for mental ill-health.

Access to mental health treatment varies by disorder severity and by socio-economic status.

Individuals with severe symptoms are 2.4 times more likely to receive mental health treatment than those with mild and moderate symptoms (Evans-Lacko et al., 2018^[7]). Furthermore, the mental health treatment gap is more pronounced among population groups with lower socio-economic status. Individuals with lower educational attainment are 20% less likely to access mental health treatment than those with higher education. This discrepancy is more pronounced when it comes to specialty services, human services, and complementary alternative medicine, while there is no statistically significant difference in access to general medicine. The effect of income level on treatment access is somewhat inconsistent. Individuals with lower income are as likely to access any type of mental treatment as those with higher income, while they are 20% less likely to access specialty services, but are 50% more likely to utilise human services. Only a small proportion of those treated receive minimum adequate mental health care.

Minimally adequate treatment refer to the minimum combination of treatments proven by research to be effective for treating depression (Moitra et al., 2022^[63]; Thornicroft et al., 2017^[64]). Among 14 OECD and EU27 countries studied, only one fifth of individuals with major depressive disorder received minimally adequate treatment. This proportion was higher than 30% in countries such as Germany and the Netherlands, but was below 10% in Bulgaria, Colombia, Mexico and Romania (Thornicroft et al., 2017^[64]). The treatment gap is exacerbated by the low recognition of depression, with only about half of individuals with major depressive disorder recognising their need for care, particularly in low-income settings. It is likely that treatment rates for less severe symptoms are even lower, as individuals may not perceive their symptoms as serious enough to seek care.

Health system and personal barriers hinder access to treatment for mental ill-health

Health system barriers to access treatment

When seeking mental health care, individuals can face challenges within the healthcare system that can hinder access to treatment. Health system characteristics, such as the availability of healthcare services and the breadth and depth of the health benefit basket, are key determinants of healthcare access (Paris et al., 2016^[56]). This section describes three main systemic barriers to mental care: financial, organisational and geographical barriers.

Financial barriers are particularly problematic in countries where mental health services are not fully covered by public health insurance, requiring individuals to pay out-of-pocket for treatment (OECD, 2021^[56]). This financial burden can deter people from seeking the help they need. A Dutch study examining over 1.4 million mental health treatment records from 2010 to 2012 found that increasing cost-sharing in 2012 led to a 13.4% reduction in regular mental health care usage among adults, with the greatest decline in low-income groups (Ravesteijn et al., 2017^[66]). This reduction was accompanied by a substantial rise in involuntary commitments and acute care needs. In the United States, in 2020, 30% of adults with any mental illness and a perceived unmet need for services reported not receiving care because their health insurance did not cover any mental health services or because insurance reimbursement was inadequate. This figure was similar for those with serious mental illnesses (Modi, Orgera and Grover, 2023^[67]).

Organisational barriers, such as long waiting times, are another significant obstacle. Longer waiting times for mental health care are associated with poorer treatment outcomes and higher treatment costs (van Dijk et al., 2023^[68]; Adu et al., 2024^[69]; Catarino et al., 2023^[70]). The perceived uncertainty and lack of support due to longer waiting times can lead to increased emotional distress, reduced functioning and worsening of existing symptoms (Punton, Dodd and McNeill, 2022^[71]). A study of patients with major depressive disorders found that longer waiting times were associated with poorer treatment outcomes once treatment was started, even after adjusting for potential confounders such as severity and suicidality (van Dijk et al., 2023^[68]). Similarly, research on early intervention in psychosis services in England showed that longer waiting times were associated with worse patient outcomes one year after treatment acceptance, particularly for waits longer than three months, with the largest impact on symptomatic and social functioning (Reichert and Jacobs, 2018^[72]).

Geographical barriers further complicate access to mental health treatment, particularly in rural and underserved areas where mental health providers are scarce. The long distances that some individuals must travel to access care can be prohibitive, especially for those without reliable transportation. A US study found that adults in rural areas were less likely to receive mental health care and more likely to receive treatment from providers with less specialised training, compared to those living in urban areas. Contributing factors included a shortage of mental health providers, limited availability of specialised care, gaps in provider training and underutilisation of existing services in rural areas (Morales, Barksdale and Beckel-Mitchener, 2020^[73]).

A fundamental constraint underpinning health system barriers is the limited capacity of mental health professionals. Shortages in mental health workforce have been identified as an issue in many OECD countries (OECD, 2021^[56]). On average across OECD and EU27 countries with available data, there are 0.53 psychologists and 0.52 mental health nurses per 1 000 population. Countries such as Iceland, Norway and Denmark, have higher rates of psychologists, exceeding 1.3 per 1 000 population, while Korea and Hungary are below 0.03. For mental health nurses, countries such as Australia, France, Belgium and Türkiye have rates above 0.9 per 1 000, while Spain and the United States report less than 0.05 (OECD, 2021^[56]).

Personal barriers to access treatment

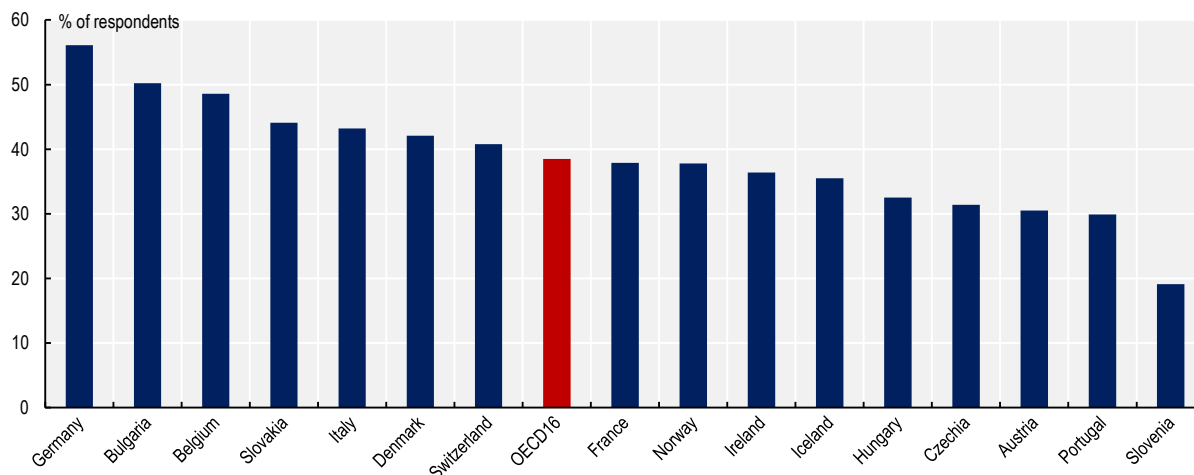
Personal barriers play an important role in deterring people from seeking and remaining in treatment. Personal barriers are reported most frequently than health system barriers, especially for individuals with mild-to-moderate symptoms (Andrade et al., 2014^[74]). Understanding and addressing personal barriers is essential for ensuring that individuals receive the appropriate support. The rest of this section further describes the personal barriers to mental health care including low perceived need for treatment, limited mental health literacy, and various forms of stigma.

Low perceived need for mental health treatment is the most common reason for not beginning treatment, particularly among those with mild-to-moderate symptoms. Data from the WHO World Mental Health surveys collected between 2001 and 2009 in 24 high- and low-income countries show that around 60% of respondents who qualified for a clinical diagnosis but reported no service use, had low perceived need for professional treatment (Andrade et al., 2014^[74]). The proportion of respondents with low perceived need is significantly higher among those with mild-to-moderate symptoms versus those with severe symptoms in nine countries, and the difference is not statistically significant in the remaining countries. For individuals who perceived a need for mental treatment but did not seek care, several reasons were provided. Nearly two in three respondents (63%) reported that they wanted to handle the problem on their own. This was the most frequently cited reason, regardless of the level of symptom severity. About 16% reported low perceived efficacy of treatment, 24% reported that the problem was not severe, 16% were convinced that the problem would resolve itself with time, and 8% reported concerns related to stigma (Andrade et al., 2014^[74]).

Decision not to seek care is influenced by the information available (or lack of information) to the individuals and their ability to use and act on this information to make decisions. Finding information on how to deal with mental health problems was reported to be difficult or very difficult by 39% of respondents in 16 OECD countries in 2019-2021 (Figure 2.9). This proportion varied from 19% in Slovenia to 50% or more in Bulgaria and Germany. It is uncertain whether these difficulties were due to a lack of mental health literacy or if the relevant information is either unavailable or not easily accessible. Besides, **the levels of mental health literacy are low** among the general population (Tay, Tay and Klainin-Yobas, 2018^[75]), as well as among adolescents and young adults (Nobre et al., 2021^[76]). Low levels of mental health literacy likely result in people not having sufficient resources to deal with mental health problems and not seeking care.

Stigma around mental health also presents a significant obstacle to accessing mental health care. Fear of judgement and discrimination prevent people from disclosing their mental struggles, then resulting in under-reporting of mental ill-health (Bharadwaj, Pai and Suziedelyte, 2017^[77]). This also prevents people from seeking the mental health treatment they need (Schnyder et al., 2017^[78]). Many individuals avoid seeking mental health treatment due to the fear of being judged or treated differently by others, a phenomenon known as perceived stigma. For example, a US study found that one in five college students with unmet mental health needs avoided seeking care due to fear of judgment (Eisenberg, Golberstein and Gollust, 2007^[79]). Similarly, one in seven adults avoided treatment due to concern about being judged by their neighbours (Mason et al., 2013^[80]). Beyond the fear of external judgement, self-stigma plays a critical role in deterring individuals from seeking mental health treatment. When people internalise negative societal beliefs about mental illness, it can lead to feelings of shame and lower self-esteem, making them less likely to seek the treatment they need (Thornicroft et al., 2022^[81]). Because of this internalisation, individuals tend to overestimate how negatively they will be perceived by others if they seek mental health care. There is a clear discrepancy between how individuals who seek mental treatment think they are perceived and how they are actually viewed by others (Pedersen and Paves, 2014^[82]).

Figure 2.9. Two in five respondents find it “very difficult” or “difficult” to find information on how to deal with mental health problems, 16 OECD countries, 2019-2021



Note: Due to the wide variety of sampling and data collection procedures across countries, country differences should be interpreted with caution. Source: The HLS19 Consortium of the WHO Action Network M-POHL (2021[19]), *International Report on the Methodology, Results, and Recommendations of the European Health Literacy Population Survey 2019-2021 (HLS19) of M-POHL*, <https://m-pohl.net/sites/mpohl.net/files/inline-files/HLS19%20International%20Report.pdf>.

Addressing stigma is essential, as it can exacerbate mental ill-health and, in some cases, cause more harm than the condition itself. Effective strategies to combat stigma include promoting social contact between those with and without mental ill-health, which has been shown to be the most effective way to change negative perceptions (Thorncroft et al., 2022^[81]). Moreover, the media plays an important role in shaping public attitudes and it is essential to involve people with lived experience in developing anti-stigma initiatives.

National policies and strategies to prevent and manage mental ill-health

The increased global attention to mental health, particularly heightened by the COVID-19 pandemic, has resulted in a growing body of research, evidence-based interventions and programmes, guidelines, and tools becoming available for implementation (WHO, 2022^[83]). In response to emerging mental health challenges, many countries and organisations have prioritised and strengthened their mental health policies, aiming to boost promotion and prevention of mental ill-health and improve access to and quality of mental health services. The OECD Mental Health Performance Framework aims to guide the development of effective and responsive mental health systems (Box 2.5).

Box 2.5. The OECD Mental Health System Performance Framework

The OECD Framework for Mental Health Performance recommends six key principles to guide the development of effective and responsive mental health systems. Among these, the focus on **prevention of mental illness and promotion of well-being** emphasises proactive measures to reduce mental health issues before they escalate and to promote overall well-being

Key sub-principles for promotion and prevention policies include:

- **Strengthening suicide prevention:** Implement strategies and programmes aimed at reducing suicide through early intervention and support.
- **Improving mental health awareness and literacy:** Increase public understanding of mental health issues to reduce stigma and encourage help-seeking behaviour.
- **Making schools mental health friendly environments that build resilience:** Ensure that educational environments support mental health by building resilience among students and providing access to mental health resources.
- **Ensuring that workplaces promote good mental health:** Develop policies and practices that foster a supportive work environment, reduce stress and enhance well-being.
- **Enabling front line actors to recognise and respond to mental distress:** Train teachers, police officers, and others to recognise and respond effectively to signs of mental distress, ensuring that individuals receive timely and appropriate support.
- **Improving access to care by making it easy for individuals to seek help:** Make it easier for individuals to seek help by reducing barriers to access, such as stigma, cost and geographical challenges.

Source: OECD (2021^[56]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, doi: 10.1787/4ed890f6-en; OECD (2019^[84]), "OECD Mental Health Performance Framework", <https://www.oecd.org/content/dam/oecd/en/topics/policy-sub-issues/mental-health/oecd-mental-health-performance-framework-2019.pdf>.

In 2023, a majority of OECD and EU27 countries reported having implemented or being currently implementing a national mental health policy. The OECD and the WHO Regional Office for Europe, with support from the European Commission Directorate General for Health and Food Safety, jointly carried out a questionnaire on mental health system capacity across European Union countries and Iceland and Norway, in 2023. The OECD has extended the survey to all OECD Member countries. Results of this survey show that around 90% of countries had a national action plan to address mental ill-health in 2023 (Table 2.2) (OECD/WHO Regional Office for Europe, 2023^[85]).

The scope of the national mental health strategies generally extends beyond the provision of mental health services. They also encompass suicide prevention, early interventions, building socio-emotional resilience, reducing stigma, collaboration with other sectors such as education or social sector, among others. For example, Australia's National Mental Health and Suicide Prevention Plan emphasises prevention, early intervention, suicide prevention, and improving children's well-being across education and health systems (Commonwealth of Australia, 2021^[86]). In France, the Mental Health and Psychiatry Roadmap focusses on promoting mental well-being, ensuring co-ordinated care, and improving the social inclusion of people with mental health disorders. The plan has a strong focus on combating stigma, early intervention and tailoring care to vulnerable groups, such as children and adolescents (Ministère du Travail, de la Santé et des Solidarités, 2024^[87]). In England, the national long-term plan serves as a comprehensive healthcare strategy that places a strong emphasis on improving mental health services. It aims to enhance access to mental health care, promote early intervention, and provide

integrated support for both physical and mental health needs, while prioritising crisis care and tailored services for vulnerable populations, particularly children and adolescents (NHS England, 2019^[88]).

A vast majority of countries have implemented suicide prevention policies. Out of the 43 countries studied, 12 countries have fully implemented suicide prevention strategies through national programmes, while 26 countries are in process of implementing these strategies at national, regional or subnational levels. Only three countries have either addressed suicide prevention in their policies without implementing any activities, or do not have clear policies in place, while two countries have no data available (Table 2.2). Most prevention programmes also address after-care for individuals who have attempted suicide.

Most OECD and EU27 countries prioritise early interventions aiming to ease access to mental health care and support, particularly for individuals with mild-to-moderate symptoms. A total of 78% of the OECD and EU27 countries with available responses (33 out of 42) have policies to enable mental health promotion, prevention, and treatment of mental health conditions to be delivered in primary care settings (Table 2.2). In addition, 96% of countries with available responses (25 out of 26) provide direct access to mental health care without referral. Yet, efforts to improve access to mental health care are often limited by shortages in mental health workforce capacity (see section on Health system barriers to access treatment), along with insufficient health infrastructure and limited engagement of people with lived experience of mental ill-health or carers (WHO, 2024^[89]).

To facilitate access to treatment for individuals with mild-to-moderate symptoms, some countries are expanding the availability of **talking therapies**. These evidence-based interventions involve guided discussions with a trained professional to help individuals understand and manage their emotional and psychological issues. They can include counselling, psychological therapies, group therapy and general advice, delivered by mental health professionals, general practitioners or through online platforms. Talking therapies can be effective for a range of mental health conditions, particularly for mild-to-moderate symptoms of depression and anxiety. Talking therapies can be delivered in a variety of settings, including primary care, schools and workplaces. Seventy-three per cent of countries with available responses reported the use of talking therapies, despite variation in the level of implementation. Around 19% reported that a few general practitioners provided talking therapies, 46% reported some, while only 8% indicated that all the general practitioners provided talking therapies (OECD, 2021^[56]).

Most countries also put a high priority on promoting good mental health and building resilience over the life course. A vast majority (90%) of countries have implemented policies and programmes to support and promote the mental health of children and adolescents. Similarly, 90% of countries have introduced policies and programmes to support mental health in educational settings. Furthermore, 83% of countries have implemented policies and programmes to reduce **stigma and discrimination**, while 88% have policies and programmes to improve mental health awareness and literacy (Table 2.2).

Table 2.2. The majority of national governments in OECD and EU27 support policies to promote mental health, 2023

	Strategy that guides implementation of the mental health policy	Policies that support suicide prevention	Mental health support/care/services that can be accessed directly without referral	Policies to enable mental health promotion, prevention and treatment in primary healthcare	Talking therapy provided by primary care providers	Policies to improve mental health awareness and literacy	Policies to address stigma and discrimination	Policies to support and promote mental health of children and adolescents	Policies to support mental health in educational settings
Australia	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Austria	Yes	Yes	Yes	No	Some	Yes	No	Yes	Yes
Belgium	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Bulgaria	Yes	Yes	n/a	No	n/a	No	No	No	No
Canada	No	Yes	Yes	n/a	Some	Yes	Yes	Yes	Yes
Chile	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Colombia	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Costa Rica	Yes	Yes	n/a	Yes	n/a	Yes	Yes	No	No
Croatia	Yes	n/a	n/a	No	n/a	Yes	Yes	Yes	Yes
Cyprus	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Czechia	n/a	Yes	Yes	Yes	None	Yes	Yes	Yes	Yes
Denmark	Yes	Yes	Yes	Yes	Some	Yes	Yes	n/a	Yes
Estonia	Yes	Yes	Yes	Yes	All	Yes	No	Yes	Yes
Finland	Yes	Yes	n/a	Yes	n/a	Yes	No	Yes	Yes
France	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Germany	No	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Greece	Yes	No	Yes	No	Few	No	Yes	Yes	Yes
Hungary	Yes	Yes	n/a	No	n/a	Yes	Yes	Yes	Yes
Iceland	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Ireland	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Israel	n/a	Yes	Yes	Yes	None	Yes	Yes	Yes	Yes
Italy	Yes	No	Yes	Yes	None	No	No	Yes	No
Japan	Yes	Yes	Yes	Yes	Few	Yes	Yes	Yes	Yes
Korea	Yes	Yes	Yes	Yes	Few	Yes	Yes	Yes	Yes
Latvia	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes	Yes
Lithuania	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Luxembourg	n/a	Yes	Yes	No	Few	Yes	Yes	Yes	Yes
Malta	No	Yes	n/a	Yes	n/a	Yes	Yes	n/a	Yes
Mexico	Yes	Yes	n/a	Yes	None	Yes	Yes	Yes	Yes
Netherlands	n/a	Yes	Yes	No	Some	Yes	Yes	Yes	Yes
New Zealand	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Norway	Yes	Yes	Yes	Yes	All	Yes	Yes	Yes	Yes
Poland	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes	n/a
Portugal	Yes	Yes	No	Yes	n/a	Yes	Yes	Yes	n/a
Romania	Yes	No	n/a	No	n/a	No	No	No	No
Slovak Republic	No	n/a	n/a	No	n/a	No	No	No	n/a
Slovenia	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
Spain	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Switzerland	Yes	Yes	Yes	Yes	Few	Yes	Yes	Yes	Yes
Türkiye	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes	Yes
United Kingdom	Yes	Yes	Yes	Yes	Some	Yes	Yes	Yes	Yes
United States	Yes	Yes	n/a	Yes	n/a	Yes	Yes	Yes	Yes
Total Yes	35	38	25	33		38	36	37	36

Note: n/a: Not available. “Yes” indicates that policies or programmes are either fully implemented or that implementation is underway either at the national or regional level, while “No” indicates that the policy has been addressed but not yet under implementation, or that there is no policy in place.

Source: OECD/WHO Regional Office for Europe (2023^[85]), *Mental Health Systems Capacity Questionnaire 2023 – Strategy or action plan that guide implementation of the mental health policy*; OECD/WHO Regional Office for Europe (2023^[90]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes that support suicide prevention*; OECD/WHO Regional Office for Europe (2023^[91]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care*; OECD/WHO Regional Office for Europe (2023^[92]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to improve mental health awareness and literacy*; OECD/WHO Regional Office for Europe (2023^[93]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to address stigma and discrimination*; OECD/WHO Regional Office for Europe (2023^[94]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to support mental health in educational settings*; OECD/WHO Regional Office for Europe (2023^[95]), *Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to support and promote mental health of children and adolescents*; OECD (2021^[56]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>.

The OECD has assessed 11 candidate best and promising practices

Subsequent chapters to this report analyse 11 candidate promising and best practices aimed at preventing mental ill-health and promoting good mental health. All the interventions and programmes identified were consistent with the policy areas included in the OECD Framework for Mental Health Performance (Box 2.5). Six of the selected interventions aimed to improve help-seeking behaviour, particularly for people with mild-to-moderate symptoms and improve access to low-threshold and specialised care services. Three of the case studies were education-based programmes that aimed to develop children’s skills to manage mental health problems, for example by strengthening their social and emotional coping skills. Two of the case studies focussed on suicide prevention, while three focussed on front-line workers, such as providing training for midwives and teachers to help people in mental distress or a crisis (Table 2.3). Some intervention covers multiple policy areas at the same time. The target population of the selected interventions is diverse, including children, adolescents, adults, perinatal women, and people with mild-to-moderate mental health symptoms, as well as those with mental illnesses and suicidal ideation. The selected interventions cover more than 11 countries as some of them are implemented in multiple countries. The interventions are delivered in various ways, such as in healthcare settings, by web-based tools, peer-based programmes and school settings.

Table 2.3. Overview of the 11 selected candidate best practices

Name	Policy areas	Description	Country
Prompt Mental Health Care (PMHC)	Facilitate access	Improved access to mental health support via PMHC centres for individuals with mild-to-moderate symptoms	Norway
iFightDepression® Tool (iFD Tool)	Facilitate access	Web-based, guided self-help programme	Germany
Next Stop: Mum	Front-line actors; Facilitate access	Early diagnosis of postpartum depression	Poland
VigilanS	Prevent suicide	Prevention of reiteration of suicide attempts	France
Belgium’s mental health reform	Facilitate access	Improved access to mental health support via a network of psychologists	Belgium
Suicide Prevention Austria (SUPRA)	Prevent suicide; Front-line actors	Suicide prevention with multiple components	Austria
Mental Health First Aid (MHFA)	Front-line actors; Mental health literacy	Training individuals to listen to people with mental distress and provide first aid	Multiple

Name	Policy areas	Description	Country
@Ease	Facilitate access	Peer-based programme for mental health support for adolescents with mild-to-moderate symptoms	Netherlands
This is Me	Facilitate access; School	Online platform for adolescents and school-based programme	Slovenia
Icehearts	School	Programme to accompany children and adolescents with mental health issues	Finland
Zippy's Friends	School	Enhancing social-emotional and coping skills in children	Multiple

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Notes

¹ For mild disease severity group: no statistically significant difference between costs in the cohort with mental conditions and those in the control without mental disorders.

3 Prompt Mental Health Care

This chapter covers the case study of the Prompt Mental Health Care, a low-threshold, free-of-charge mental health care scheme in Norway. The case study includes an assessment of the Prompt Mental Health Care against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

Prompt Mental Health Care: Case study overview

Description: *Prompt Mental Health Care (PMHC)* is a Norwegian programme that aims to provide low-threshold, free-of-charge access to mental health care. It is designed to offer short waiting times and allow for access without a general practitioner's referral. Treatment at PMHC is based on Cognitive Behavioural Therapy (CBT) and is divided into low-intensity treatment (teaching-based courses and guided self-help) and high-intensity treatment (individual psychotherapy).

Best practice assessment:

OECD best practice assessment of Prompt Mental Health Care

Criteria	Assessment
Effectiveness 	PMHC is significantly more effective than treatment as usual in reducing depression and anxiety, increasing recovery rates by 83% at 6-months, with sustained improvements lasting up to 36 months. The SPHeP-NCD model estimated that by 2050, expanding PMHC would result in: • A cumulative gain of about 46 000 DALY for Norway. • An average of 35 and 33 DALYs per 100 000 persons per year for OECD and EU27 countries, respectively.
Efficiency	When transferring PMHC to all OECD and EU27 countries, average annual health expenditure savings amount to EUR 4.7 and EUR 3.5 on average per person between 2025 and 2050, for OECD and EU27 countries, respectively, excluding intervention costs. PMHC would be cost saving in eight OECD and EU27 countries and cost-effective in all remaining countries.
Equity	PMHC is a service free at the point of care, easily accessible and does not require a referral, ensuring direct access for individuals aged 16 and older with mild-to-moderate mental health needs.
Evidence-base 	The effectiveness of PMHC is supported by data from a randomised controlled trial study, with long-term benefits shown at 12-, 24-, and 36-month follow-ups. The overall quality of this study was considered as moderate, with strong quality regarding study design, control of cofounders and data collection method, moderate quality regarding selection bias and withdrawal, and poor quality in blinding.
Extent of coverage	75 PMHC teams provide services across 88 municipalities and city districts in Norway, with approximately 23 500 individuals receiving PMHC treatment annually.

Enhancement options: To *enhance effectiveness* of PMHC, establishing systematic monitoring and assessment to collect data could improve the quality and effectiveness of the programme. Further use of digital tools could increase the availability and accessibility of the service. To *enhance equity*, strengthening collaboration with community organisations and primary care providers can also support outreach to populations that are less likely to seek mental health support. To *enhance extent of coverage*, expanding PMHC services to more municipalities could extend the programmes benefits to a larger portion of the population.

Transferability: PMHC is based on the Improving Access to Psychological Therapies programme in the United Kingdom, and has been adapted in various countries, including Australia, New Zealand, Japan, Canada and Spain. PMHC is highly transferable in nearly 47% of OECD and EU countries with available data (20 out of 43 countries), and intermediately transferable to nine countries.

Conclusion: PMHC is effective in reducing symptoms of anxiety and depression, achieving higher recovery rates and sustained long-term improvements compared to treatment as usual.

Intervention description

Prompt Mental Health Care (PMHC) is a Norwegian initiative that aims to provide low-threshold, free-of-charge access to mental health care. It is an innovative strategy to increase the access to evidence-based primary care treatment, such as cognitive behavioural therapy (CBT) (Box 3.1), for individuals above 16 years old with mild-to-moderate symptoms of depression and/or anxiety (Knapstad et al., 2020^[1]). PMHC is also accessible for individuals with incipient substance use problems or sleep difficulties (although these are not assessed in this Chapter). PMHC is adapted from the United Kingdom's Improving Access to Psychological Therapies (IAPT) programme. IAPT was developed by the UK Government in 2008 to improve access to evidence-based psychological therapies for depression and anxiety disorders after the National Institute for Health and Care Excellence (NICE) guidelines recommended evidence-based psychological interventions in a stepped care model (Wakefield et al., 2021^[2]), and exists under its current form "NHS Talking Therapies".

Box 3.1. Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is an evidence-based talking therapy designed to help individuals manage psychological challenges by identifying and changing unhelpful thoughts, beliefs and behaviours. In CBT, patients work collaboratively with a therapist to address negative thinking patterns and develop coping strategies.

CBT is widely used to treat a variety of mental health conditions but is most commonly used to treat anxiety and depression. Research shows that CBT is effective in reducing symptoms of depression and anxiety, with evidence suggesting associated improvements in overall functioning and well-being.

Source: American Psychological Association (2017^[3]), "What is cognitive behavioural therapy?", <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.pdf>; Hofman et al. (2012^[4]), "The efficacy of cognitive behavioral therapy: A review of meta-analyses", <https://doi.org/10.1007/s10608-012-9476-1>.

The key characteristics of PMHC in Norway are as follows:

- Users can contact and get access to the PMHC service directly, without having to be referred by a general practitioner (GP).
- The service is easily accessible and reduces waiting times. The aim is to provide access within 7-14 days, whereas the national average waiting time for mental health services is 54 days (Helsedirektoratet, 2023^[5]).
- The service is designed to provide more users with access to treatment, as it involves less therapist contact through "low-intensity treatment" (such as guided self-help and teaching-based courses).

PMHC was initiated by the Norwegian Directorate of Health commissioned by the Ministry of Health in 2012 as a pilot project in 12 pilot sites in different geographical areas of Norway. There are currently 75 PMHC teams registered. These are spread across 88 municipalities, city districts, and inter-municipal co-operations (NAPHA, 2022^[6]). Around 60% of the adult population resides in municipalities where PMHC has been implemented (Smith et al., 2025^[7]). The services are organised within municipal healthcare and function as low-threshold programmes, accessible through self-referral or referral from GPs. The programme aims to reduce the gap between the number of people suffering from anxiety and depression and the number of those seeking and receiving treatment, by increasing access to mental health care.

PMHC is organised around a mixed-care model where the information from an initial assessment carried out by a CBT-therapist and the preferences of the patient are combined to determine the choice of treatment. The right treatment at the appropriate level is decided between the user and the therapist based

on the severity of symptoms, the mental health problems, the situation, and the resources. An initial assessment is conducted when the user first contacts the PMHC centre, which determines their suitability for PMHC treatment. Users who are not considered suitable, such as those with severe depression or other severe mental health disorders, are supported in accessing other appropriate services, including referrals to their GP or other specialised services appropriate to their needs (NAPHA, 2022^[6]).

Treatment and follow-up in PMHC are provided by multidisciplinary teams of independent therapists, with at least one psychologist in each team. PMHC staff have at least three years of relevant higher education related to mental health. In addition, all personnel are required to complete a mandatory training programme in CBT, which has been developed as part of the PMHC programme and is funded by the Norwegian Directorate of Health (NAPHA, 2022^[6]). Although GP referral is not required for PMHC treatment, the PMHC teams aim to work closely with GPs and other primary or secondary services.

Treatment in PMHC is based on CBT and is divided into low- and high-intensity care. Low-intensity care consists of teaching-based courses and guided self-help, while more high-intensity care consists of treatment groups and individual face-to-face psychotherapy (Knapstad et al., 2020^[1]) (Box 3.2). Because PMHC uses a mixed-care approach, the user does not necessarily start with low-intensity training but can also start with higher-intensity. This contrasts to the stepped care model used in IAPT, where users start with low-intensity training. In PMHC, the type and the intensity of treatment is decided between the user and the therapist.

Box 3.2. Different types of treatment offered by Prompt Mental Health Care

PMHC offers four types of treatment. The type and the intensity of treatment depend on user's needs evaluated by the CBT-therapist and user's preferences. All the treatment offered are guided by a therapist and can be provided either in-person or virtually.

- *Teaching-based courses* in PMHC have a fixed content, are led by course instructors, and can involve 8 to 40 participants. Users participate in four group sessions. Each session generally lasts two hours and consists of 25 participants.
- *Guided self-help* is offered to the user with weekly structured guidance from the same therapist. It usually consists of six guiding sessions of approximately 20 minutes. The user works with a programme over a set period to acquire knowledge and techniques to cope with various psychological problems. Online self-help programmes or self-help books are often used.
- *Treatment groups* usually consist of 6-10 people who meet for 6-8 sessions of 2.5 hours each. In the group, they discuss their experiences, receive education about mental health, and are assigned various exercises to do between sessions.
- *Individual psychotherapy* has a fixed structure and works towards the goals of the treatment through talking therapy. Users usually attend six sessions, but this can vary from two to 15 sessions. Each session lasts for 45 minutes.

Source: NAPHA (2022^[6]), "RPH-håndboka: anbefalinger basert på nasjonale retningslinjer og ti års erfaringer med rask psykisk helsehjelp".

OECD Best Practices Framework assessment

This section analyses PMHC against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 3.3 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 3.3. Assessment of Prompt Mental Health Care

Effectiveness

- PMHC demonstrates significantly greater effectiveness than treatment as usual (i.e. usual services available to the target population, such as general practitioners or private psychologists) with large effects in reducing depression ($d = -0.88$) and anxiety ($d = -0.60$).
- PMHC increases recovery by 83% at six-month follow-up compared to treatment as usual.
- Improvements in depression and anxiety symptoms are sustained over long-term follow-ups at 12, 24 and 36 months.
- The SPHeP-NCD model estimated that by 2050, scaling-up and transferring PMHC would result in a cumulative gain of about 46 000 disability-adjusted life years (DALYs) for Norway; and an average of 35 and 33 DALYs per 100 000 population per year in OECD and EU27 countries, respectively.

Efficiency

- When scaled up across the whole of Norway, it is estimated that PMHC will lead to cumulative health expenditure savings of EUR 240 per person by 2050, excluding the intervention cost.
- When transferring PMHC to all OECD and EU27 countries, average annual health expenditure savings – excluding the intervention cost – amount to EUR 4.7 and EUR 3.5 on average per person between 2025 and 2050, for OECD and EU27 countries, respectively.
- PMHC would be cost saving in eight OECD and EU27 countries and cost-effective in all remaining countries.
- Transferring PMHC intervention would save OECD countries up to EUR 3.8 per person per year in labour market costs (EUR 3.5 in EU27 countries).

Equity

- PMHC is a service that is free at the point of care easily accessible and that does not require a doctor's referral, ensuring direct access for individuals aged 16 and older with mild-to-moderate mental health needs.
- PMHC is more often utilised by women, individuals with higher education, and non-immigrants, though user demographics vary by municipality.

Evidence-base

- The evidence for the effectiveness of PMHC is based on data from a randomised controlled trial study.
- The overall quality of this study was considered as moderate, with strong quality regarding study design, control of cofounders and data collection method, moderate quality regarding selection bias and withdrawal, and poor quality in blinding.
- The long-term benefits of PMHC have been assessed through follow-up studies at 12, 24 and 36 months.

Extent of coverage

- As of March 2023, 75 PMHC teams operate in 88 municipalities and city districts across Norway, with approximately 23 500 individuals receiving PMHC treatment annually.

Note: d refers to Cohen's d effect size and is generally interpreted as small (0.20), medium (0.50) and large (0.80).

Effectiveness

A randomised controlled trial (RCT) of the PMHC programme was used to assess the effectiveness of PMHC compared to a control group that received treatment as usual (TAU) (Knapstad et al., 2020^[1]). The study included 681 participants from two PMHC pilot sites (Kristiansand and Sandnes) above 18 years old with mild-to-moderate symptoms of depression and anxiety, who were randomly assigned to the PMHC group ($n=463$) or to the TAU group ($n=218$). The follow-up period was six months. TAU included all standard services available to the target population, typically involving follow-up by a GP, or alternatively by private psychologists or occupational services. Individuals in the TAU group received a letter encouraging them to contact their GP for further follow-up as well as references to publicly available self-help resources, such as websites and books. Change in symptoms of depression was assessed using the Patient Health Questionnaire (PHQ-9, range 0-27) and the change in symptoms of anxiety was assessed using the Generalised Anxiety Disorder scale (GAD-7, range 0-21). Threshold values for PHQ-9 and GAD-7 are presented in Box 3.4. In this study, recovery was defined as users scoring above the threshold on the PHQ-9 (≥ 10) and/or GAD-7 (≥ 8) at the beginning of the treatment and below the threshold on both measures at six-month follow-up. The reliable recovery rate was used as a measure of sufficient reduction in symptom severity, accounting for measurement error (Knapstad et al., 2020^[1]).

Box 3.4. Thresholds for PHQ-9 and GAD-7

This box presents two widely used scales, the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder (GAD-7) scale, for the assessment of depression and anxiety severity. The PHQ-9 scale presents a series of nine questions to assess the severity of depressive symptoms. Each question aims to rate the frequency of symptoms over the past two weeks on a scale from 0 to 3. The total score ranges from 0 to 27, with higher score indicating greater severity of symptoms. Likewise, the GAD-7 scale presents seven questions, each scoring from 0 to 3, with a total score ranging from 0 to 21. The score cut-offs are shown in Table 3.1.

Table 3.1. PHQ-9 and GAD-7 severity levels

PHQ-9	GAD-7
0-4: Minimal depression	0-4: Minimal anxiety
5-9: Mild depression	5-9: Mild anxiety
10-14: Moderate depression	10-14: Moderate anxiety
15-19: Moderately severe depression	15-21: Severe anxiety
20-27: Severe depression	

People with severe symptoms of depression or anxiety are typically not eligible for treatment in PMHC and are directed to alternative services, such as referral to their GP, secondary services, or other relevant healthcare providers.

Source: Kroenke et al. (2001^[8]), "The PHQ-9: Validity of a brief depression severity measure", <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>; Spitzer et al. (2006^[9]), "A brief measure for assessing generalized anxiety disorder: the GAD-7".

The study shows that PMHC is significantly more effective than TAU in reducing the depression and anxiety scores. The estimated mean score for PHQ-9 was reduced from 15.72 to 7.45 in the PMHC group and from 15.57 to 11.15 in the TAU group over six months, resulting in a between-group effect size¹ $d=-0.88$ (with 95% confidence intervals (CI) ranging from -1.23 to -0.43) in favour of the PMHC group. Over the same period, the GAD-7 mean score was reduced from 13.13 to 5.88 in the PMHC group and from 12.85 to 8.27 in the TAU group, resulting in a between-group effect size $d=-0.60$ (95% CI -0.90 to -0.30).

(Knapstad et al., 2020^[11]). In addition, PMHC increases recovery at six-month follow-up by 83% compared to TAU. The reliable recovery rate observed in the PMHC group was 58.5% compared to 31.9% in the TAU group at six-month follow-up, giving a between-group effect size of 0.61 (95% CI 0.37 to 0.85, $p < 0.001$). Finally, PMHC treatment shows greater improvement in functional status ($d=-0.39$), health-related quality of life ($d=-0.46$), and mental well-being ($d=0.65$) with medium between-group effect sizes.

PMHC also produces long-lasting improvements in symptoms of depression and anxiety. Studies suggest that PMHC is an effective treatment programme for people with mild-to-moderate depression and anxiety, and that these effects are maintained over time. Results from a 12-month post-treatment evaluation of PMHC show substantial reductions in symptoms from the baseline to the 12-month follow-up for both measures of depression (PHQ-9) ($d=-0.98$) and anxiety (GAD-7) ($d=-0.94$). These observed improvements were largely sustained 12 months after the treatment (Sæther et al., 2019^[10]). It has also been shown that for individuals assigned to PMHC treatment, the observed improvements in symptoms are sustained or further improved at 24- and 36-month follow-ups (Smith et al., 2022^[11]).

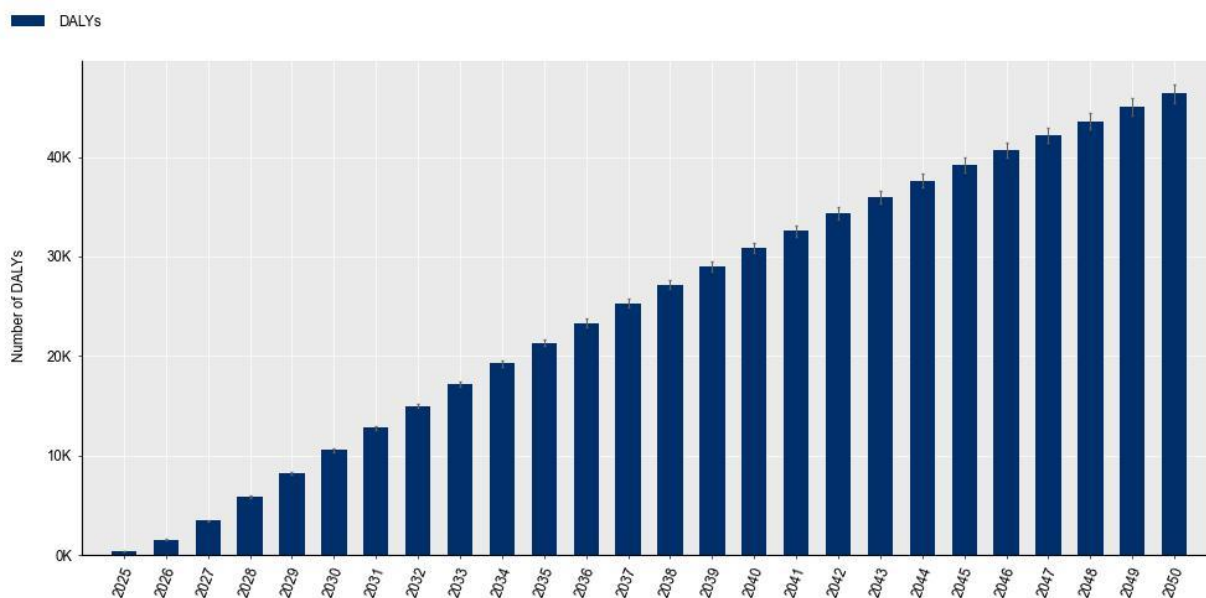
The OECD's **Strategic Public Health Planning for non-communicable diseases** (SPHeP-NCDs) microsimulation model was used to estimate the health and economic impact of expanding PMHC across Norway, and across all OECD and non-OECD European countries, assuming that 3% of the target population received the intervention. Details on the model are in Annex A, while the list of model assumptions are in Annex 3.A at the end of this Chapter.

The rest of this section presents results for Norway, followed by remaining OECD and non-OECD European countries.

Norway

The OECD's SPHeP-NCD micro-simulation model estimates that 46 000 disability-adjusted life years (DALYs) would be gained between 2025-2050 in Norway (Figure 3.1).

Figure 3.1. Cumulative number of DALYs gained (2025-2050) – PMHC, Norway

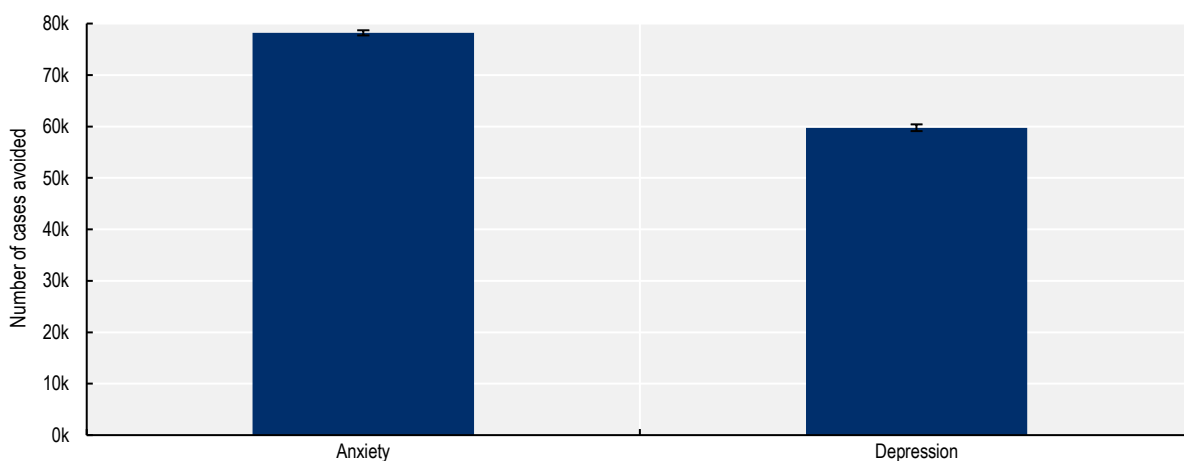


Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

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

Early intervention programmes that treat mild and moderate symptoms of anxiety and depression and reduce scores for PHQ-9 and GAD-7, such as PMHC, are expected to have large impact on anxiety and depressive disorders. If PMHC was scaled up in Norway, the number of anxiety and depressive disorders cases would fall by 78 000 and 59 000 cases, respectively, between 2025 and 2050 (Figure 3.2).

Figure 3.2. Cumulative number of diseases avoided by 2050 – PMHC, Norway



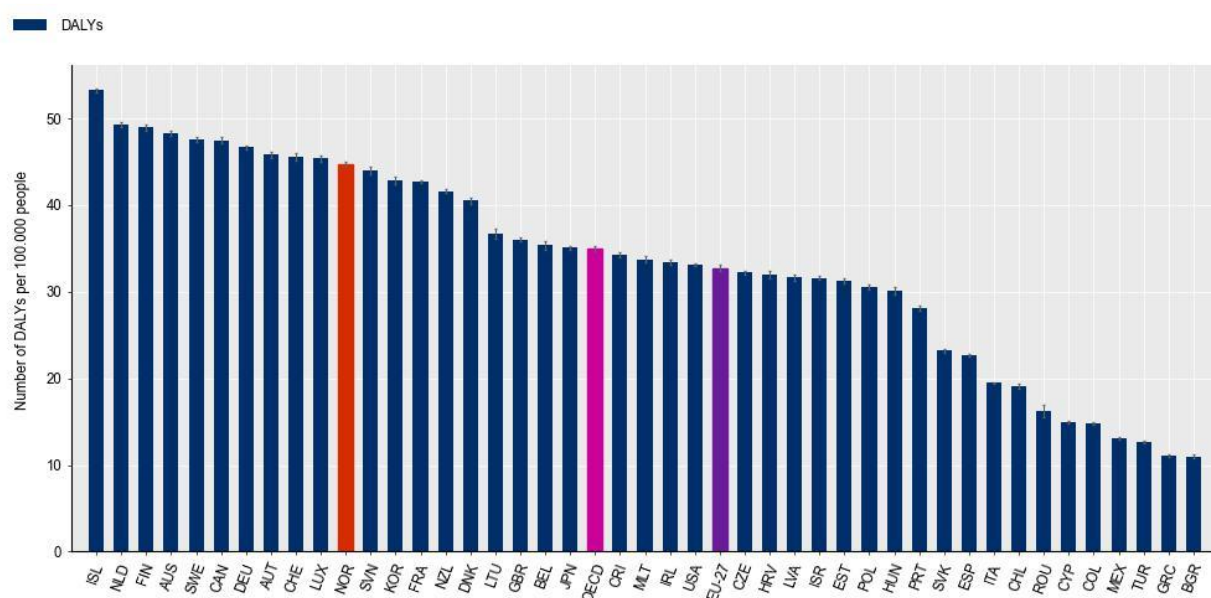
Note: NS = non-significant. The black lines represent 95% confidence intervals.

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

OECD and non-OECD European countries

Transferring PMHC to all OECD and EU27 countries is estimated to result in 35 and 33 DALYs gained per 100 000 people, respectively, on average per year between 2025 and 2050. This ranges from 11 in Bulgaria to 53 in Iceland (Figure 3.3).

Figure 3.3. DALYs gained annually per 100 000 people, 2025-2050 – PMHC, all countries

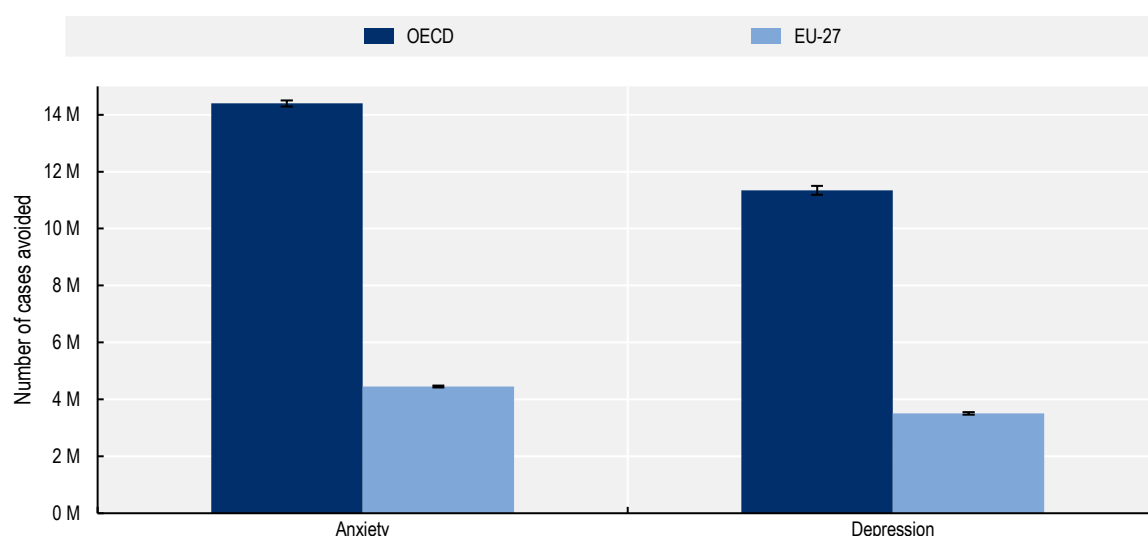


Note: The black lines represent 95% confidence intervals.

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

Overall, PMHC is expected to have the greatest impact on anxiety and depression. In gross terms, between 2025 and 2050, it is estimated that PMHC will reduce anxiety disorder cases by 14.4 million in OECD countries and by 4.4 million in EU27 countries (Figure 3.4). PMHC is also estimated to reduce depressive disorder cases by 11.3 million in OECD countries and by 3.5 million in EU27 countries. This represents about 0.6% and 1.4% of all cases of anxiety and depression across OECD and EU27 countries.

Figure 3.4. Total disease cases avoided, between 2025 and 2050 – PMHC, OECD and EU27 countries



Note: The black lines represent 95% confidence intervals.

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

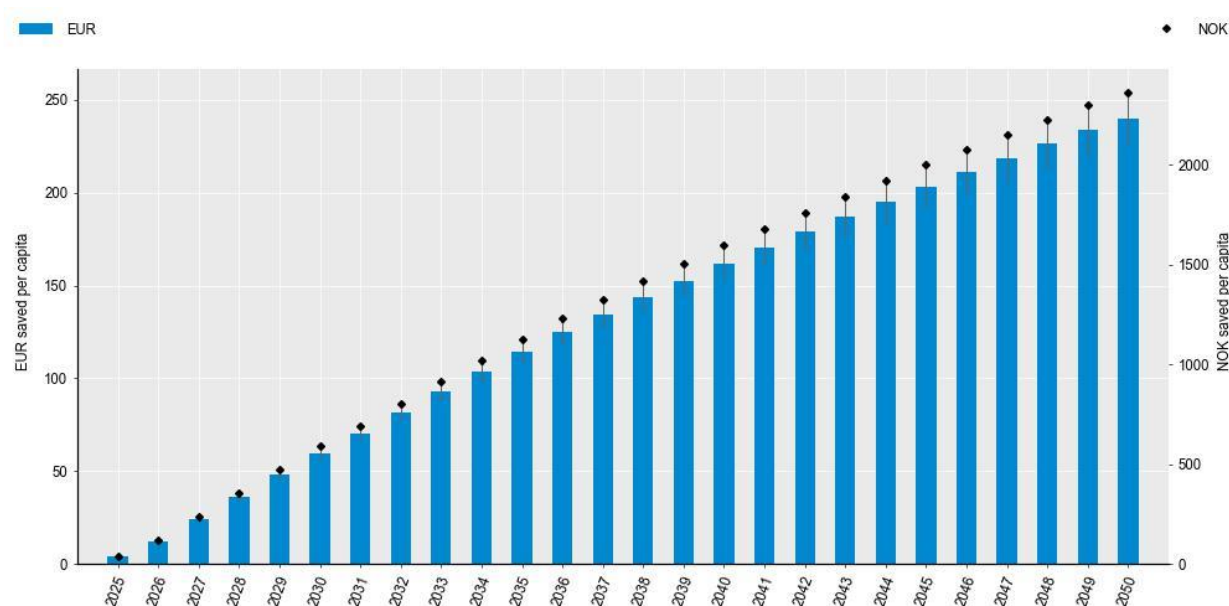
Efficiency

Similar to “Effectiveness”, this section presents results for Norway followed by remaining OECD and non-OECD European countries. It presents the potential impact of the intervention on healthcare expenditure and a cost-effectiveness analysis assuming programme costs as reported in Annex 3.A at the end of this Chapter.

Norway

By decreasing symptoms of anxiety and depression and scores for PHQ-9 and GAD-7, PMHC can reduce healthcare costs by preventing symptoms from escalating and avoiding GP consultations and hospitalisations. Over the modelled period of 2025-2050, the OECD’s SPHeP-NCD model estimates that PMHC would lead to cumulative health expenditure savings of EUR 240 per capita by 2050 (Figure 3.5).

Figure 3.5. Cumulative health expenditure savings per person, EUR, 2025-2050 – PMHC, Norway



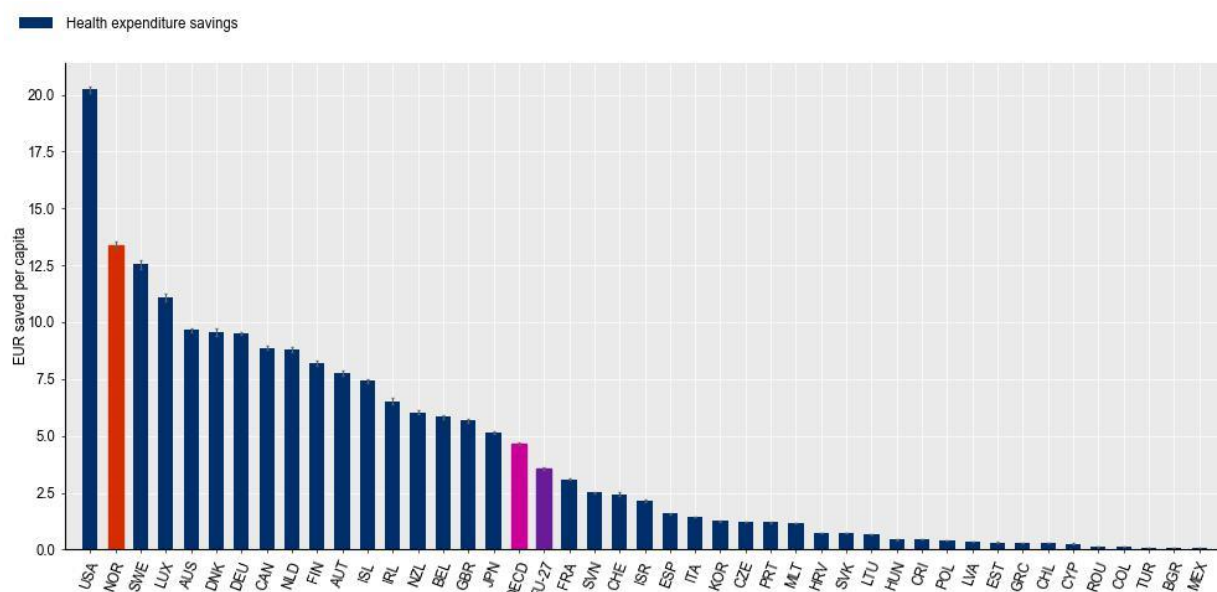
Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

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

OECD and non-OECD European countries

Average annual health expenditure (HE) savings amount to EUR 4.7 and EUR 3.5 on average per person between 2025 and 2050, for OECD and EU27 countries, respectively (Figure 3.6). Results may be explained by country-specific characteristics such as the proportion of individuals with mild-to-moderate symptoms, treatment cost, and the level of access to treatment by country (see treatment coverage by country in Chapter 2). For instance, Norway and the United States have higher levels of treatment coverage compared to other countries, resulting in higher potential economic savings. In contrast, Bulgaria and Mexico have lower treatment coverage.

Figure 3.6. Health expenditure (HE) savings per capita (EUR), average 2025-2050 – PMHC, all countries



Note: The black lines represent 95% confidence intervals.

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

Table 3.2 provides information on intervention costs, total health expenditure savings and the cost per DALY gained in local currency for OECD and non-OECD European countries. PMHC is cost-saving in eight countries (Croatia, Denmark, Germany, Luxembourg, the Netherlands, Norway, Sweden and the United States). In all other countries, PMHC is considered cost effective with the cost per DALY far below the average cost-effectiveness threshold applied in European countries (i.e. EUR 50 000 based on (Vallejo-Torres et al., 2016_[12])).

Table 3.2. Cost effectiveness figures in local currency – PMHC, all countries

Country	Local currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Australia	AUD	15.6	46 0 540 531	119
Austria	EUR	7.8	69 478 939	88
Belgium	EUR	6.74	69 235 481	2590
Bulgaria	BGN	3.76	847 227	33 070
Canada	CAD	13.19	565 535 523	8
Chile	CLF	2929.85	4 585 210 313	14 186 154
Colombia	COP	7 811.98	22 386 675 921	49 997 166
Costa Rica	CRC	3 055.33	1 519 322 408	8 076 358
Croatia	HRK	3.88	19 587 123	Cost saving
Cyprus	EUR	3.4	385 097	21 006
Czechia	CZK	113.07	328 332 609	253 074
Denmark	DKK	63.87	436 965 666	Cost saving
Estonia	EUR	5.1	400 475	15 268
Finland	EUR	9	45 221 073	1665
France	EUR	7.2	205 584 259	9 644
Germany	EUR	7.92	766 817 096	Cost saving

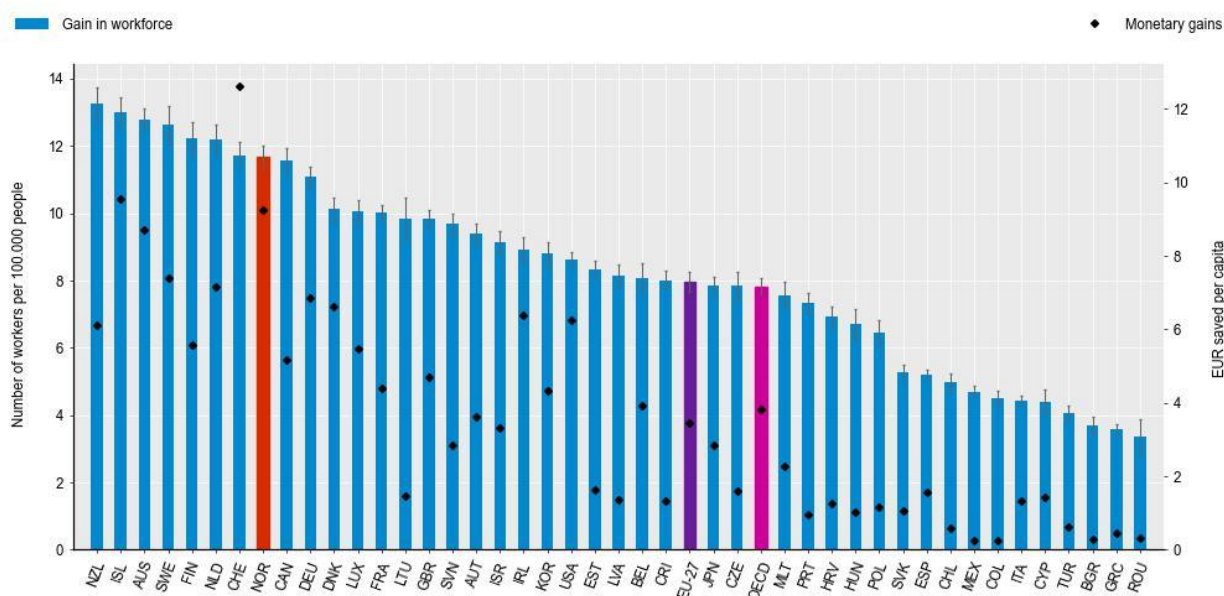
Country	Local currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Greece	EUR	2.67	2 762 893	21 543
Hungary	HUF	1398.7	1 314 994 737	4 166 503
Iceland	ISK	1631.79	429 933 908	1 153 203
Ireland	EUR	6.83	37 274 840	927
Israel	ILS	30.09	99 869 545	68 145
Italy	EUR	4.25	80 386 677	14 410
Japan	JPY	923.96	70 448 655 212	841 928
Korea	KRW	8 927.02	80 087 394 865	17 005 636
Latvia	EUR	4.63	557 907	13 605
Lithuania	EUR	4.71	1 724 128	11 004
Luxembourg	EUR	8.88	8 219 496	Cost saving
Malta	EUR	5.25	643 078	12 090
Mexico	MXN	52.26	183 184 274	388 877
Netherlands	EUR	8.4	164 803 787	Cost saving
New Zealand	NZD	15.24	56 958 511	11 969
Norway	NOK	91.96	766 358 665	Cost saving
Poland	PLN	15.91	62 240 591	46 438
Portugal	EUR	4.54	12 156 535	11 910
Romania	RON	10.84	11 376 526	62 775
Slovak Republic	EUR	3.83	3 772 660	13 403
Slovenia	EUR	5.76	5 171 559	7 391
Spain	EUR	4.49	74 093 817	12 809
Sweden	SEK	94.26	1 464 969 751	Cost saving
Switzerland	CHE	10.91	25 100 987	17 971
Türkiye	TRY	24.83	54 820 713	191 388
United Kingdom	GBP	6.31	362 239 814	3 662
United States	USD	9.35	7 985 964 275	Cost saving

Note: * Cost per DALY gained is measured using total intervention costs less total health expenditure savings divided by total DALYs gained over the period 2025-2050.

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

The reduction in anxiety and depression resulting from PMHC has, in turn, impacts on the labour market participation and productivity (see Chapter 2). PMHC is expected to lead to an increase in employment and a reduction in absenteeism, presenteeism and early retirement. Converting these labour market outputs into full-time equivalent (FTE) workers, it is estimated that OECD and EU27 countries will gain 7.8 and 8 FTE per 100 000 persons, for working-age people per year between 2025 and 2050, respectively. In monetary terms, this translates into average per capita increase in labour market production of EUR 3.8 and EUR 3.5 for OECD and EU27 countries, respectively (Figure 3.7).

Figure 3.7. Labour market workforce gains and savings, average per year, 2025-2050 – all countries



Note: The black lines represent 95% confidence intervals.

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

Equity

PMHC is a free-of-charge, easily accessible service (without a GP referral) for people over the age of 16 who need treatment for mild-to-moderate depression or anxiety. Specifically, there is no need for a GP referral, so the public can find and contact the service themselves. For individuals with more severe mental health problems, such as indications of psychosis, personality disorder, bipolar disorder, suicide risk or severe drug abuse, PMHC serves as a gateway to secondary healthcare services or to GPs (NAPHA, 2022^[6]).

In Norway, there is no national system in place for collecting and reporting user data from various low-threshold municipal services. Additionally, there is no national reporting of service data from PMHC teams, which means that information on the characteristics of individuals receiving PMHC treatment is not readily available. Despite the lack of a national reporting system in place, some studies conducted on PMHC have provided information on the characteristics of PMHC users, as indicated below.

PMHC services are more likely to be sought by women, people with higher education and non-immigrants. Knapstad and colleagues (2020^[11]) found that baseline demographics and characteristics were generally similar between the PMHC group and the TAU group. Overall, 66.5% of the participants were female, 41.6% had higher education (compared to 37% in the general Norwegian population) and 11.5% reported an immigrant background (16% in the general Norwegian population) (SSB, 2023^[13]; SSB, 2022^[14]). Likewise, a survey based on 32 PMHC teams in 2020 confirmed that most PMHC users were female (between 55% and 80% of users in different PMHC teams), aged between 30 and 50, and were highly educated (Oslo Economics, 2020^[15]), although the characteristics varied between municipalities.

The effectiveness of PMHC programme may be influenced by individual characteristics. A study, based on the 12 initial pilot sites of PMHC in Norway, found that some user groups tended to improve less during treatment than others. Although all groups of users showed substantial improvement, the strongest predictors of poorer treatment response were having an immigrant background, being unemployed at baseline, taking antidepressant medication and reporting bullying as the cause of their problems

(Knapstad, Nordgreen and Smith, 2018^[16]). Men, older people, those with lower education and those with an immigrant background were under-represented among the study participants. In contrast, findings from an RCT suggest that PMHC is equally effective as treatment-as-usual across a wide range of potential moderators such as sociodemographic, lifestyle, social, and cognitive variables (Sæther et al., 2022^[17]). This suggests that, despite earlier indications, the overall effectiveness of PMHC may not be significantly moderated by individual characteristics.

Evidence-base

The results for the effectiveness of PMHC are based on data from a RCT study. The results from the study have been published in a journal article (Knapstad et al., 2020^[1]) and the details of the study design are described in the study protocol.

The RCT study included 681 participants (aged ≥ 18 years) randomly assigned (70:30 ratio, $n=463$ to PMHC, $n=218$ to TAU). Participants were assessed at baseline and six-month follow-up and were compared in terms of recovery rates and changes in symptoms of depression (PHQ-9) and anxiety (GAD-7). The PHQ-9 has shown good psychometric properties, and the Cronbach's alpha² for the sample was 0.80. The GAD-7 has shown good reliability and validity for measuring generalised anxiety and other anxiety disorders, and the Cronbach's alpha for the sample was 0.83 (Knapstad et al., 2020^[1]).

The main strength of this study is the study design, as a RCT study is considered to provide the most reliable evidence on the effectiveness of interventions while also minimising the risk of confounding factors influencing the results (Akobeng, 2005^[18]). On the other hand, a couple of limitations of the study have been pointed out. First, missing outcome data could be a source of potential bias. Almost a third of the participants had missing data on the primary outcomes at the 6-month follow-up. However, all sensitivity analyses pointed in the same direction with effect sizes of similar magnitude, suggesting that selection bias is unlikely to have significantly influenced the estimated effects of PMHC. Second, the study design did not allow for blinding, meaning both users and therapists were aware of their group assignments.

The *Quality Assessment Tool for Quantitative Studies* rates the overall quality of this study as moderate, with strong study design, strong control of cofounders and strong data collection method, moderate quality regarding selection bias and withdrawal, and poor quality in blinding (see Table 3.3).

Table 3.3. Evidence Base assessment, Prompt Mental Health Care

Assessment category	Question	Rating
Target population		People with mild-to-moderate depression and anxiety
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Somewhat likely
	What percentage of selected individuals agreed to participate?	80%-100%
	<u>Selection bias score</u>	Moderate
Study design	Indicate the study design	RCT
	Was the study described as randomised?	Yes
	<u>Study design score</u>	Strong
Confounders	Were there important differences between groups prior to the intervention?	No
	What percentage of potential confounders were controlled for?	80%-100%
	<u>Confounder score</u>	Strong
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Yes
	<u>Blinding score</u>	Weak

Assessment category	Question	Rating
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
Data collection methods score		Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	60%-79%
Withdrawals and dropout score		Moderate

Source: Effective Public Health Practice Project (1998^[19]) "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Knapstad et al. (2020), "Effectiveness of Prompt Mental Health Care, the Norwegian Version of Improving Access to Psychological Therapies: A Randomized Controlled Trial", <https://doi.org/10.1159/000504453>.

Extent of coverage

Based on available estimates provided by PMHC's owner, approximately 23 500 individuals receive PMHC treatment in Norway each year. As of March 2023, there were 75 PMHC teams providing services in a total of 88 municipalities and city districts across the country. This shows an increase from the 62 teams that were established in 2020. In Oslo, there is a PMHC team in each city district, while some other municipalities work together to provide services through a joint team in inter-municipal co-operation.

The Norwegian Association for Cognitive Therapy has been responsible for the educational training of PMHC therapists since the beginning of the PMHC service. There are currently no national figures of the number of therapists working in PMHC. However, based on estimates of those who have completed the educational training and those who are currently in training, there are approximately 450 therapists working with PMHC.

Policy options to enhance performance

Enhancing effectiveness

Establishing systems for monitoring and assessment would improve the quality and effectiveness of PMHC

PMHC services are organised using a decentralised system where each municipality is responsible for how it organises mental health care. There is no standard practice across PMHC centres in the different municipalities, and therefore, it is challenging to monitor the quality for the service as a whole. In addition, there is limited evidence on the effectiveness of PMHC treatment across the municipalities.

A monitoring system that can collect data in a systematic and standardised way can improve the quality and effectiveness of PMHC. For instance, IAPT in England established an outcome monitoring system that ensures that symptom scores are obtained from 98% of the users. Outcome monitoring of IAPT showed that there is a wide variation in the performance of individual IAPT services (Clark et al., 2018^[20]). Such monitoring system and the systematic use of the collected data would also be essential for the assessment of the extent to which PMHC contributes to achieving treatment goals, and could contribute to increase the effectiveness of the services and further develop PMHC. In addition, user feedback can ensure the quality of the treatment, increase user engagement, and prevent dropout from the treatment (NAPHA, 2022^[6]).

The use of recognised assessment tools can help to monitor the evolution of symptoms of depression and anxiety. Using assessment tools, both at the start of treatment and during treatment, can track symptom progression and guide treatment accordingly. Assessment tools can help evaluate a person's condition and to guide treatment. Tools such as the PHQ-9 scale to measure the level of depressive symptoms and

GAD-7 to measure the level of anxiety are recommended for this type of use (NAPHA, 2022^[6]). Other tools or measures may be used for more specific mental health problems, such as for specific anxiety disorders.

Digital tools can increase the availability and accessibility of PMHC and offer cost-effective alternatives

Digital treatment can increase the availability and accessibility to healthcare. In PMHC, the CBT-based treatment can also be delivered via video communication, which may offer several advantages such as increased availability and accessibility, and lower dropout. Specifically, a report from the Norwegian Resource Centre for Community Mental Health (NAPHA) suggests that several users have reported that the use of video communication in PMHC has worked well. Some users reported that the use of video in PMHC has made treatment more accessible, as they have saved valuable time by not having to travel back and forth to the service, thus reducing geographical barriers to treatment. Some have also appreciated being able to sit at home in a safe environment and talk about difficult issues (NAPHA, 2022^[6]). In addition, many PMHC teams have had lower dropout rates when using digital treatment issues (NAPHA, 2022^[6]), since users can follow the treatment regardless of where they are located without it affecting the continuity of the treatment.

Guided internet-based CBT treatment is a cost-effective alternative to other forms of treatment for individuals struggling with anxiety and depression. CBT is well suited to online delivery through video communication. A systematic review shows that internet-based CBT – where therapists guide patients by providing feedback, support and encouragement through online messages rather than scheduled appointments or live video – is just as effective as traditional face to face CBT (Hedman-Lagerlöf et al., 2023^[21]), confirming earlier findings (Carlbring et al., 2018^[22]). The flexibility and accessibility of guided internet-based treatment, along with its reduced time commitment when compared with face-to-face treatment, makes it a cost-effective solution. The Norwegian Directorate of Health piloted guided internet-based treatment in collaboration with six PMHC teams across 11 municipalities, using tools from “Assistert Selvhjelp”. The results show that although statistical non-inferiority to standard therapy could not be confirmed, both approaches led to significant improvement, with recovery rates of over 50%. Clients were satisfied with the digital treatment, which required half the therapist time, suggesting that it is a promising option within PMHC (Knapstad et al., 2025^[23]).

There are, however, potential barriers to the use of digital tools in mental health treatment. A systematic review found that although technology can offer flexibility and facilitate anonymity, technical issues and privacy concerns are common barriers to user engagement (Borghouts et al., 2021^[24]). People’s literacy in understanding mental health and using technology can also affect their ability to use digital tools. Low digital health literacy and negative experiences with mental health services can be barriers to engagement with digital tools and digital mental health interventions (Borghouts et al., 2021^[24]).

Enhancing efficiency

One potential way to enhance the efficiency of PMHC is to encourage the use of low-intensity treatment approaches wherever appropriate. Evidence suggests that such approaches, including guided self-help and group-based treatment, are effective in treating anxiety and depression, and can achieve outcomes that are comparable to individual therapy (Sæther et al., 2022^[17]). This approach has the potential to result in cost savings and optimised resources. By promoting the use of low-intensity treatment options, resources can be allocated more efficiently, allowing a greater number of people to access and benefit from PMHC. To enhance the efficiency of PMHC, it is therefore recommended to further utilise low-intensity forms of treatment, such as guided self-help and group courses, along with workplace-focussed CBT (NAPHA, 2022^[6]). The expansion of the use of these approaches could more effectively achieve the goals of PMHC, ensuring better access and timely support for people in need.

Enhancing equity

Men, older people, those with lower education and those with an immigrant background were under-represented among the study participants (Knapstad et al., 2020^[1]). To enhance equity, targeted outreach strategies, culturally adapted materials and models of care that are responsive to the needs of diverse groups can help close these gaps. Strengthening collaboration with community organisations and primary care providers can also support outreach to populations that are less likely to seek mental health support.

Enhancing the evidence-base

PMHC has a strong evidence base with a RCT used to evaluate the effectiveness of the programme. Long-term studies have also been conducted, suggesting that long-term symptom improvement is maintained at 12-, 24- and 36-month intervals.

As a part of the development of the PMHC models and the research into the impact of interventions and programmes at the municipal level, the Norwegian Directorate of Health is investigating the possibility of creating a national electronic collection of outcome data. These data would be used by all PMHC teams to measure the impact before, during and after treatment, with the possibility of further strengthening the evidence base of PMHC with a large number of user data (Helsedirektoratet, 2021^[25]).

Enhancing extent of coverage

Improving geographical accessibility

The extend of PMHC coverage is limited due to restricted geographical accessibility. While people living in a municipality where PMHC is implemented can access the services, those who do not have access to the programme in their municipality may face barriers to receiving the care they need. Expanding the reach of PMHC to additional municipalities could help bridge this gap and extend the benefits of the programme to a larger population. The Norwegian health authorities are encouraging municipalities to expand PMHC services and establish new PMHC teams.

Preventing dropout from therapy

Dropout of treatment is common in PMHC. A study found a dropout rate of 25%, indicating that one out of four users end their treatment early without clarifying this with their therapist (Hanevik and Røvik, 2022^[26]). The results also showed that users dropped out most frequently between the first and second treatment session. This emphasises that early prevention of dropout is important already in the assessment phase (i.e. first session). Dropout is costly to the service and can be demotivating for both the users and the therapists. There are a number of measures that can be implemented to prevent dropout, including providing users with an estimate of the treatment duration and enabling them to influence and take part in the treatment process (NAPHA, 2022^[6]). PMHC can also benefit from routine tracking of PMHC site outcomes, making systematic monitoring of dropout rates possible.

Certain user groups are more likely to drop out of PMHC treatments. A study found that being younger, having limited social support, and having lower levels of educations were associated with disengagement in PMHC (Hanevik and Røvik, 2022^[26]). Therapists should therefore be encouraged to pay particular attention to these groups. If aware of the increased risk of dropping out for these groups, therapists can adopt a more proactive and flexible approach in their work with them. For individuals with lower levels of education and weak social networks, co-operation with other services can be considered. Services such as the Norwegian Labour and Welfare Organisation can help users to improve their socio-economic status, and co-operation between services can be beneficial for certain individuals (NAPHA, 2022^[6]).

Transferability

This section explores the transferability of PMHC and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring PMHC.

Previous transfers

There are several models that are similar to the PMHC programme, many of which originated from the IAPT model in England, including initiatives in Spain, Australia, Canada, Japan and New Zealand.

The Improving Access to Psychological Therapies (IAPT) programme was launched in **England** in 2007. The programme focussed on providing treatment for common mental health disorders in the general population through the use of CBT in a primary care setting. IAPT has shown good results in providing access to broadly effective, evidence-based psychological therapies for a large number of users, further reducing disability, social care and healthcare costs (Wakefield et al., 2021^[2]).

In **Spain**, the PsicAP programme was launched by the General Council of Psychology and Psicofundación (Spanish Foundation for the Promotion and Development of Scientific and Professional Psychology), following the precedent programme set by the IAPT. The programme aimed to compare psychological therapy with TAU for the treatment of common mental disorders (Cano-Vindel et al., 2022^[27]). PsicAP was a clinical trial designed to validate the efficacy of a group transdiagnostic treatment (TD) in Spanish primary care centres. The transdiagnostic approach focusses on treating the common factors involved in many emotional disorders. The results supported the inclusion of psychological treatment, particularly a transdiagnostic approach, in a primary care setting (Cano-Vindel et al., 2022^[28]).

NewAccess is an **Australian** low-intensity cognitive behavioural therapy service that was developed in 2013 based on IAPT. Coaches are recruited and trained to deliver the programme and it is targeted at people who are not currently accessing mental health services (Cromarty et al., 2016^[29]). This includes groups that are hard to reach, such as rural communities with lower access to mental health services and men. Results from NewAccess have shown improved recovery rates for both depression and anxiety. NewAccess is an appropriate and effective model to address mild-to-moderate depression and anxiety in an Australian context (Baigent et al., 2020^[30]).

In **Canada**, publicly funded programmes have focussed on improving access to CBT for common mental health disorders. In Ontario, free internet-based CBT services such as LifeWorks AbilitiCBT and MindBeacon Therapist-Guided iCBT, are available via self-referral. Evaluations have reported reductions in symptoms of anxiety and depression among programme participants (Khan et al., 2024^[31]).

In **Canada**, publicly funded programmes have focussed on improving access to CBT for common mental health disorders. In Ontario, free internet-based CBT services such as LifeWorks AbilitiCBT and MindBeacon Therapist-Guided iCBT, are available via self-referral. Evaluations have reported reductions in symptoms of anxiety and depression among programme participants (Khan et al., 2024^[31]).

Japan adapted the IAPT model in the Chiba CBT, a Japanese training course for clinicians in Chiba. The model focussed on individual CBT for obsessive-compulsive disorder, bulimia nervosa, or social anxiety disorder. The results demonstrated statistically significant reductions in symptom severity for all three disorders (Kobori et al., 2014^[32]).

New Zealand implemented the Piki Pilot Project to increase access to mental health and well-being support for young people aged 18-25, following the IAPT model (Dowell et al., 2019^[33]).

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of PMHC were identified (see Table 3.4). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 3.4. Indicators to assess the transferability of Prompt Mental Health Care

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey (%) (Eurostat, 2022 ^[34])	PMHC is more transferable to a context where mental health services are more accessible. Therefore, the programme is more transferable in countries where people consult mental health professionals.	↑ value = more transferable
<i>Sector specific context</i>		
Healthcare Access and Quality Index (IHME, 2017 ^[35])	PMHC is more transferable in a context where access to healthcare is facilitated	↑ value = more transferable
Psychologists per 1 000 population (OECD, 2021 ^[36])	PMHC is more transferable in countries with a higher proportion of psychologists	↑ value = more transferable
Mental health nurses (including professionals) per 1 000 population (OECD, 2021 ^[36])	PMHC is more transferable in countries with a higher proportion of mental health nurses	↑ value = more transferable
Talking therapy provided by primary care providers (OECD, 2021 ^[36])	PMHC is more transferable in countries that prioritise talking therapy	Yes = more transferable
Mental health that can be accessed directly, without referral (OECD, 2021 ^[36])	PMHC is more transferable where mental health services are accessible without previous referral	Yes = more transferable
<i>Political context</i>		
Policies and programmes for enabling self-care and self-management for people experiencing mental health conditions (OECD/WHO Regional Office for Europe, 2023 ^[37])	PMHC is more transferable in countries that have implemented policies and programmes for self-care and self-management for people experiencing mental health conditions	Yes = more transferable
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[38])	PMHC is more transferable in countries that have implemented policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare	Yes = more transferable
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[39])	PMHC is more transferable in countries that have a strategy or action plan in place to guide the implementation of mental health policy	Yes = more transferable
Policies and programmes to improve mental health awareness and literacy (OECD/WHO Regional Office for Europe, 2023 ^[40])	PMHC is more transferable in countries that work to improve mental health awareness and literacy	Yes = more transferable
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[41])	PMHC is a prevention programme and is more transferable to countries that allocate a higher proportion of health spending to prevention	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below (see Table 3.5 for results at the country level):

- a) In terms of access to mental health care, 7% reported consulting mental health care or rehabilitative care professionals in Norway, compared to around 6% on average across OECD countries. Norway is among the best performers in the Healthcare Access and Quality index, with a rate higher than the OECD average. More than two-thirds of OECD countries have a score over 80%.
- b) In Norway, the number of psychologists (1.4) and mental health nurses (0.66) per 100 000 is higher than in most other OECD countries.
- c) In Norway, talking therapy is provided by all primary care providers, which is more than most other OECD countries. In most OECD countries, including Norway, patients can access mental health care without the need of a referral.
- d) Policies and programmes for enabling self-care for people experiencing mental health conditions are implemented or underway in 72% of countries (28 out of 39), including in Norway. The majority of countries (79%) have policies and programmes in place to enable mental health promotion, prevention and treatment of mental health care conditions in primary healthcare.
- e) As in Norway, the vast majority of countries (90%) have a strategy or action plan to guide the implementation of mental health policy. A majority of countries (88%) also have policies and programmes to improve mental health awareness and literacy – including Norway.
- f) Norway has a lower level of prevention spending as a percentage of GDP, compared to other countries (0.27% vs. 0.40% for the median in OECD and EU countries). Countries with higher spending on prevention would be more likely to have economic support for the transfer of PMHC.

Table 3.5. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates PMHC is more suitable for transferral in that particular country

	Self-reported consultations	Psychologists per 1 000 population	Mental health nurses per 1 000 population	Talking therapy	Direct access without referral	Healthcare Access and Quality Index	Policies for enabling self-care and self-management	Policies for promotion, prevention and treatment in primary care	Strategy or action plan that guide policy implementation	Policies for improving awareness and literacy	Prevention spending (% GDP)
Norway	7.00	1.40	0.66	All	Yes	90.5	Yes	Yes	Yes	Yes	0.27
Australia	n/a	1.03	0.91	Some	Yes	89.8	Yes	Yes	Yes	Yes	0.35
Austria	7.40	1.18	n/a	Some	Yes	88.2	Yes	No	Yes	Yes	1.25
Belgium	9.50	0.10	1.26	Some	Yes	87.9	Yes	Yes	Yes	Yes	0.35
Bulgaria	1.50	n/a	n/a	n/a	n/a	71.4	Yes	No	Yes	No	n/a
Canada	n/a	0.49	0.69	Some	Yes	87.6	n/a	n/a	No	Yes	0.68
Chile	n/a	n/a	n/a	n/a	n/a	76.0	No	Yes	Yes	Yes	0.31
Colombia	n/a	n/a	n/a	n/a	n/a	67.8	Yes	Yes	Yes	Yes	0.16
Costa Rica	n/a	n/a	n/a	n/a	n/a	72.9	Yes	Yes	Yes	Yes	0.06
Croatia	5.70	n/a	n/a	n/a	n/a	81.6	No	No	Yes	Yes	n/a
Cyprus	1.00	n/a	n/a	n/a	n/a	85.3	Yes	Yes	Yes	Yes	n/a
Czechia	3.90	0.03	0.31	Nobody	Yes	84.8	n/a	Yes	n/a	Yes	0.77
Denmark	10.40	1.62	n/a	Some	Yes	85.7	Yes	Yes	Yes	Yes	0.48
Estonia	8.10	0.06	0.23	All	Yes	81.4	No	Yes	Yes	Yes	0.62
Finland	9.20	1.09	n/a	n/a	n/a	89.6	Yes	Yes	Yes	Yes	0.48
France	7.20	0.49	0.98	n/a	n/a	87.9	Yes	Yes	Yes	Yes	0.68
Germany	10.90	0.50	n/a	n/a	n/a	86.4	Yes	Yes	No	Yes	0.83
Greece	4.10	0.09	0.13	Few	Yes	87.0	No	No	Yes	No	0.37
Hungary	4.70	0.02	0.34	n/a	n/a	79.6	No	No	Yes	Yes	0.56
Iceland	12.60	1.37	n/a	Some	Yes	93.6	Yes	Yes	Yes	Yes	0.28
Ireland	4.70	n/a	n/a	Some	Yes	88.4	Yes	Yes	Yes	Yes	0.36
Israel	n/a	0.88	n/a	Nobody	Yes	85.5	Yes	Yes	n/a	Yes	0.02
Italy	3.50	0.04	0.23	Nobody	Yes	88.7	Yes	Yes	Yes	No	0.59
Japan	n/a	0.03	0.84	Few	Yes	89.0	n/a	Yes	Yes	Yes	0.36
Korea	n/a	0.02	0.14	Few	Yes	85.8	Yes	Yes	Yes	Yes	0.77
Latvia	4.30	0.67	0.23	Nobody	Yes	77.7	Yes	Yes	Yes	Yes	0.46

	Self-reported consultations	Psychologists per 1 000 population	Mental health nurses per 1 000 population	Talking therapy	Direct access without referral	Healthcare Access and Quality Index	Policies for enabling self-care and self-management	Policies for promotion, prevention and treatment in primary care	Strategy or action plan that guide policy implementation	Policies for improving awareness and literacy	Prevention spending (% GDP)
Lithuania	6.00	0.16	0.50	Some	Yes	76.6	Yes	Yes	Yes	Yes	0.44
Luxembourg	9.90	0.59	n/a	Few	Yes	89.3	No	No	n/a	Yes	0.26
Malta	5.30	n/a	n/a	n/a	n/a	85.1	Yes	Yes	No	Yes	n/a
Mexico	n/a	n/a	n/a	Nobody	n/a	62.6	No	Yes	Yes	Yes	0.18
Netherlands	9.80	0.94	n/a	Some	Yes	89.5	No	No	n/a	Yes	0.58
New Zealand	n/a	0.86	0.75	Some	Yes	86.2	Yes	Yes	Yes	Yes	n/a
Poland	4.10	0.16	0.31	Nobody	Yes	79.6	n/a	Yes	Yes	Yes	0.14
Portugal	7.30	n/a	n/a	n/a	No	84.5	Yes	Yes	Yes	Yes	0.35
Romania	0.90	n/a	n/a	n/a	n/a	74.4	No	No	Yes	No	n/a
Slovak Republic	3.90	n/a	n/a	n/a	n/a	78.6	No	No	No	No	0.13
Slovenia	5.80	0.09	0.36	Some	Yes	87.4	No	Yes	Yes	Yes	0.50
Spain	4.80	0.55	0.03	n/a	n/a	89.6	Yes	Yes	Yes	Yes	0.37
Sweden	11.20	0.99	0.51	n/a	n/a	90.5	Yes	Yes	Yes	Yes	0.55
Switzerland	n/a	0.26	n/a	Few	Yes	91.8	Yes	Yes	Yes	Yes	0.33
Türkiye	6.30	0.03	1.50	Nobody	Yes	76.2	Yes	Yes	Yes	Yes	n/a
United Kingdom	n/a	0.36	0.53	Some	Yes	84.6	Yes	Yes	Yes	Yes	1.55
United States	n/a	0.30	0.04	n/a	n/a	81.3	Yes	Yes	Yes	Yes	0.84

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details can be found in Table 3.4.

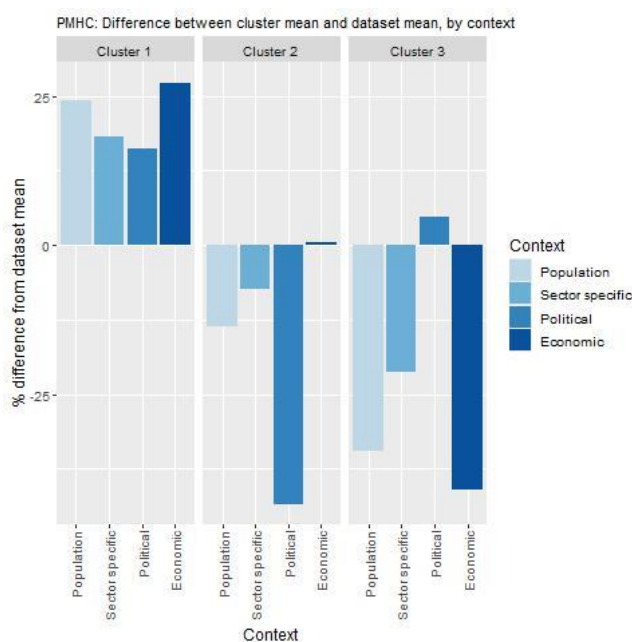
Source: OECD/WHO Regional Office for Europe, (2023^[37]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes for enabling self-care and self-management for people experiencing mental health conditions; OECD/WHO Regional Office for Europe (2023^[38]), Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care; OECD/WHO Regional Office for Europe (2023^[39]), Mental Health Systems Capacity Questionnaire 2023 – Strategy or action plan that guide implementation of the mental health policy; OECD/WHO Regional Office for Europe (2023^[40]), Mental Health Systems Capacity Questionnaire 2023 – Policies and programmes to improve mental health awareness and literacy; OECD (2024^[41]), “OECD Data Explorer - Prevention spending as a percentage of GDP”, <http://data-explorer.oecd.org/s/1n/>; Eurostat (2022^[34]), Self-reported consultations of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level, https://doi.org/10.2908/HLTH_EHIS_AM6E; IHME (2017^[35]), Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990–2015, <https://ghdx.healthdata.org/record/ihme-data/gbd-2015-healthcare-access-and-quality-index-1990-2015>; OECD (2021^[36]), A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health, <https://doi.org/10.1787/4ed890f6-en>.

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 3.5. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 3.8 and Table 3.6:

- Countries in cluster one has population, sector specific, political and economic arrangements in place to facilitate the transfer of PMHC. Overall, these countries are less likely to experience issues in implementing and operating PMHC in their local context. This group includes 20 countries.
- Countries in cluster two might face moderate issues in population and sector-specific contexts, and more significant challenges in political context. The economic context for these countries is close to the dataset mean. These countries might struggle with PMHC implementation due to political barriers. This group includes 9 countries.
- Countries in cluster three might experience barriers in population, sector-specific, and political contexts, despite having the economic support in place. These countries might have difficulties to translate economic resource into effective PMHC implementation due to shortcomings in other areas. This group includes 14 countries.

Figure 3.8. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 3.6. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia	Bulgaria	Chile
Austria	Croatia	Colombia
Belgium	Estonia	Costa Rica
Canada	Greece	Czechia
Cyprus	Hungary	Israel
Denmark	Luxembourg	Italy
Finland	Netherlands	Japan
France	Romania	Latvia
Germany	Slovenia	Malta
Iceland		Mexico
Ireland		Poland
Korea		Slovak Republic
Lithuania		Switzerland
New Zealand		Türkiye
Norway		
Portugal		
Spain		
Sweden		
United Kingdom		
United States		

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 3.5 outlines several new indicators policymakers could consider before transferring PMHC.

Box 3.5. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What are the main barriers to accessing to mental health care services?
- What is the level of mental health literacy in the population?
- What proportion of individuals would seek professional help for mental health concerns?

Sector specific context

- Is there a monitoring system in place to collect data of PMHC services?
- What are the proportion of trained professionals available to deliver CBT-based interventions?

Political context

- Does the country or region have national or regional mental health strategies that prioritise early intervention and low-threshold services?

Economic context

- What is the cost per patient treated in the PMHC model compared to other mental health care services?
- What are the estimated costs of scaling PMHC to new regions?

Conclusion and next steps

PMHC is a Norwegian programme that provides low-threshold, free mental health care to individuals aged 16 and older with mild-to-moderate symptoms of depression and/or anxiety. With treatment grounded in evidence-based CBT, PMHC offers two types of treatment: low-intensity (teaching-based courses and guided self-help) and high intensity (individual psychotherapy).

PMHC has proven highly effective in reducing depression and anxiety symptoms, compared to treatment as usual (including usual services such as general practitioners or private psychologists). It achieves an 83% increase in recovery rate at six months and demonstrates sustained improvements over 12, 24 and 36 months. It is estimated that transferring PMHC to all OECD and EU27 countries would be cost saving in eight OECD and EU27 countries and cost-effective in all remaining countries.

Currently, 75 PMHC teams operate across 88 municipalities and city districts in Norway, providing care to approximately 23 500 individuals annually. PMHC is based on IAPT in the United Kingdom (currently known as “NHS Talking Therapies”), and similar services or programmes exist in countries such as Australia, New Zealand, Japan and Spain. PMHC is highly transferable in nearly 47% of OECD and EU countries with available data (20 out of 43 countries), and intermediately transferable to nine countries. All countries have the opportunity to tailor mental health prevention strategies according to their specific needs, resources and context.

Box 3.6 outlines next steps for policymakers and funding agencies.

Box 3.6. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance PMHC are listed below:

- Extend the reach of PMHC to more municipalities, regions or potentially nationwide.
- Develop and implement a monitoring system that can collect data in a systematic and standardised way.
- Improve the ability of PMHC to attract and support traditionally underserved groups, such as gender and sexual minorities, minority ethnic groups or those with low socio-economic status.

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Annex 3.A. Modelling assumptions for PMHC

Annex Table 3.A.1. Parameters to model the impact of PMHC

Model parameters	Prompt Mental Health Care model inputs
Effectiveness	Reduction in PHQ score for people with score 10-14: -24% [CI: -33%; -16%] Reduction in GAD score for people with score 8-14: -20% [CI: -29%; -12%] Reduction in Health-Related Quality of Life (EQ-5D): -13% [CI: -20%; -7%]
Time to maximum effectiveness	Maximum effectiveness at 6-months (linear increase), maintain the effect until 3 years; then return to 0 (linear decrease from 3 years to 4 years)
Target population	Individuals aged 16 and over with PHQ score 5-14 and/or GAD score 5-14
Exposure	3% of the target population receive PMHC
Per capita cost, EUR	Cost per patient: EUR 1825 (NOK 17 054)

Effectiveness

The effectiveness of PMHC was evaluated using data from a randomised controlled trial (RCT) (Knapstad et al., 2020^[1]) and using a Difference-in-Difference (DiD) analysis to estimate the relative impact of PMHC compared to Treatment as Usual (TAU). The RCT showed that PMHC was significantly more effective than TAU in reducing symptoms of depression and anxiety:

- PHQ: Mean scores decreased from 15.72 to 7.45 in the PMHC group, compared to 15.57 to 11.15 in the TAU group over six months, resulting in a between-group effect size of -0.88.
- GAD: Mean scores decreased from 13.13 to 5.88 in the PMHC group, compared to 12.85 to 8.27 in the TAU group, with a between-group effect size of -0.60.
- EQ-5D: Mean scores decreased from 10.93 to 8.20 in the PMHC group, compared to 10.86 to 9.59 in the TAU group, with a between-group effect size of -0.46.

A DiD analysis was used to measure the change in outcomes over time for the PMHC group relative to the TAU group while accounting for baseline differences and trends unrelated to the intervention. The study included both the PMHC and the TAU group with before-and-after research design:

$$(I_{post} - I_{pre}) - (C_{post} - C_{pre})$$

Where I_{post} is the mean score in the PMHC group at six months, I_{pre} the mean score in the PMHC group at baseline, C_{post} is the mean score in the TAU group at six months, and C_{pre} the mean score in the TAU group at baseline.

The standard error (SE) of the DiD estimator was calculated following the methods detailed in Xiao et al. (2019^[42]) and using the formula:

$$SE(DiD) = S_p \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}$$

Where S_p is the estimate of the pooled standard deviation (SD) of the PMHC and TAU groups.

Where n_1 is the sample size of the PMHC group and n_2 is the sample size of the TAU group.

Time to maximum effectiveness

The time to maximum effectiveness of PMHC was assumed to be six months (Smith et al., 2022^[11]). The maximum effect was assumed to have been maintained for three years, based on evidence showing sustained improvements up to 36 months (Smith et al., 2022^[11]). From three years to four years, the effect was assumed to diminish linearly, returning to baseline levels.

Target population

PMHC targets individuals aged 16 years and older with mild-to-moderate symptoms of depression and/or anxiety. The inclusion criteria for the modelling were based on clinical thresholds for PHQ and GAD scores:

- Individuals with a PHQ-9 score between 5 and 14, indicating mild-to-moderate depression.
- Individuals with a GAD-7 score between 5 and 14, indicating mild-to-moderate anxiety.

Exposure

It is estimated that 2.9% of the target population currently receive PMHC in Norway. Based on information provided by PMHC owner, approximately 23 500 individuals receive PMHC treatment in Norway each year. Given the size of the population aged 16 and over in Norway (4 507 271 people, as of 2023, according to Statistisk Sentralbyrå (Statistisk sentralbyrå, 2023^[43])), and given that 18% of this group has mild or moderate symptoms of depression or anxiety (according to data from the European Health Interview Survey 2019), it is assumed that 2.9% of the target population receives the intervention ($23\,418 / (18\% \times 4\,507\,271) = 2.9\%$).

There are no figures available for the dropout rate of PMHC in real life, but the dropout rate in the RCT study was 23.1%. Another study looking at user predictors of dropout from PMHC services found a dropout rate of 25% (Hanevik and Røvik, 2022^[26]).

Based on this evidence, and assuming a higher coverage, it is assumed that 4% of the target population will receive the intervention in the model (higher than the estimated 2.9% to reflect a scale-up scenario). Of those receiving the intervention, 75% will take up the full programme (dropout rate of 25%). Therefore, the exposure rate is 3% ($4\% \times 75\%$).

Cost

A study estimated that the average cost per PMHC patient is EUR 1 825 (NOK 17 054) (Smith et al., 2025^[7]). This is based on data provided by the participating municipalities and the Norwegian Association for Cognitive Therapy.

Notes

¹ Between-group effect sizes (Cohen's d) were calculated by dividing the mean difference in estimated change scores from baseline to six months by the standard deviation at baseline. Generally, the effect size is interpreted as small (0.20), medium (0.50), and large (0.80).

² Cronbach's alpha is a way of assessing reliability by comparing the amount of shared variance among the questions in the instrument to the amount of overall variance (Collins, 2007^[44]).

4

iFightDepression® Tool

This chapter covers the case study of iFightDepression® (iFD) Tool, a web-based, guided, self-help tool for individuals with mild-to-moderate depression. The case study includes an assessment of the iFD Tool against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to OECD and EU27 countries.

iFightDepression® Tool: Case study overview

Description: iFightDepression® (iFD) Tool is a web-based intervention for people with mild-to-moderate depression, based on the principles of cognitive behavioural therapy (CBT). The content and concept of the tool were originally developed as part of the EU-funded project “*Preventing Depression and Improving Awareness Through Networking in the EU (PREDI-NU)*”, which ran from 2011 to 2014. The technical updates of the tool were completed in 2016, marking the start of its integration into routine care in Germany. The introduction to iFD Tool is guided by a general practitioner (GP) or a mental health professional who have been trained in the programme. While the use of the tool is self-managed by the user, the healthcare professional remains in contact with them throughout the duration of its use, providing guidance and support as needed. The iFD Tool is free-of-charge for users and translated into 16 languages, including Ukrainian and Russian. iFD Tool complements therapy, rather than replacing it. The guidance of patients by an iFD-trained professional is key. It is recommended that the patient completes one module per week, for a total of six modules.

Best practice assessment:

OECD best practice assessment of iFightDepression® Tool

Criteria	Assessment
Effectiveness	iFD Tool reduces depressive symptoms by 40% more than an active control group after six weeks, while also improving quality of life by 89% after six weeks and 56% after three months. The SPHeP-NCD model estimates that by 2050, expanding the use of iFD Tool would result in: - A cumulative gain of more than 6 500 DALY for Germany. - An average of 0.3 and 0.29 DALYs per 100 000 persons per year for OECD and EU27 countries, respectively.
Efficiency	It is estimated that transferring iFD Tool to the 43 OECD and EU27 countries would result in no health expenditure savings in 24 countries, but to statistically significant savings in 19 countries. iFD Tool would be cost saving in three countries, cost-effective in 34 countries and cost-effective at potentially higher threshold in five countries.
Equity	The iFD Tool is free-of-charge, available in 16 languages, and is accessible via referral by GP or a mental health professional who have been trained in the programme.
Evidence-base 	A randomised controlled trial (RCT) provides strong evidence for iFD, with strong quality in domains such as study design, control for confounders, withdrawals and dropouts, and moderate in data collection methods.
Extent of coverage	Since the initiation of the iFD Tool in Germany in 2016, 9 624 people have been identified and offered the use of iFD by a mental health professional. Around 14% of this target group had actually participated in the initial phase of the intervention, with a smaller proportion completing the whole programme, but data are not available.

Enhancement options: To *enhance effectiveness* of iFD Tool it is important to optimise the integration of regular check-ins and feedback mechanisms from healthcare professionals to provide users with timely, personalised feedback and ongoing encouragement. The use of online training for GPs and healthcare professionals can *enhance efficiency* of iFD Tool. To *enhance equity* of iFD Tool, target strategies are needed to ensure equal access to the tool and its benefits for all individuals. This includes removing financial barriers and addressing stigma, particularly among vulnerable and underserved groups. To *enhance the evidence-base of iFD Tool*, it is essential to establish a systematic and continuous evaluation process, including as RCTs, and implement a robust monitoring system to collect data on iFD usage and outcomes. To *enhance the extent of coverage* of iFD Tool, efforts should focus on reducing user dropout rates and expanding the recruitment of mental health professionals.

Transferability: The iFD Tool has been successfully transferred and implemented in Bulgaria, Estonia, Greece, Hungary, Ireland, Italy, Poland and Spain through the EU-funded European Alliance Against

Depression “EAAD-Best” project. By 2024, the iFD Tool was available in 16 languages, and the website (<https://ifightdepression.com/en/>) offers content in 21 languages.

Conclusion: iFD Tool has been shown to effectively reduce depressive symptoms in individuals with mild-to-moderate depression and has also been associated with improvements in users’ overall quality of life.

Intervention description

iFightDepression® (iFD) Tool is a non-commercial web-based intervention for **people with mild-to-moderate depression**, based on the principles of **cognitive behavioural therapy** (CBT) (Box 3.1). The iFD Tool is free-of-charge for users and is intended to help individuals to self-manage their symptoms of depression and promote recovery, with support from a trained general practitioner (GP) or mental health professionals.

Box 4.1. Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is an evidence-based talking therapy designed to help individuals manage psychological challenges by identifying and changing unhelpful thoughts, beliefs and behaviours. In CBT, patients work collaboratively with a therapist to address negative thinking patterns and develop coping strategies.

CBT is widely used to treat a variety of mental health conditions but is most commonly used to treat anxiety and depression. Research shows that CBT is effective in reducing symptoms of depression and anxiety, with evidence suggesting associated improvements in overall functioning and well-being.

Source: American Psychological Association (2017^[1]), “What is cognitive behavioural therapy?”, <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.pdf>; Hofmann et al. (2012^[2]), “The efficacy of cognitive behavioral therapy: A review of meta-analyses”, <https://doi.org/10.1007/s10608-012-9476-1>.

The intervention consists of three parts dedicated to either the patient or the professional who guides the patient while using the tool:

1. a guided, internet-based self-management tool for individuals experiencing mild-to-moderate depression that is free of charge for users and uses the principles of CBT.
2. a website providing detailed information on depression addressed to the general population, young people, family and friends, community workplace managers and colleagues, and healthcare professionals.
3. training materials for healthcare professionals who are interested in implementing iFD Tool in their practice.

iFD is a guided self-help tool. Individuals are typically introduced to the programme by a GP or a psychotherapist who has completed the standardised professional training programme. These trained health professionals provide access to the tool and motivate patients to complete the iFD modules over seven or eight weeks. The guidance aspect is key to achieve better outcomes. Evidence from Germany supports that adherence and clinical outcomes (measured by reduction in depression symptoms) were improved for patients adhering to the guided iFD Tool compared to those using an unguided tool (Oehler et al., 2021^[3]).

iFD Tool consists of six modules that focus on increasing daily activity, identifying and challenging negative thought patterns, monitoring mood and sleep. In addition to the six core modules, there are two optional modules for young people and one optional module for both young people and adults, that address related psychosocial issues, namely, relationships, social anxiety, and healthy lifestyle habits. Associated worksheets and exercises encourage users of the tool to practice and consolidate new skills and to promote self-monitoring.

iFD Tool complements therapy, rather than replacing it. The guidance of patients by an iFD trained professional is key. It is recommended that the patient completes one module per week for a total of up to seven or eight weeks (Arensman et al., 2015^[4]). The completion of iFD modules aims at reducing the time of a traditional psychological therapy. Furthermore, iFD can be particularly useful for patients who are on waiting list for mental health care, as those people – referred by a GP- can start to receive information and complete exercises of the iFD modules while waiting for an appointment with a mental health professional.

To implement the iFD Tool in a country, a national co-ordinator is required. This role should be fulfilled by an organisation such as the Ministry of Health, non-governmental organisation, hospital, or university. The national co-ordinator is responsible for promoting the iFD Tool, organising iFD training sessions for healthcare professionals, and registering them as iFD guides, enabling them to access and offer the tool to their patients. Additionally, organisations interested in becoming a national co-ordinator are required to contribute an annual fee to support the technical maintenance and adaptation of the iFD Tool.

The concept and content of the iFD Tool were developed as part of the EU-funded project Preventing Depression and Improving Awareness Through Networking in the EU (PREDI-NU), which ran from 2011 to 2014. Technical updates of the tool were completed in 2016, marking the beginning of its integration into routine care in Germany. The tool's use was later expanded to several European countries through Adapting and Implementing European Alliance Against Depression (EAAD)'s Best Practice Model to Improve Depression Care and Prevent Suicidal Behaviour in Europe – EAAD-Best project (see below section on Previous transfers).

OECD Best Practices Framework assessment

This section analyses iFD Tool against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 3.3 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 4.2. Assessment of iFightDepression®

Effectiveness

- iFD Tool reduces the duration of the depression episode compared to an active control. After six weeks of therapy, the reduction in depressive symptoms is 40% higher with iFD compared to the active control group.
- The increase in quality of life is 89% higher in the iFD group compared to the control group after six weeks, and 56% higher after three months.
- The SPHeP-NCD model estimates that by 2050, expanding and transferring iFD Tool would results in a cumulative gain of more than 6 500 DALYs for Germany; and an average of 0.3 and 0.29 DALYs per 100 000 persons per year for OECD and EU27 countries, respectively.

Efficiency

- It is estimated that transferring iFD Tool to the 43 OECD and EU27 countries would result in no health expenditure savings in 24 countries, but to statistically significant savings in 19 countries.
- iFD Tool would be cost saving in three countries (the Netherlands, Norway and Sweden), cost-effective in 34 countries and cost-effective at potentially higher threshold in five countries.

Equity

- iFD Tool is accessible via referral by a GP or a mental health professional who have been trained in the programme.
- iFD Tool is free-of-charge and is available in 16 languages, including Ukrainian and Russian.

Evidence-base

- A randomised controlled trial (RCT) study supports the evidence for iFD (Oehler et al., 2020^[5]). This study performs well against the Quality Assessment Tool for Quantitative Studies, in particular in terms of study design, control for confounders, and withdrawals and dropout.

Extent of coverage

- Since the initiation of the iFD Tool in Germany in 2016, 9 624 people have been identified and offered the use of iFD Tool by a mental health professional. Around 14% of this target group had actually participated in the initial phase of the intervention, with a smaller proportion completing the whole programme, but data are not available.

Effectiveness

A German Randomised Controlled Trial (RCT) study found that iFD Tool leads to greater reduction in depression symptoms and greater quality of life after six weeks, compared to the control group who received web-based progressive muscle relaxation (Oehler et al., 2020^[5]). This study included 348 participants and followed participants at several points in time (after 3 weeks, 6 weeks, 3 months, 6 months, 12 months). The change in depression severity was assessed with the Inventory of Depressive Symptomatology-self-rating (IDS-SR) score (range 0-84). The change in self-perceived health-related quality of life was assessed with the Short-Form 12 (SF-12) (both mental and physical score, ranging from 0 to 100), and the possible deterioration in depressive symptoms toward suicidality was assessed with the Patient Health Questionnaire (PHQ-9).

Depression symptoms

The iFD group shows a significant reduction in depressive symptoms after six weeks and three months compared to the active control group, significantly reducing the *duration* of the depression episode. The progress achieved after six weeks and after three months was greater in the iFD group compared to the active control group. Specifically, after six weeks, the depression score decreased by 6.7 points (from 27.5 to 20.8 on score scale from 0 to 84, with confidence intervals (CI) of 2.4 to 39.2) compared to a 4.8-point decrease in the control group, meaning that the **reduction in the depression score is 40% higher in the iFD group** (Oehler et al., 2020^[5]). The depression score further decreased after three months down to 19.3 [CI: -3.0; 41.6] compared to 22.0 [CI: -0.9; 44.9] in the control group, corresponding to a **39% higher reduction in the iFD group**. After 12 months, the depression score decreased in both groups, with no statistical difference between groups. This likely reflects the fact the depression episode lasts for several months and resorbs after a year.

Quality of life

The study by Oehler et al. shows that quality of life **significantly improved in both iFD and control groups, with greater improvements in the iFD group after six weeks and three months**. The SF-12 Mental component score in the iFD group increased from 33.6 in the baseline to 38.9 [CI: 19.9; 57.9] after six weeks, and 40.3 [CI: 19.1; 61.5] after three months (the score ranges from 0-100), whereas the score in the control group increased from 33.3 in the baseline to 36.1 [CI: 16.1; 56.1] after six weeks, and 37.6 [CI: 17.8; 57.4] after three months (Oehler et al., 2020^[5]). In other words, the increase in quality of life is 89% higher in the iFD group compared to the control group after six weeks, and respectively 56% higher after three months.

Remission from depression

A Spanish RCT study found that **iFD Tool improves the rate of remission from depression** within eight weeks. The study focussed on patients with mild-to-moderate depression who followed a therapy, using the Hamilton Depression Rating Scale (HDRS). Remission was defined as a HDRS score below 7. Patients who received a link to a website about depression and were guided to use iFD Tool (intervention group) were more likely to remit from depressive symptoms eight weeks after the intervention than those treated and receiving a link to a website about depression (active control), although the effect was not quantified in the study (Justicia Diaz, 2021^[6]). Besides, in the intervention group, the number of modules completed was significantly higher in remitters than in non-remitters, suggesting the adherence to iFD Tool contributed to remission.

Quality of care: Patient satisfaction

The same Spanish RCT study found that patient satisfaction was measured to be higher in the intervention group, according to the Client Satisfaction Questionnaire (CSQ-8). The mean score was 23.5 in the intervention group compared to 19.5 in the control group (the score ranges from 4 to 32) (Justicia Diaz, 2021^[6]).

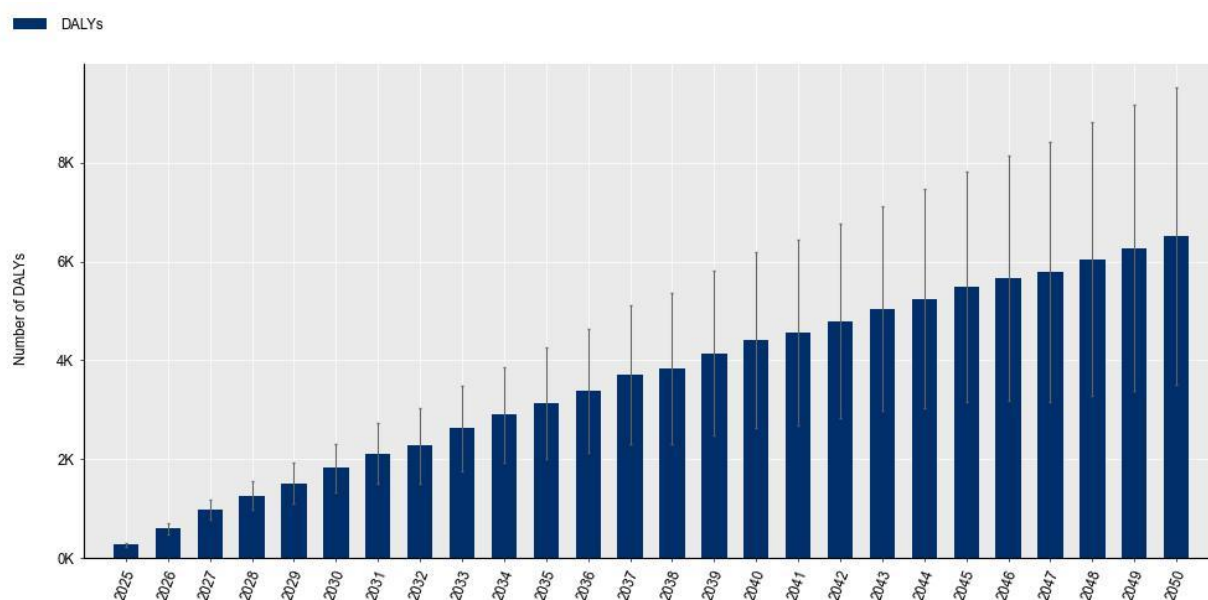
The OECD's **Strategic Public Health Planning for non-communicable diseases** (SPHeP-NCDs) microsimulation model was used to estimate the health and economic impact of expanding iFD Tool across Germany, and across all OECD and non-OECD European countries, assuming that 1.12% of the target population would receive the intervention. Details on the model are in Annex A, while the list of model assumptions are in Annex 4.A at the end of this Chapter.

The rest of this section presents results for Germany, followed by remaining OECD and non-OECD European countries.

Germany

The OECD's SPHeP-NCD micro-simulation model estimates that the implementation of *iFD Tool* would lead to gain more than 6 500 disability-adjusted life years (DALYs) between 2025-2050 in Germany (Figure 4.1). In gross terms, between 2025 and 2050, the number of depression cases are estimated to fall by around 23 000 in Germany.

Figure 4.1. Cumulative number of DALYs gained (2025-2050) – iFD Tool, Germany



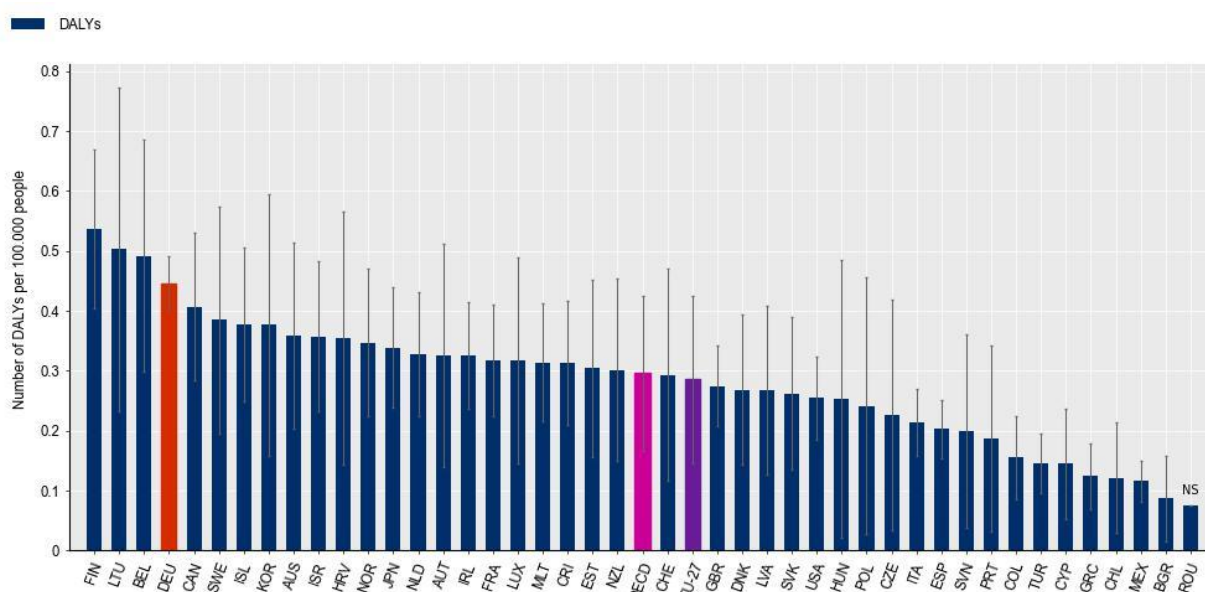
Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

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

OECD and non-OECD European countries

Transferring *iFD Tool* to all OECD and EU27 countries is estimated to result in 0.3 and 0.29 DALYs gained per 100 000 people, respectively on average per year between 2025 and 2050. This ranges from 0.54 in Finland to 0.07 in Romania (Figure 4.2), although the health impact is non-significant in Romania.

Figure 4.2. DALYs gained annually per 100 000 people, 2025-2050 – iFD Tool, all countries



Note: The black lines represent 95% confidence intervals. NS means non significant.

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

While preventing mild-to-moderate symptoms of depression, iFD Tool will effectively contribute to prevent cases of depressive disorders. In gross terms, between 2025 and 2050, the SPHeP-NCD model estimates that iFD Tool will reduce depression cases by around 346 000 in OECD countries and by 107 000 cases in EU27 countries. This represents about 0.04% of all cases of depression across OECD and EU27 countries.

Efficiency

This section presents the potential impact of the intervention on healthcare expenditure and a cost-effectiveness analysis assuming programme costs as reported in Annex 4.A at the end of this Chapter.

It is estimated that transferring iFD Tool to the 43 OECD and EU27 countries would result in no health expenditure savings in 24 countries, but to statistically significant savings in 19 countries. Country-specific characteristics such as the level of access to treatment by country (see Chapter 2 for treatment coverage) may shape the outcome. For instance, Norway and Sweden have higher levels of treatment coverage than other countries, which could result in higher potential economic savings.

Table 4.1 provides information on interventions costs, total health expenditure savings and the cost per DALY gained local currency for OECD and non-OECD European countries. iFD Tool is cost saving in three countries (the Netherlands, Norway and Sweden). In 34 countries, iFD Tool is considered cost effective with the cost per DALY below the average cost-effectiveness threshold applied in European countries (i.e. EUR 50 000 based on (Vallejo-Torres et al., 2016^[7])). In five countries, iFD Tool is considered cost-effective on average, but there is uncertainty since the upper range of the 95% confidence interval is higher than the threshold of EUR 50 000 per DALY. It is estimated that the intervention will be non-effective in Romania.

Table 4.1. Cost effectiveness figures in local currency – iFD Tool, all countries

Country	Local currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Australia	AUD	0.20	ns	29 909
Austria	EUR	0.10	328 573	18 287
Belgium	EUR	0.08	863 729	2 034
Bulgaria	BGN	0.04	ns	39 194**
Canada	CAD	0.17	3 457 399	21 445
Chile	CLF	30.28	ns	24 872 950
Colombia	COP	74.51	332 741 193	44 082 853
Costa Rica	CRC	35.56	ns	10 792 752
Croatia	HRK	0.05	ns	13 037
Cyprus	EUR	0.03	ns	21 533
Czechia	CZK	1.34	ns	507 520
Denmark	DKK	0.79	3 284 254	92 092
Estonia	EUR	0.06	ns	19 735
Finland	EUR	0.12	ns	19 830
France	EUR	0.09	ns	28 305
Germany	EUR	0.10	3 255 934	13 440
Greece	EUR	0.02	ns	19 742
Hungary	HUF	16.34	ns	5 883 525**
Iceland	ISK	20.85	ns	4 437 040
Ireland	EUR	0.08	ns	15 349
Israel	ILS	0.35	1 168 817	69 174
Italy	EUR	0.05	634 923	18 228
Japan	JPY	11.35	ns	2 666 065
Korea	KRW	111.63	ns	27 714 942
Latvia	EUR	0.05	5 598	20 706
Lithuania	EUR	0.06	11 562	11 857
Luxembourg	EUR	0.11	ns	19 029
Malta	EUR	0.06	5 484	16 038
Mexico	MXN	0.48	2 788 456	393 291
Netherlands	EUR	0.11	2 258 299	Cost saving
New Zealand	NZD	0.19	344 750	42 213
Norway	NOK	1.15	8 253 657	Cost saving
Poland	PLN	0.19	ns	73 108**
Portugal	EUR	0.05	ns	21 343
Romania	RON	0.11	ns	Non effective***
Slovak Republic	EUR	0.04	ns	15 264
Slovenia	EUR	0.07	34 978	25 016**
Spain	EUR	0.05	ns	24 645
Sweden	SEK	1.19	14 789 843	Cost saving
Switzerland	CHE	0.14	ns	43 596**
Türkiye	TRY	0.23	ns	156 983
United Kingdom	GBP	0.08	1 628 597	21 038
United States	USD	0.11	35 948 773	3 932

Note: * Cost per DALY gained is measured using total intervention costs less total health expenditure savings divided by total DALYs gained over the period 2025-2050. "ns" means not significant. ** On average, the cost per DALY is below EUR 50 000, but uncertainty remains as the upper range of 95% confidence interval is higher. *** The impact on health is non-significant.

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

The reduction in depression symptoms resulting from iFD Tool has, in turn, impacts on the labour market participation and productivity, such as increases in employment and reductions in absenteeism and presenteeism. It is estimated that transferring iFD Tool to the 43 OECD and EU27 countries would result in no impact on labour market outcomes in 33 countries, but to statistically significant gains in 10 countries. In these 10 countries, gains would range between 0.08 and 0.24 full-time equivalent (FTE) workers per 100 000 persons per year between 2025 and 2050.

Equity

iFD Tool is affordable to all population groups as it is free-of-charge for users. It is available in 16 languages, including Ukrainian and Russian, offering mental health support for displaced populations. The acceptability of computerised CBT tool – such as iFD Tool – are shown to be greater for people living in rural areas than in urban participants (Vallury, Jones and Oosterbroek, 2015^[8]).

However, the accessibility and the effective use of such digital tools may vary across population groups. For instance, access to iFD Tool usually depends on being introduced to the tool by a GP or a psychotherapist. Individuals who are less likely to access health services, such as displaced people, those with lower socio-economic status or those with lower health literacy (OECD, 2019^[9]), may be less likely to benefit from the programme. In addition, there is a higher risk of dropout from web-based interventions – such as iFD Tool – for people with low level of education, who are male and younger (Varga et al., 2024^[10]).

Evidence-base

Results of the effectiveness of iFD Tool are based on an RCT study (Oehler et al., 2020^[5]). Details of the study design is described in the study protocol (Oehler et al., 2019^[11]). This study included 348 participants and followed participants at several points in time (after 3 weeks, 6 weeks, 3 months, 6 months, 12 months). The change in depression severity was assessed with the IDS-SR score, which has substantial face validity (John Rush, Carmody and Reimitz, 2000^[12]). The change in self-perceived health-related quality of life with the SF-12 both mental and physical scores.

The quality of evidence from the RCT study by Oehler et al. (2020^[5]) was assessed using the *Quality Assessment Tool for Quantitative Studies* (Effective Public Health Practice Project, 1998^[13]). The quality of evidence was rated as strong in the domains of “Study design”, “Confounders”, “Withdrawals and dropouts”; moderate in “Data collection methods”; and as weak in “Selection bias” and “Blinding” (Table 4.2) Regarding the unblinding of study assessor, the authors do not consider it as a risk of bias since the results are based on self-ratings only (Oehler et al., 2019^[11]).

Table 4.2. Evidence Base assessment, iFightDepression® Tool

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Not likely
	What percentage of selected individuals agreed to participate?	80-100%
<u>Selection bias score</u>		Weak
Study design	Indicate the study design	Randomised Controlled Trial
	Was the study described as randomised?	Yes
<u>Study design score</u>		Strong
Confounders	Were there important differences between groups prior to the intervention?	No
	What percentage of potential confounders were controlled for?	80-100%
<u>Confounder score</u>		Strong
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes

Assessment category	Question	Rating
	Were the study participants aware of the research question?	Yes
	<u>Blinding score</u>	Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Can't tell
	<u>Data collection methods score</u>	Moderate
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	90-100%
	<u>Withdrawals and dropout score</u>	Strong

Source: Effective Public Health Practice Project (1998^[13]), "Quality Assessment Tool for Quantitative Studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Oehler et al. (2020^[5]), "Efficacy of a guided web-based self-management intervention for depression or dysthymia: Randomized controlled trial with a 12-month follow-up using an active control condition", <https://doi.org/10.2196/15361>.

Extent of coverage

The iFD Tool is designed for individuals aged 15 and older with mild-to-moderate depression, offering a version for adults aged 25 and above and another specifically for young adults aged 15 to 24. The programme was initiated in 2016 and is now in its scale-up phase. Over the last five years, 1 618 participants on average per year were invited to use the iFD programme.

iFD Tool user data from Germany in 2024 show that since 2016, 9 624 people have been identified and offered the use of iFD Tool by a mental health professional. Some 6 106 people have accepted the invitation and completed the registration process, while only 1 319 people have completed at least two of the six core modules -defined as a minimal dose. These data suggest that around 14% (1 319/9 624) of the target group actually participated in the initial phase of the intervention, although a smaller proportion did complete the whole programme, but data are not available.

Policy options to enhance performance

Enhancing effectiveness

The effectiveness of iFD Tool can be improved by optimising the integration of regular check-ins and feedback mechanisms from healthcare professionals. By ensuring that users receive timely, personalised feedback and ongoing encouragement, iFD Tool can leverage these benefits to maintain user motivation. While iFD Tool already incorporates guidance from healthcare professionals, increasing the frequency and structure of these interactions can improve user outcomes. Evidence supports this approach, as regular clinician contact has been shown to improve adherence to treatment and to enhance clinical outcomes in digital mental health interventions. Titov et al (2010^[14]) showed that both clinician-assisted and technician-assisted iCBT led to greater improvements in users' mental health compared to those without support. In addition, Kelders et al. (Kelders et al., 2012^[15]) found that providing human support in eHealth interventions increased user engagement and adherence. Research on the iFD programme has also yielded similar results, with evidence demonstrating that increasing user guidance, for instance through weekly phone calls with therapists, can yield higher clinical outcomes. However, this will be at a cost. A Hungarian pilot study of 143 participants found a larger reduction in depression symptoms in participants who received iFD and those receiving iFD with additional weekly phone calls by therapists (iFD+phone), compared to the treatment-as-usual group (pharmacotherapy, psychotherapy, or both) (Varga et al., 2024^[10]). The study found that iFD is associated with 18 times higher odds in reaching a reliable improvement in depression, and iFD+phone with 126 times higher odds. After six weeks, the average score of depression (measured with PHQ-9; range 0-27) decreased by nearly 4 points in the iFD group (from 14.3 to 10.0), and by more

than 6 points in the iFD+phone group (from 12.9 to 6.7), while it remained statistically unchanged in the control group. This suggests higher effectiveness of the iFD and iFD+phone treatments compared to treatment as usual.

Enhancing efficiency

Using online guide training (e-learning via iFD guide website) for GPs and healthcare professionals can enhance the efficiency of iFD Tool. Compared to in-person training, online guide training may offer more flexibility and greater cost effectiveness. To maintain the quality of training, a blended approach can be used, combining e-learning with face-to-face or virtual interactive sessions. Regular assessment and feedback within the online training platform can further ensure high standards of training.

Enhancing equity

iFD Tool contains elements promoting a favourable equity impact since the tool is free-of-charge for users and its content is adapted to country-specific cultural context (e.g. phrasing of questions, explanations and examples are adapted to country's specificities). Enhancing the equity of iFD Tool involves implementing strategies to ensure that all individuals, regardless of socio-economic status, identity, or background, have equal access to the tool and its benefits. A key aspect of iFD Tool is that it is free-of-charge for users. Research shows that disadvantaged groups, such as those with lower socio-economic status, are less likely to access the healthcare services they need (OECD, 2019^[9]). Providing iFD Tool free-of-charge to these populations can help removing financial barrier and partly improve access to mental health support.

But beyond financial aspects, inequalities in access can persist for people who are vulnerable to mental health problems, such as LGBTQI+ individuals, indigenous populations, ethnic minorities, and refugees (Vargas Lopes and Llena-Nozal, 2025^[16]). These groups often face additional barriers, including discrimination, stigma, and lack of culturally competent care. To address these inequalities, iFD Tool national co-ordinators can implement targeted outreach and communication strategies that are tailored to these communities. By promoting mental health literacy (Box 4.3) and raising awareness of iFD Tool among these groups, the programme can increase its reach and impact. In addition, developing culturally relevant content and ensuring that the tool is available in multiple languages can make iFD Tool more accessible and effective for diverse populations.

Box 4.3. Mental health literacy

Mental health literacy refers to the knowledge of good mental health and mental health problems, and the understanding of how to seek mental health care when needed.

Decision making about seeking mental health care is influenced by individual's access to information and their ability to act on it. However, finding information about how to manage health problems is often challenging. A survey conducted across 16 OECD countries from 2019-2021 found that 29% of respondents reported difficulty or extreme difficulty in finding such information (See Chapter 2). This proportion ranged from 19% in Slovenia to over 50% in Bulgaria and Germany.

Many countries put effort to improve mental health literacy. Out of 43 OECD and EU countries, 38 have policies and programmes to improve mental health awareness and literacy either implemented or underway (WHO, 2024^[17]). For instance, events and activities around World Mental Health Day appear to be a key part of countries' efforts to increase mental health literacy, and to tackle stigma around mental health. An exemplary initiative is the annual Yellow Day -usually in September- in Iceland that aims to raise awareness about mental health and suicide prevention.

Source: OECD (2021^[18]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>.

Enhancing the evidence-base

To enhance the evidence base, it is essential to establish a systematic and continuous evaluation process, such as RCTs, to ensure the effectiveness and efficacy of the programme. This will provide high-quality evidence on the effectiveness of the programme and identify components that are beneficial and those that require improvement. It is vital that the iFD Tool content is updated regularly in line with the latest research findings into depression treatment. It is also beneficial that iFD Tool is kept up to date with emerging mental health trends and new therapeutic techniques, and that the information within iFD Tool is current and evidence based. Engaging in partnership with academic institutions and research organisations can facilitate these updates.

Implementing a monitoring system that collects data on the use of iFD Tool (e.g. referral, utilisation and dropout) would facilitate the understanding of the utilisation patterns. This would in turn enhance the quality and the effectiveness of the programme. For instance, systematically collecting and examining data of the use of iFD Tool in several European countries, and evaluating the iFD Tool impact on different population groups (e.g. by socio-economic group, and focussing on vulnerable populations, such as LGBTQI+ individuals, indigenous populations, ethnic minorities, and refugees) could provide valuable insights into the programme's effectiveness across different socio-demographic groups. This would contribute to building a stronger evidence base.

Enhancing extent of coverage

The enhancement of the extent of coverage of iFD Tool can be done by reducing user dropout rates and broadening the recruitment of mental health professionals. To reduce dropout rates, three key options could be advanced:

- Improving health literacy: increasing users' understanding of mental health and the benefits iFD Tool can lead to better engagement and sustained use.

- Raising internet accessibility and skills: Many potential users may face barriers related to internet access and digital literacy. Addressing these issues by promoting internet access in underserved areas and providing digital literacy training can help more people use iFD Tool effectively. To achieve this, collaborations with community organisations could be efficient.
- Developing an iFD mobile app: creating a mobile application for iFD can enhance its accessibility, particularly among young people who are more likely to use smartphones. A mobile app can offer the same benefits as the web-based version, with added convenience and usability, potentially reducing drop-out rates by making the programme more user-friendly and adaptable to users' lifestyles. In 2024, initiatives were undertaken to improve the iFD Tool's smartphone compatibility by shortening its content and enhancing technical features. Building on these efforts, starting in April 2025, the iFD Tool will introduce a more user-friendly interface and improved smartphone accessibility, further enhancing the overall user experience.

Expanding the recruitment of GPs and therapists can be effective to extend the reach of iFD Tool. This can be achieved through:

- Reinforced active communication: Actively engaging with GPs and therapists through targeted communication strategies can encourage their participation in iFD Tool. Providing clear information about the benefits of iFD Tool and how it can be integrated into their practice can facilitate their involvement.
- Using evidence-based data: Leveraging evidence-based data to demonstrate the effectiveness of iFD Tool can be used to convince GPs and therapists to participate. Sharing research findings, effectiveness, and case studies can help healthcare professionals see the value of iFD Tool and make them confident in recommending it to their patients.

Transferability

This section explores the transferability of iFD Tool and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring iFD Tool.

Previous transfers

iFD Tool was originally developed within the EU-funded project *Preventing Depression and Improving Awareness through Networking in the EU (PREDI-NU)*. As part of the PREDI-NU project, iFD Tool was implemented in five European pilot regions from Hungary, Estonia, Ireland, Spain and Germany. It has then been successfully transferred and implemented in eight European countries, including Bulgaria, Estonia, Greece, Hungary, Ireland, Italy, Poland and Spain, as part of the EU-funded EAAD-Best project which commenced in 2021. This project was managed by a consortium of 10 partners, including the EAAD and ended in 2024.

Furthermore, as part of the EU-funded *Mental Health Support for Ukrainian Refugees (MESUR)* project, which ran from 2022 to November 2024, the iFD Tool was culturally adapted and translated into Ukrainian and Russian to support displaced Ukrainians. Additionally, new workshops were specifically developed to provide mental health support to displaced Ukrainians across six EU countries: Bulgaria, Germany, Greece, Estonia, Hungary and Poland. In 2024, the iFD Tool was available in 16 languages and the website in 21 languages.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of iFD Tool were identified (see Table 3.4). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 4.3. Indicators to assess the transferability of iFightDepression®

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Share of individuals having at least basic digital skills (%) (Eurostat, n.d. ^[19])	The intervention requires taking web-based training and exercises. Therefore, the intervention is more transferable in countries where people have at least basic digital skills.	↑ = more transferable
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey (%) (Eurostat, 2022 ^[20])	The iFD Tool is introduced by GP, psychotherapist, or mental health professional to the patient. Therefore, the intervention is more transferable in countries where people consult mental health professionals.	↑ = more transferable
<i>Sector specific context</i>		
Psychologists per 1 000 population (OECD, 2021 ^[18])	The intervention is a self-help tool guided by psychologists, GPs or other mental health professionals. Therefore, the intervention is more transferable in countries with a higher proportion of psychologists.	↑ = more transferable
Healthcare Access and Quality Index (IHME, 2017 ^[21])	iFD Tool is more transferable in a context where access to mental health care is facilitated and where the unmet need for mental health care is lower.	↑ = more transferable
<i>Political context</i>		
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[22])	The intervention aims to provide a rapid access to psychological therapy in primary healthcare settings. Therefore, the intervention is more transferable in countries that support mental health prevention and treatment in primary healthcare settings.	Implemented or underway = more transferable No = less transferable
Policies and programmes for integrating digital technologies and tools into mental health service delivery (OECD/WHO Regional Office for Europe, 2023 ^[23])	The intervention uses internet-based tools. Therefore, the intervention is more transferable in countries that use digital tools into mental health services delivery.	Implemented or underway = more transferable No = less transferable
Policies and programmes for enabling self-care and self-management for people experiencing mental health conditions (OECD/WHO Regional Office for Europe, 2023 ^[24])	The intervention is a guided, self-help programme for people suffering from mild to moderate depression, entailing exercises to do at home. Therefore, the intervention is more transferable in countries that enable self-management for mental health conditions.	Implemented or underway = more transferable No = less transferable
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[25])	The implementation of iFD Tool is more transferable in countries that have a strategy or action plan in place to guide the implementation of mental health policy	Implemented or underway = more transferable No = less transferable
<i>Economic context</i>		
Primary healthcare expenditure as a percentage of GDP (OECD, 2024 ^[26])	The intervention places a stronger emphasis on primary care, therefore, it is likely to be more successful in countries that allocate a higher proportion of health spending to primary care.	↑ = more transferable
Prevention spending as a percentage of GDP (OECD, 2024 ^[27])	The intervention places a stronger emphasis on prevention, therefore, it is likely to be more successful in countries that allocate a higher proportion of health spending to prevention.	↑ = more transferable

Results

Results from the transferability assessment using publicly available data are summarised below (see Table 4.4 for results at the country level):

- In terms of access to mental health care, 10.9% of the German population reported consulting mental health care or rehabilitative care professionals, compared to around 6% on average across OECD countries. Germany performs well in the Healthcare Access and Quality Index, with a rate higher than the OECD average. More than two-thirds of OECD countries have a score over 80%.
- The analysis shows that the number of psychologists is higher in at least 13 countries, with Germany having 0.5 psychologists for 1 000 inhabitants. In terms of digital literacy, 52% of the German population has at least basic digital skills, compared to 58% in OECD countries on average.
- Spending on prevention across OECD countries is typically lower than in Germany, with more than four in five countries presenting lower rates. Likewise, the country's expenditure on primary healthcare exceeds the OECD average, standing at 1.6% of the total country GDP.
- Like most countries, Germany has policies or programmes for mental health promotion, prevention and treatment in primary healthcare, as well as for integrating digital technologies and tools into mental health service delivery, and policies that enable self-care and self-management for people experiencing mental health conditions. A majority of countries have a strategy or action plan to guide implementation of mental health policies, suggesting higher potential for transfer. Germany does not have such a strategy, indicating this is not a prerequisite for the transfer of iFD Tool.

Table 4.4. Transferability assessment by country (OECD and non-OECD European countries) – *iFightDepression®* Tool

A darker shade indicates *iFightDepression®* is more suitable for transferral in that particular country

	Basic digital skills	Self-reported consultations	Psychologists per 1 000 population	Healthcare Access and Quality Index	Policies for promotion, prevention and treatment in primary care	Policies for integrating digital technologies	Policies for enabling self-care and self-management	Strategy or action plan that guide policy implementation	Primary healthcare spending (% GDP)	Prevention spending (% GDP)
Germany	52.22	10.90	0.50	86.40	Yes	Yes	Yes	No	1.62	0.83
Australia	n/a	n/a	1.03	89.80	Yes	Yes	Yes	Yes	1.55	0.35
Austria	64.68	7.40	1.18	88.20	No	Yes	Yes	Yes	1.25	1.25
Belgium	59.39	9.50	0.10	87.90	Yes	Yes	Yes	Yes	1.41	0.35
Bulgaria	35.52	1.50	n/a	71.40	No	No	Yes	Yes	1.12	n/a
Canada	n/a	n/a	0.49	87.60	n/a	n/a	n/a	No	1.34	0.68
Chile	n/a	n/a	n/a	76.00	Yes	Yes	No	Yes	n/a	0.31
Colombia	n/a	n/a	n/a	67.80	Yes	Yes	Yes	Yes	n/a	0.16
Costa Rica	n/a	n/a	n/a	72.90	Yes	Yes	Yes	Yes	1.12	0.06
Croatia	58.95	5.70	n/a	81.60	No	No	No	Yes	0.96	n/a
Cyprus	49.46	1.00	n/a	85.30	Yes	Yes	Yes	Yes	n/a	n/a
Czechia	69.11	3.90	0.03	84.80	Yes	No	n/a	n/a	1.12	0.77
Denmark	69.62	10.40	1.62	85.70	Yes	No	Yes	Yes	1.64	0.48
Estonia	62.61	8.10	0.06	81.40	Yes	Yes	No	Yes	1.39	0.62
Finland	81.99	9.20	1.09	89.60	Yes	Yes	Yes	Yes	1.56	0.48
France	59.67	7.20	0.49	87.90	Yes	No	Yes	Yes	1.54	0.68
Greece	52.40	4.10	0.09	87.00	No	No	No	Yes	n/a	0.37
Hungary	58.89	4.70	0.02	79.60	No	Yes	No	Yes	0.92	0.56
Iceland	n/a	12.60	1.37	93.60	Yes	Yes	Yes	Yes	1.37	0.28
Ireland	69.40	4.70	n/a	88.40	Yes	Yes	Yes	Yes	n/a	0.36
Israel	n/a	n/a	0.88	85.50	Yes	Yes	Yes	n/a	3.04	0.02
Italy	45.75	3.50	0.04	88.70	Yes	No	Yes	Yes	n/a	0.59
Japan	n/a	n/a	0.03	89.00	Yes	n/a	n/a	Yes	2.10	0.36
Korea	n/a	n/a	0.02	85.80	Yes	Yes	Yes	Yes	2.04	0.77
Latvia	45.34	4.30	0.67	77.70	Yes	Yes	Yes	Yes	2.05	0.46

	Basic digital skills	Self-reported consultations	Psychologists per 1 000 population	Healthcare Access and Quality Index	Policies for promotion, prevention and treatment in primary care	Policies for integrating digital technologies	Policies for enabling self-care and self-management	Strategy or action plan that guide policy implementation	Primary healthcare spending (% GDP)	Prevention spending (% GDP)
Lithuania	52.91	6.00	0.16	76.60	Yes	Yes	Yes	Yes	1.43	0.44
Luxembourg	60.14	9.90	0.59	89.30	No	Yes	No	n/a	0.52	0.26
Malta	63.02	5.30	n/a	85.10	Yes	Yes	Yes	No	n/a	n/a
Mexico	n/a	n/a	n/a	62.60	Yes	n/a	No	Yes	0.98	0.18
Netherlands	82.70	9.80	0.94	89.50	No	No	No	n/a	1.02	0.58
New Zealand	n/a	n/a	0.86	86.20	Yes	Yes	Yes	Yes	n/a	n/a
Norway	81.09	7.00	1.40	90.50	Yes	Yes	Yes	Yes	1.11	0.27
Poland	44.30	4.10	0.16	79.60	Yes	Yes	n/a	Yes	1.11	0.14
Portugal	55.97	7.30	n/a	84.50	Yes	n/a	Yes	Yes	n/a	0.35
Romania	27.73	0.90	n/a	74.40	No	No	No	Yes	0.62	n/a
Slovak Republic	51.31	3.90	n/a	78.60	No	No	No	No	0.84	0.13
Slovenia	46.70	5.80	0.09	87.40	Yes	Yes	No	Yes	1.81	0.50
Spain	66.18	4.80	0.55	89.60	Yes	Yes	Yes	Yes	1.45	0.37
Sweden	66.44	11.20	0.99	90.50	Yes	Yes	Yes	Yes	1.35	0.55
Switzerland	77.52	n/a	0.26	91.80	Yes	Yes	Yes	Yes	0.92	0.33
Türkiye	33.11	6.30	0.03	76.20	Yes	Yes	Yes	Yes	n/a	n/a
United Kingdom	n/a	n/a	0.36	84.60	Yes	Yes	Yes	Yes	1.95	1.55
United States	n/a	n/a	0.30	81.30	Yes	Yes	Yes	Yes	n/a	0.84

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 3.4.

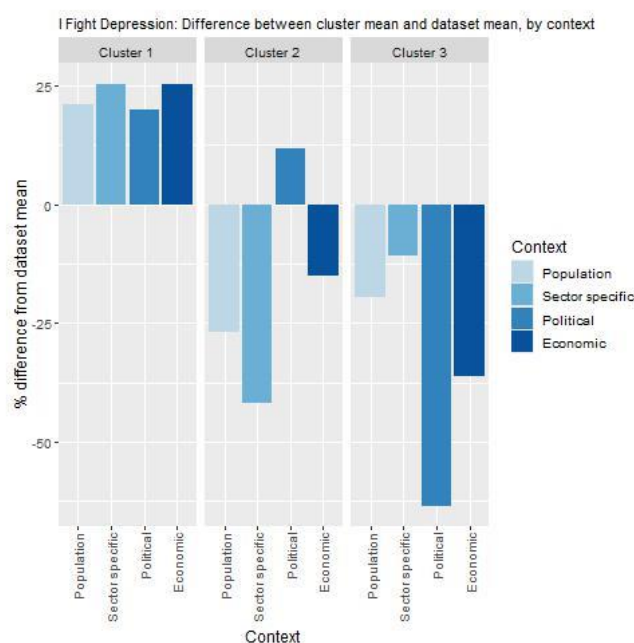
Source: Eurostat (n.d.^[19]), *Share of individuals having at least basic digital skills (%)*, https://ec.europa.eu/eurostat/databrowser/view/sdg_04_70/default/table; Eurostat (2022^[20]), “Self-reported consultation of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level”, https://doi.org/10.2908/HLTH_EHIS_AM6E; OECD (2021^[18]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>; IHME (2017^[21]), *Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990-2015*, <https://ghdx.healthdata.org/record/ihme-data/gbd-2015-healthcare-access-and-quality-index-1990-2015>; OECD/WHO Regional Office for Europe (2023^[22]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care*; OECD/WHO Regional Office for Europe (2023^[23]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes for integrating digital technologies and tools into mental health service delivery*; OECD/WHO Regional Office for Europe (2023^[24]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes for enabling self-care and self-management for people experiencing mental health conditions*; OECD/WHO Regional Office for Europe (2023^[25]), *Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy*, OECD, (2024^[26]), *OECD Data Explorer - Primary health care expenditure as a percentage of GDP*; OECD (2019^[9]), *OECD Data Explorer - Prevention spending as a percentage of GDP*.

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 3.4. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 3.8 and Table 3.6:

- Countries in cluster one, including Germany, have population, sector specific, economic and political arrangements in place to transfer iFD Tool. Overall, these countries are less likely to experience issues associated with implementing and operating the programme in their local context. This group includes 22 countries.
- Countries in cluster two have political arrangements to support iFD Tool. Prior to transferring the intervention, however, these countries may wish to consider ensuring that the sector is ready to implement the programme and ensure long-term affordability by increasing preventive and primary healthcare expenditure. This group includes 11 countries.
- Remaining countries are in cluster three. These should consider whether the intervention aligns with political priorities and might benefit from undertaking further analyses to ensure iFD Tool is affordable and feasible within existing healthcare infrastructures. This group includes nine countries.

Figure 4.3. Transferability assessment using clustering – *iFightDepression®* Tool



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 4.5. Countries by cluster – *iFightDepression® Tool*

Cluster 1	Cluster 2	Cluster 3
Australia	Chile	Bulgaria
Austria	Colombia	Croatia
Belgium	Costa Rica	Czechia
Cyprus	Estonia	Greece
Denmark	Italy	Hungary
Finland	Japan	Luxembourg
France	Lithuania	Netherlands
Germany	Mexico	Romania
Iceland	Poland	Slovak Republic
Ireland	Slovenia	
Israel	Türkiye	
Korea		
Latvia		
Malta		
New Zealand		
Norway		
Portugal		
Spain		
Sweden		
Switzerland		
United Kingdom		
United States		

Note: Due to high levels of missing data, the following country was omitted from the analysis: Canada.

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 3.5 outlines several new indicators policymakers could consider before transferring iFD Tool.

Box 4.4. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the population attitude towards internet-based mental health support?
- What is the level of health literacy in the population?

Sector specific context

- What is professional's attitude (GP, therapists) towards internet-based support?
- What are the main barriers to engage and recruit GP and therapists?

Political context

- Has the intervention received political support from key decision makers?
- Has the intervention received financial commitment from key decision makers?

Conclusion and next steps

iFD Tool is a web-based intervention for people with mild-to-moderate depression based on the principles of CBT. The tool is designed to help people self-manage their symptoms of depression and promote faster recovery, with support from a GP or mental health professional. The tool is free-of-charge for users and has been translated into 16 languages.

iFD Tool has been effective in reducing depressive symptoms at six weeks and three months compared to an active control group, and significantly reduced the duration of depressive episodes. Using the SPHeP-NCD model, it is estimated that transferring iFD Tool to all OECD and EU countries would be cost-effective in most countries and cost saving in three countries.

The iFD Tool was originally developed as part of the PREDI-NU project and has since been successfully implemented in nine European countries through the EU-funded EAAD-Best project which ran from 2021 to 2024. By 2024, it was available in 16 languages and utilised in 12 countries, including Albania, Bulgaria, Estonia, Germany, Greece, Hungary, Ireland, Italy, Norway, Poland, Spain and Türkiye. OECD analysis shows that iFD Tool is highly transferable to more than 50% of OECD and EU countries with available data (22 out of 42 countries), and intermediately transferable to 11 countries.

Box 4.5. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance iFD Tool are listed below:

- Increase the availability of iFD Tool, ensuring its access to underserved populations.
- Raise awareness of iFD Tool among healthcare professionals, potential users, and the general public.
- Provide funding for training programmes to equip GPs, therapists, and other healthcare providers with the skills to guide patients in using iFD Tool effectively.

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Annex 4.A. Model parameters

Effectiveness	Change in depression score at 3 months: -8.4% [-16.4%;-0.4%]
Time to Effectiveness	Maximum effect at 3 months (linear increase); then return to baseline level at 6 months (linear decrease from 3 month to 6 month)
Target population	Individuals aged 15+, with PHQ-9 score from 5 to 14
Exposure	80% of people visit a GP per year; 10% of GP agree to participate; 14% of patients undertakes the programme. Therefore, 1.12% of the target population is covered.
Cost	Composed of administrative cost (EUR 8 per treated patient), training cost (EUR 0.24 per treated), and medical consultation (about 6 minutes of a GP visit).

Effectiveness

The effectiveness of iFD Tool was evaluated using data from a randomised controlled trial (RCT) (Oehler et al., 2020^[5]) and using a Difference-in-Difference (DiD) analysis to estimate the relative impact of iFD compared to an active control group. The IDS-SR was used as the primary outcome measure (range 0-84) to assess changes in depression severity. The RCT showed that IDS-SR mean scores decreased from 27.5 to 19.3 in the iFD group, compared to 27.9 to 22 in the active control group from baseline to three month follow up. Using a DiD estimation, iFD Tool was significantly more effective than the active control in reducing symptoms of depression with a change by -8.4% (CI: [-16.4%; -0.4%]) in depression score at three months.

A DiD analysis was used to measure the change in IDS-SR score over time for the iFD group relative to the active control group while accounting for baseline differences and trends unrelated to the intervention. The study included both the iFD and the active control group with before-and-after research design:

$$(I_{post} - I_{pre}) - (C_{post} - C_{pre})$$

Where I_{post} is the mean score in the iFD group at three months, I_{pre} the mean score in the iFD group at baseline, C_{post} is the mean score in the active control group at three months, and C_{pre} the mean score in the active control group at baseline.

The standard error (SE) of the DiD estimator was calculated following the methods detailed in Xiao et al. (2019^[28]) and using the formula:

$$SE(DiD) = S_p \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}$$

Where S_p is the estimate of the pooled standard deviation (SD) of the iFD and active control groups.

Where n_1 is the sample size of the iFD group and n_2 is the sample size of the active control group.

Time to effectiveness

The time to maximum effectiveness for iFD Tool was assumed to be three months (Oehler et al., 2020^[5]), with the effect increasing linearly from baseline to its maximum level during this period. Following this, the effect was assumed to decrease linearly, returning to baseline levels at six months.

Target population

The target population for iFD include individuals aged 15 years and older with a PHQ-9 score from 5 to 14 (mild to moderate severity of depression).

Exposure

It was assumed that 80% of the target population would visit a general practitioner (GP) at least once per year (OECD, 2019^[9]). Of those, 10% of GPs were assumed to agree to participate in iFD Tool, based on hypothetical assumption. Among patients attending participating GPs, 14% were assumed to undertake the intervention, according to data provided by the iFD owner. This results in an estimated 1.12% of the target population being exposed to the programme ($80\% \times 10\% \times 14\% = 1.12\%$).

Cost

The majority of the cost of iFD Tool are covered by the EU-funded EEAD-Best project. Countries who want to implement iFD Tool are responsible for ongoing costs, including administration, training and medical counselling:

- **Cost of administration:** estimated at EUR 13 640 annually in Germany, corresponding to 0.3 full-time equivalent workers. Based on an average of 1 618 users per year, this results in an administrative cost of EUR 8 per treated patient.
- **Training cost:** Based on the 2022 average national wage in Germany (EUR 45 457 per year or EUR 21.9 per hour), the cost of a 90-minute face-to-face session is estimated at EUR 31.80. With 30 participants per session, the cost per participant is EUR 1.10. Based on data from Germany, it is assumed that 78% of professionals complete the online E-learning training, while 22% attend the face-to-face sessions. This results in an estimated average training cost of EUR 0.24 per participant.
- **Medical counselling:** Estimated at six minutes of a GP's time per patient to introduce the tool.

5

Next Stop: Mum

This chapter covers the case study of Next Stop: Mum, a postpartum depression screening programme in Poland. The case study includes an assessment of Next Stop: Mum against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

Next Stop: Mum: Case study overview

Description: *Next Stop: Mum* is a preventive programme based in northern Poland, that aims to screen for postpartum depression (PPD) in women throughout the last trimester of pregnancy and the first year after childbirth. The programme aims to train healthcare professionals (e.g. midwives and nurses) for PPD screening, inform women on PPD, screen women for the risk of PPD, and refer those with higher risks to psychological consultations as needed (up to three consultations at no cost for the higher-risk patients, covered by the programme). Conducted in 40 primary healthcare centres and in seven state hospitals for a duration of four years (2019-2023), the intervention covered over 21 600 women at mid-point in April 2022. The programme has provided better care to women with PPD through a better diagnosis and support pathway for psychological care, while raising awareness on the condition among healthcare professionals and the general public.

Best practice assessment:

OECD best practice assessment of *Next Stop: Mum*

Criteria	Assessment
Effectiveness	<i>Next Stop: Mum</i> enables better identification and diagnosis of postpartum depression and nearly doubles the number of referrals to psychological support, with more than one in four women with subclinical or probable PPD receiving psychological consultations. The scale-up of <i>Next Stop: Mum</i> in Poland is estimated to gain a cumulative total of about 3 960 disability-adjusted life years (DALYs) by 2050. Transferring <i>Next Stop: Mum</i> to OECD and EU27 countries is estimated to result in 0.83 and 0.74 DALYs gained per 100 000 people, on average per year between 2025 and 2050, respectively.
Efficiency 	It is estimated that scaling up a PPD screening programme such as <i>Next Stop: Mum</i> – assuming the healthcare system covers psychological consultations beyond the first three- would be cost saving in 28% of countries studied and cost-effective in remaining countries.
Equity	The programme aims to provide cost-free screening to all women following childbirth and integrate screening into regular postpartum check-ups within primary healthcare settings.
Evidence-base	An observational study was conducted on 7 345 patients who received the in-person screening programme to assess postpartum depression risk and evaluate the uptake of psychological consultations. Screening results were also assessed for 10 454 online self-screenings for postpartum depression.
Extent of coverage	<i>Next Stop: Mum</i> has reached about 5% of postpartum women in northern Poland with in-person screening. Another 5% have participated through online screening.

Enhancement options: *To enhance the effectiveness*, particular attention should be paid to several implementation factors, such as prioritising anonymous screening, providing effective and time-efficient referral pathways, conducting regular follow-up screening and identifying training gaps. *To enhance the evidence-base*, cut-off points for diagnosis could be adapted to specific populations. *To enhance equity*, policymakers can pay particular attention to underprivileged and underserved groups and facilitate access to mental health care through information campaigns, telemedicine and the promotion of diversity in the healthcare workforce to facilitate trust between patients and their healthcare providers. *To enhance extent of coverage*, interventions should extend screening to mothers who are minors or that are passed the first postpartum year.

Transferability: *Next Stop: Mum* is broadly transferable to other settings within OECD and European countries. It is likely that PPD screening programmes receive political support due to existing mental health prevention policies and programmes in primary care settings.

Conclusion: The *Next Stop: Mum* approach has the potential to significantly reduce the incidence of PPD, as well as alleviate stigma around depression during maternity.

Intervention description

Next Stop: Mum (NSM) is a preventive programme in Poland that aims to promote peripartum and postpartum (PPD) screening in women throughout the last trimester of pregnancy and the first year after childbirth (Box 5.1). This programme fulfils the need for peripartum depression screening, as PPD screening became a national standard in January 2019 and was expanded in 2022 to include screening of peripartum depression for women in their last trimester of pregnancy. The new standard requires medical staff to monitor the mental health of pregnant and postpartum women. NSM aims to train healthcare professionals for PPD screening, inform women on PPD, screen women for the risk of PPD, and as needed, refer women with higher risk of PPD to a psychologist for further diagnosis, recommendations on next steps and eventually treatment (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[11]).

Box 5.1. Postpartum depression, definition and prevalence

Postpartum depression (PPD) is a very common medical condition experienced by women after childbirth, consisting of the onset of depressive episodes characterised by despondency, emotional lability, feelings of guilt, loss of appetite, suicidal ideation, fatigue, irritability, poor concentration and memory, sleep disturbances as well as feelings of difficulty to cope with the child (Robertson et al., 2004^[2]). PPD is often confused with baby blues that however only occurs for a very short period following childbirth, usually resolving after two weeks and for which treatment is not required (Woody et al., 2017^[3]). If left untreated, PPD can last for seven months on average, and up to more than a year (Shorey et al., 2018^[4]). PPD can also lead to additional health consequences for both mother and child (Sockol, Epperson and Barber, 2013^[5]). Women experiencing PPD may, over time, develop social relationship problems, difficulties with breastfeeding, addictive behaviours, and overall poorer mental health (persistent depression, mood disorders, stress, anxiety and suicidal ideation) (Slomian et al., 2019^[6]). These symptoms can reduce women's quality of life, limit responsiveness to caregiving and impair mother-infant bonding. Consequences of PPD for infants and children can be significant. PPD has been associated with increased childhood morbidity and mortality, as well as lasting developmental consequences, particularly concerning cognitive development, social engagement, and emotional and behavioural regulation (Grace, Evindar and Stewart, 2003^[7]; Sockol, Epperson and Barber, 2013^[5]).

In high-income countries, between 10% and 20% of women experience PPD after giving birth, a rate that has been shown to be similar and even increased in low and middle-income countries (Hansotte, Payne and Babich, 2017^[8]; Wang et al., 2021^[9]). These numbers are however very likely to be underestimated, as most countries have not yet implemented systematic screening of PPD and lack of awareness on PPD persists.

Based in the northern region of Poland, the NSM intervention was conducted in 40 primary healthcare centres and in seven state hospitals for a duration of four years (2019-2023) and was part of the National Health Policy Programme of the Ministry of Health, called "*The Program of education and prevention of postpartum depression*". Managed by a consortium between the Copernicus hospital, the University of Gdansk and the Creative Women Foundation (Fundacja Twórczych Kobiet), the programme is a part of the "*Operational Programme: Knowledge Education Development 2014 – 2020*" co-financed by the European Social Fund. Across partner healthcare centres and hospitals, all women within their first year postpartum were offered to participate in the NSM screening programme.

PPD symptoms are assessed with the Edinburgh Postnatal Depression Scale (EPDS) questionnaire (Box 5.2), a tool recommended by the American Medical Association and one of the most used tools in perinatal care (Chrzan Dętkoś and Walczak Kozłowska, 2020^[10]).

Box 5.2. EPDS questionnaire

In the programme, Edinburgh Postnatal Depression Scale (EPDS) was used to screen women during the first year of postpartum. The EPDS tool provides users with a score that indicates the likelihood of experiencing PPD. Comprising 10 questions on well-being, the score ranges from 0 to 30 points, with higher scores indicating more pronounced symptoms of depression and a greater likelihood of PPD. Two cut-off points within this range are used to assess participants: scoring 12 points or more suggests 'probable depression', while scoring between 10 and 11 points suggests 'subclinical, possible depression'. Scores are grouped into three categories:

- "Normal Range" for scoring 0 to 9 points;
- "Slightly Increased" for scoring 10 to 11 points, indicating subclinical PPD; and
- "Increased" for scoring 12 points or above, indicating probable PPD. Questions within the EPDS touch upon feelings of unhappiness, stress, anxiety and sleep disturbances. Examples of questions include the following: "I have looked forward with enjoyment to things", "I have blamed myself unnecessarily when things went wrong", "I have been so unhappy that I have had difficulty sleeping". Responses are structured across four levels of frequency (Cox, Holden and Sagovsky, 1987^[11]).

This tool has been validated as appropriate for identifying probable PPD in pregnant and postpartum women, including postpartum adolescent mothers, and particularly accurate for anhedonia, anxiety, and depression (McBride et al., 2014^[12]). However, further clinical assessment during screening is necessary to confirm results.

Healthcare professionals, such as midwives and nurses, are responsible for conducting *Next Stop: Mum* screening assessments during face-to-face medical visits, primarily at the patients' homes (e.g. postpartum visits, immunisation or medical appointments). In addition, the screening assessments are available via an internet-based platform, offering women the option to self-screen at no cost. Healthcare professionals appointed to the screening procedures obtain a 6-hour training on perinatal mental health and screening methods, conducted by psychologists. These are preceded and followed by a knowledge test, to assess learning achievements and the effectiveness of the training.

Women with higher risk of PPD (scoring 10 or more points on the EPDS) are referred for up to three psychological consultations (45 minutes each) embedded in as part of the programme, at no cost. These consultations have a diagnostic function, not a curative one, and seek to further diagnose PPD. Based on needs, women are then referred to psychological therapy and pharmacotherapy if needed, a feature not included in the programme but that is covered by national health insurance in Poland (Narodowy Fundusz Zdrowia, 2021^[13]). Among the women identified through screening as being at risk of probable or subclinical PPD, 26% attended at least one psychological consultation included in the programme.

OECD Best Practices Framework assessment

This section analyses NSM against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 3.3 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 5.3. Assessment of Next Stop: Mum

Effectiveness

- *Next Stop: Mum* enables better identification and diagnosis of postpartum depression, and nearly doubles the number of referrals to psychological support, with more than one in four (26%) women with subclinical or probable PPD receiving psychological consultations.
- Based on 7 345 in-person screenings, 7% of women were identified as having probable depression and 5% subclinical depression.
- The scale-up of *Next Stop: Mum* in Poland is estimated to gain a cumulative total of about 3 960 disability-adjusted life years (DALYs) by 2050. Transferring *Next Stop: Mum* to OECD and EU27 countries is estimated to result in 0.83 and 0.74 DALYs gained per 100 000 people, on average per year between 2025 and 2050, respectively.

Efficiency

- It is estimated that scaling up a PPD screening programme such as NSM – assuming the healthcare system covers psychological consultations beyond the first three- would be cost saving in 28% of countries studied and cost-effective in the remaining countries.

Equity

- NSM aims to reach all women within their last trimester of pregnancy and first year after birth, as the intervention is implemented within primary healthcare settings, incorporating PPD screening within routine postpartum check-ups.
- The programme effectively reaches rural women, with 23.7% of participants from rural areas, but only 2.3% of participants have primary education, highlighting limited reach among women with low education levels.

Evidence-base

- An observational study was conducted on 7 345 patients who received the in-person screening programme to assess postpartum depression risk and evaluate the uptake of psychological consultations. Screening results were also assessed for 10 454 online self-screenings for postpartum depression. The study measures improvements in healthcare staff's knowledge on postpartum depression screening following training.
- The study had a “strong” data collection method and performed moderately in the domains of “Selection Bias” and “Study Design”.

Extent of coverage

- NSM has reached around 5% of postpartum women in the three northern regions of Poland with in-person screening. Another 5% has participated through online screening

Effectiveness

This section describes the impact NSM has had on the diagnosis of PPD in women following the first year after childbirth.

Improving the identification and diagnosis of women with PPD

NSM enables better identification and diagnosis of women experiencing PPD. An observational study was conducted on 7 345 postpartum women in their first year following childbirth, to assess their risk of PPD, track changes in risk of PPD over time, and measure the uptake of psychological consultations following referral. Data was gathered via EPDS questionnaires assessing PPD symptoms, which were completed by midwives and nurses during in-person postpartum medical visits as part of the first screening. A follow-up screening was carried out by telephone in the same group, three to nine months after the first screening, to re-assess PPD symptoms (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[1]).

Results from the first screening show that, based on EPDS scores, 7.3% of women were identified as having probable PPD and 5% with subclinical PPD. In total, 12% of women included in the study had probable PPD or subclinical PPD, a result that is confirmed by recent estimations of PPD prevalence varying around 10 and 20% within high income countries (Wang et al., 2021^[9]). A majority of women (88%) did not present elevated PPD symptoms. However, this trend changes among respondents who completed the survey online, where higher rates of probable or subclinical PPD were observed (Box 5.4).

Reassessments of PPD risk conducted through the follow-up screening indicate that PPD risk can fluctuate over time and can develop if left untreated. Among the 1 297 women who completed the follow-up screening three to nine months after initial screening, over 55% showed an increase in their EPDS scores and 16.5% identified as having probable PPD – up from 7.3% during the first screening (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[1]).

Box 5.4. Online screening outcomes for PPD

Data was also collected from 10 454 postpartum women who anonymously self-screened online on the programme's website, using an EPDS questionnaire.

Results from the online self-screening vary greatly from those obtained through in-person assessments. EPDS scores of the participants of the online screening programme show that 77% of women were identified as having probable PPD and 8.3% as having subclinical PPD. These results are derived from self-screenings conducted independently by women from and outside of the programme, without the involvement of a midwife or a nurse. The absence of a healthcare professional might potentially prompt more genuine responses, as women might feel pressured and uncomfortable during the discussion. Conversely, the PPD prevalence obtained from online self-screenings may be overestimated due to the motivations driving individuals to undertake these screenings and their awareness of PPD.

Online screening has attracted much more interest than expected, with participation at mid-point being at almost twice the amount fixed at the start of the study (6 000 expected and 10 454 obtained at mid-point). The COVID-19 crisis and related movement restrictions may have contributed to an increased use of the online tool (rather than the in-person screening) since the intervention lasted from 2019 to 2023.

Source: Chrzan-Dętkoś et al. (2022^[1]), "Next Stop: Mum': Evaluation of a Postpartum Depression Prevention Strategy in Poland", <https://doi.org/10.3390/ijerph191811731>.

Reducing the risk of depression

Literature shows that PPD screening can increase awareness of mental health disorder and make women more likely to seek psychological support and receive it, and thereby, reduce symptoms and prevalence of depression. A systematic review based on six studies carried out on pregnant and postpartum women

(up to eight weeks following birth) found that among women who underwent screening, the risk of depression is lowered by 18% to 59% (relative risks (RR) varying between 0.41 and 0.82) at follow-up (between 1.5 and 16 months across studies), compared to women who were not screened or did not have screening test results sent to their clinician. Likewise, the likelihood of achieving significant improvement or remission from depression is significantly increased for women who were screened, by between 21% and 182% compared to their non-screened counterparts (RR between 1.21 and 2.82) (O'Connor et al., 2016^[14]).

In addition, there is evidence to suggest that early detection of PPD can be effective in the long term. Screening and preventing PPD cases can reduce the likelihood of future depressive episodes, as individuals who develop PPD are at higher risk of developing depressive symptoms again in the following five years (Castle, 2008^[15]).

Impact of screening on referrals and consultation outcomes

Screening programmes for PPD have nearly doubled the number of referrals for psychological support, with more than one in four women with subclinical or probable PPD receiving psychological consultations. Of the women who had an increased EPDS score at direct assessments in NSM, 26% (about 300 women) have benefitted from the embedded psychological consultations – a rate nearly twice as high as the one expected at the start of the intervention. The referral rate may have been slightly underestimated, as the follow-up screenings revealed that 19.6% of the contacted women had not been informed of their EPDS results or of the possibility of seeing a psychologist. Previous studies support that PPD screening increases the likelihood of receiving referrals for psychological support by 16 times, compared to women who do not undergo any mental health assessment (Reilly et al., 2013^[16]). Moreover, screening for depression led to decreases in depressive symptoms and improved mental health within the studied populations (Myers et al., 2013^[17]).

Greater awareness of PPD in healthcare personnel

Training healthcare professionals on the assessment, treatment and management of antenatal and postnatal depression can improve their knowledge on these medical conditions. Healthcare providers participating in this intervention received a 6-hour training conducted by psychologists on mental health in the perinatal period and screening methods. Among the 323 healthcare providers taking part in the training, a majority (88.2%) took the pre- and post-training tests. Of those having received the knowledge tests, nearly 80% raised their knowledge on this medical condition following the training sessions. Others presented either lower scores in their post-training test – around 10%- or unchanged results – around 12%.

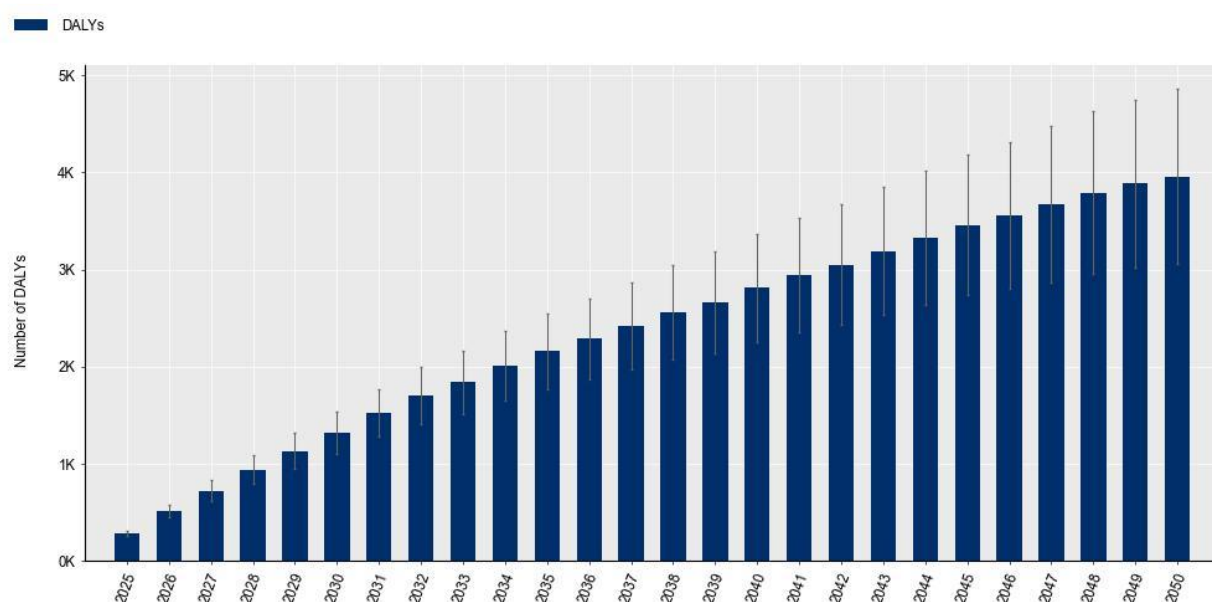
The OECD's **Strategic Public Health Planning for non-communicable diseases** (SPHeP-NCDs) microsimulation model was used to estimate the health and economic impact of expanding *Next Stop: Mum* across Poland and across all OECD and non-OECD European countries, assuming that 10% of the target population across the whole country would enter in a PPD screening programme and, when needed, receive three psychological consultations. Details on the model are in Annex A, while the list of model assumptions are in Annex 5.A at the end of this Chapter.

The rest of this section presents results for Poland, followed by remaining OECD and non-OECD European countries.

Poland

By enhancing diagnosis and referrals for psychological support, the implementation of NSM in Poland is estimated to gain a cumulative total of about 3 960 disability-adjusted life years (DALYs) by 2050 (Figure 5.1).

Figure 5.1. Cumulative number of DALYs gained (2025-2050) – NSM, Poland



Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

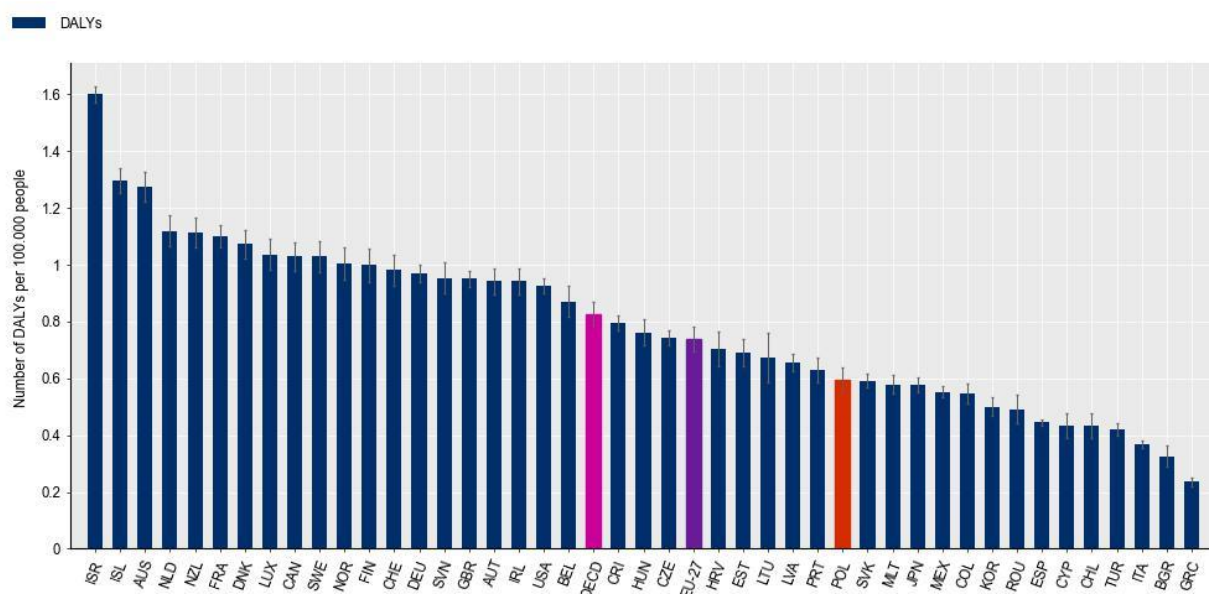
Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

In gross terms, NSM is expected to have the greatest impact on depression and anxiety. As depression and anxiety are related, a PPD screening programme, such as NSM, can help reduce anxiety. Between 2025 and 2050, the number of depression and anxiety cases is estimated to fall by about 3 430 and 2 260 cases, respectively. No significant changes in the number of self-harm cases are observed within the same period.

OECD and EU countries

Transferring NSM to OECD and EU27 countries is estimated to result in 0.83 and 0.74 DALYs gained per 100 000 people, on average per year between 2025 and 2050 (ranging from 0.24 in Greece to 1.6 in Israel) (Figure 5.2).

Figure 5.2. DALYs gained annually per 100 000 people, 2025-2050 – NSM, OECD and EU27 countries



Note: The black lines represent 95% confidence intervals.

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

In gross terms, NSM would have the greatest impact on depression and anxiety, with the intervention estimated to reduce the number of cases by about 389 660 and 131 980 cases in OECD countries, and by 120 330 and 40 750 cases in EU27 countries between 2025 and 2050, respectively. This represents about 0.03% and 0.01% of all cases of depression and anxiety, respectively, in the entire population across OECD and EU27 countries.

Efficiency

This section presents a cost-effectiveness analysis of scaling up NSM and potential impacts on labour market outcomes assuming programme costs as reported in Annex 5.A at the end of this Chapter. The analysis assumes that 10% of target women would enter in the screening programme across the whole country and, when needed, receive up to three psychological consultations. Further psychological support and care, outside of the programme, are assumed to be covered by the healthcare system.

Table 5.1 provides information on intervention costs, total health expenditure savings and the cost per DALY gained in local currency for OECD and EU27 countries. Results show NSM is cost saving in 12 countries (28% of countries studied). For the remaining countries, NSM is cost-effective – given the cost per DALY is below the average cost-effectiveness threshold applied in European countries (i.e. EUR 50 000 based on (Vallejo-Torres et al., 2016^[18])).

Table 5.1. Cost effectiveness figures in local currency – NSM, OECD and EU27 countries

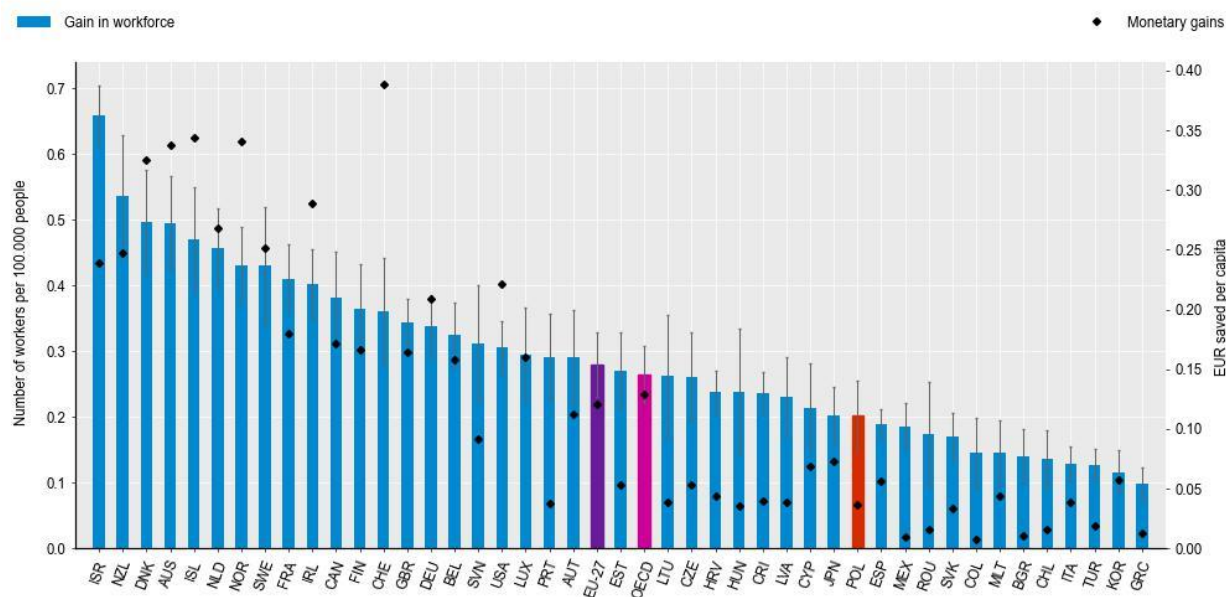
Country	Local Currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Australia	AUD	0.16	7 497 424	Cost-saving
Austria	EUR	0.08	810 911	Cost-saving
Belgium	EUR	0.08	1 032 412	Cost-saving
Bulgaria	BGN	0.08	11 372	26 752
Canada	CAD	0.14	8 037 140	Cost-saving
Chile	CLF	51.7	65 602 456	11 165 973
Colombia	COP	163.22	467 232 179	28 305 260
Costa Rica	CRC	40.02	20 214 980	4 550 538
Croatia	HRK	0.06	182 088	Cost-saving
Cyprus	EUR	0.06	9 644	14 330
Czechia	CZK	1.5	3 364 431	157 473
Denmark	DKK	0.74	6 483 507	Cost-saving
Estonia	EUR	0.06	5 221	9 203
Finland	EUR	0.1	444 455	1309
France	EUR	0.08	3 425 627	2786
Germany	EUR	0.08	7 976 071	Cost-saving
Greece	EUR	0.06	32 068	24 797
Hungary	HUF	19.04	16 338 756	2 267 399
Iceland	ISK	16.8	5 970 867	205 402
Ireland	EUR	0.08	593 662	Cost-saving
Israel	ILS	0.44	3 108 785	10 193
Italy	EUR	0.08	894 672	15 329
Japan	JPY	11.5	564 507 982	1 119 588
Korea	KRW	98.4	482 502 921	17 685 924
Latvia	EUR	0.06	5 380	8 724
Lithuania	EUR	0.06	17 307	7 422
Luxembourg	EUR	0.1	124 020	Cost-saving
Malta	EUR	0.06	7 936	9 142
Mexico	MXN	1.18	4 705 647	207 105
Netherlands	EUR	0.08	1 469 837	879
New Zealand	NZD	0.18	915 034	1048
Norway	NOK	1.02	10 556 133	Cost-saving
Poland	PLN	0.22	546 592	33 902
Portugal	EUR	0.06	169 926	7 449
Romania	RON	0.2	213 960	39 834
Slovak Republic	EUR	0.06	39 478	8 835
Slovenia	EUR	0.06	50 471	4 142
Spain	EUR	0.08	761 146	12 164
Sweden	SEK	1.02	19 264 071	Cost-saving
Switzerland	CHE	0.12	275 310	9 114
Türkiye	TRY	0.56	1 071 468	130 333
United Kingdom	GBP	0.08	5 335 729	587
United States	USD	0.12	144 724 824	Cost-saving

Note: * Cost per DALY gained is measured using total intervention costs less total health expenditure savings divided by total DALYs gained over the period 2025-2050.

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

The reduction in cases of depression resulting from NSM has, in turn, an impact on labour market participation and productivity. It is estimated that NSM will contribute to a reduction in the incidence of depression among new mothers, thereby encouraging increased employment and reduced absenteeism and presenteeism among women as they resume their positions in the workforce. Converting these labour market outputs into full-time equivalent (FTE) workers, it is estimated that OECD and EU27 countries will gain 0.26 and 0.28 FTE per 100 000 working age people per year between 2025 and 2050, respectively (Figure 5.3). In monetary terms, this translates into average per capita increase in labour market production of EUR 0.13 for OECD countries and EUR 0.12 for EU27 countries (Figure 5.3).

Figure 5.3. Labour market impacts, average per year, 2025-2050 – NSM, OECD and EU27 countries



Note: The black lines represent 95% confidence intervals.

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

Equity

At a high level, NSM aims to raise awareness and promote PPD screening for all women, regardless of income or place of residence. Notably, the rural population is well represented, with 23.7% of total study participants living in rural areas. Yet, there are sociodemographic differences in the uptake of the screening programme.

More vulnerable sociodemographic groups are found to be at higher risk of developing PPD and less likely to seek psychological support. PPD is more prevalent in minority and disadvantaged groups. Women with lower sociodemographic background, women of young age and ethnic minorities are disproportionately more affected by the challenges of the perinatal period (Pilav et al., 2022^[19]). These challenges are exacerbated by a more limited access to healthcare and poorer treatment of mental illness after child delivery, which in turn can lead to an under-representativeness of these population groups in the literature and in the intervention's participation, and a possible underestimation of PPD prevalence (Kozhimannil, 2011^[20]). Evidence from the Next Stop Mum intervention consistently points to these inequalities. Women with a higher gestational age at birth, higher income and education levels were more likely to attend the psychologist consultation embedded in the programme (Chrzan-Dętkoś, Murawska and Łockiewicz, 2025^[21]). The positive association with education can however be partially attributable to the fact that less educated women were less likely to participate in the screening programme. Merely 2.3% of

participating women had primary education level, compared to 11.7% in the general population in Poland (Główny Urząd Statystyczny, 2022^[22]).

The intervention can help reducing barriers to access to mental health support. Barriers that prevent women from attending mental health care include, for instance, issues with logistics, transportation, childcare, time, health insurance and financial hurdles. The study revealed that women who did not attend the consultations embedded in the programme were more likely to have experienced an at-risk pregnancy and were less likely to have a higher education level, compared to those who attended the consultation. NSM offers the option of attending consultations remotely, which may contribute to reducing barriers to access to mental health support and thereby narrowing inequalities in access.

Evidence-based

The evidence on NSM is mainly collected from a study carried out in the northern regions of Poland (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[11]). This study includes a total of 21 692 participants, for which the risk of depression was assessed using the EPDS tool. This tool has been validated as a reliable and accurate screening method for perinatal and postpartum depression (McBride et al., 2014^[12]) (Levis et al., 2020^[23]).

The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domain of “Data collection methods”, moderate in the domains of “Selection Bias” and “Study Design” and weak in “Blinding” (see Table 3.4) (Effective Public Health Practice Project, 1998^[24]).

Table 5.2 Evidence-based assessment, Next Stop: Mum

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Very likely
	What percentage of selected individuals agreed to participate?	Can't tell
<u>Selection bias score</u>		Moderate
Study design	Indicate the study design	Observational study
	Was the study described as randomised?	No The follow-up screening however was described as randomised
<u>Study design score</u>		Moderate
Confounders	Were there important differences between groups prior to the intervention?	Not applicable
	What percentage of potential confounders were controlled for?	No applicable
<u>Confounder score</u>		Not applicable
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Yes
<u>Blinding score</u>		Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
<u>Data collection methods score</u>		Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Not applicable
	Indicate the percentage of participants who completed the study?	Not applicable
<u>Withdrawals and dropout score</u>		Not applicable

Source: Effective Public Health Practice Project (1998), “Quality assessment tool for quantitative studies”, <https://www.nccmt.ca/knowledge-repositories/search/14>; Chrzan-Dętkoś et al. (2022), “Next Stop: Mum’: Evaluation of a Postpartum Depression Prevention Strategy in Poland”, <https://doi.org/10.3390/ijerph191811731>.

Extent of coverage

The NSM intervention spans four years (2019-2023) and currently covers three years of data collection (2019-2022) from direct assessments conducted by nurses and midwives from 40 primary healthcare centres and seven state hospitals, as well as online assessments. At the project's mid-point analysis in 2022, a total of 21 692 women were covered by the programme (i.e. being screened for PPD either in-person or online), with the inclusion criteria of being within their last trimester of pregnancy or the first year postpartum. Out of this total number, 11 238 (52%) of women were screened in-person (direct screening), of whom 7 345 were included in the study for analysis.

Based on yearly national statistics, the three northern regions where the study took place (Pomorskie, Kujawsko-Pomorskie, Warmińsko-Mazurskie) have an estimated 223 544 women within their first year postpartum between 2019 and 2022 (Główny Urząd Statystyczny (Statistics Poland), n.d.^[25]). The programme therefore has reached about 5% of postpartum women in northern Poland with in-person screening, and another 5% have participated through online screening.

Policy options to enhance performance

This section outlines policy options to enhance the performance of the Next Stop: Mum approach against the five best practice criteria.

Enhancing effectiveness

Anonymous screening

Strengthening the anonymity feature of the programme could enhance its effectiveness. Online self-assessments are effective in providing patients with anonymity and intimacy when completing the EPDS or any other screening tool for depression. Evidence shows that online screenings result in greater self-disclosure due to the privacy they offer, in the absence of social pressure, feelings of discomfort, stigma and taboo (Rains, 2014^[26]) (Moore, Drey and Ayers, 2020^[27]). In contrast, in-person screenings present limitations, such as an under-detection of cases of depression which can lead to delayed care and worsening of symptoms (Lim et al., 2018^[28]). To enhance the effectiveness of in-person screenings, the NSM programme could aim to reassure women about the anonymity of their results and the confidentiality of their consultations. It could also seek to integrate the online screening tool seamlessly into in-person visits.

Increasing referral uptake

Increasing the uptake of referral consultation is essential to improve the effectiveness of the programme. Referral uptake within the NSM programme remained low, as nearly 8% of the referred patients enrolled in at least one psychological consultation embedded in the programme, and over 80% of them took part in all three consultations. There are possible options to improve referral uptake. First, **enhancing communication** with patients on the obtained results could help to improve referral uptake by patients who are at risk of PPD. Second, the possibility to refer patients should be given to various healthcare providers (such as general practitioners, family physicians and gynaecologists), so as to enable different referral pathways. Third, **improving referral pathways** that would **minimise waiting time** and **improve access** to psychological consultations would also improve referral uptake. This can be done by: 1) establishing standard guidelines on screening and referral to avoid the use of non-standardised methods, 2) creating perinatal mental health services, 3) organising medical networks within local areas that associate hospitals and healthcare centres to psychological and psychiatric units and professionals,

4) creating free-of-charge maternal mental health hotlines for confidential support, as was developed in the United States (U.S. Health and Human Services Department, 2022^[29]).

Regular follow-up screening

To further enhance the effectiveness, it is advisable to make regular follow-up screenings at various points in the postpartum period, as PPD can develop or worsen if left untreated. Relapse remains a concern within and beyond the first year postpartum, as illustrated by the increase in EPDS scores observed in the study's follow-up PPD assessments (Chrzan Dętkoś and Walczak Kozłowska, 2020^[10]). These results are consistent with previous findings that show increasing PPD rates during the second and third trimesters after birth (Bennett et al., 2004^[30]). These findings underscore the importance of screening for PPD at various points in the postpartum period.

Improving professional training

Improving professional training is essential to improve screening, thereby enhancing the effectiveness of the programme. As outlined in the current national standard of screening perinatal mental health disorders in Poland (Chrzan Dętkoś and Walczak Kozłowska, 2020^[10]), a previous study found that only 20% of midwives felt educationally prepared to screen and manage women with perinatal depression. This suggests that there is scope for improvement and standardisation of health professional training, guidelines for screening, referral, and treatment for PPD. Key steps forward would be to generalise the training of healthcare professionals on PPD diagnostic tools, such as EPDS, and to seek to improve the quality of training. Training of healthcare providers on the use of the EPDS screening tool is highly recommended, to limit the use of non-standardised methods and the misuse of the tool (De Figueiredo et al., 2015^[31]). Evaluating professional training and learning, through systematic assessments and professional follow-ups, could help to optimise the quality of training, and create training content that meets the needs. Lastly, regular updates for educational purposes, through newsletters or other communication pathways, could help medical professionals stay up to date with information on PPD.

Enhancing efficiency

Policies that boost effectiveness will have a positive impact on efficiency (see Enhancing effectiveness).

Enhancing equity

NSM targets the whole community. However, vulnerable groups may experience greater barriers to accessing perinatal healthcare and psychological support, such as systemic healthcare barriers and personal barriers. To optimise access to qualitative perinatal healthcare and psychological support, the programme could consider the following enhancement options:

- **A particular attention could be directed towards underprivileged communities**, including migrants, refugees and groups with lower socio-economic status. These communities are more at risk of developing depressive symptoms and encounter further barriers to access perinatal psychological support. Strategies of stigma reduction, cultural and financial adaptation, and enabling flexible scheduling options can help to facilitate access to the programme (Iturralde et al., 2021^[32]).
- The diversification of healthcare providers that work with pregnant and postpartum women would increase **racial and ethnic representativeness** and foster greater trust between patients and caregivers.

- Increasing the provision of **teleconsultations** could alleviate issues related to time and geographic access (especially for those living in underserved areas), thereby improving access to perinatal psychological support.
- **Communication and information campaigns** on PPD could help destigmatise mental health disorders and better equip pregnant women with the necessary information to identify symptoms and seek help. Targeted communication directed towards vulnerable groups is key to increase the **level of health literacy** on maternal mental health, which in turn can enhance adherence to care pathways in these groups, thereby reducing health inequalities.

Enhancing the evidence-base

Strengthening the quality of evidence using a robust study design. The current evidence on PPD reduction following screening and psychological care is derived from a systematic review (O'Connor et al., 2016^[14]), whereas the NSM study relies solely on observational data on the prevalence of PPD and the uptake of psychological sessions, in absence of a control group. To strengthen the evidence base, it is important to evaluate the programme through a randomised study using a control group. A stronger methodology would enhance the evaluation of how PPD screening for postpartum women impacts the uptake of psychological consultations and the subsequent reduction in PPD risk. In the case of NSM, a randomised controlled trial may pose ethical concerns regarding the denial to access to PPD screening for a population with high risks of depression. Alternatives may be worth considering, such as using statistical methods and econometric tools to allow for causal inference in observational settings (e.g. matching). Quasi-experimental studies, such as pre-post cohort analytic could be considered. These studies would compare psychological consultation uptake in previous settings where PPD screening was not mandatory to those where it has been implemented.

Enhancing extent of coverage

Broadening the post- and prenatal screening period can help to enhance the extend of coverage. NSM covers postpartum women within their last trimester of pregnancy and first year following birth, within three regions in Poland. However, the period for developing depressive symptoms is broader, starting from pregnancy and potentially persisting a few years after childbirth (National Institute of Mental Health, 2023^[33]). Around a quarter of women are estimated to have elevated symptoms of depression up to three years after childbirth (Putnick et al., 2020^[34]). Data collected about the use of the online questionnaire indicates a need that extends beyond this timeframe. Although the NSM programme was destined for women within their first postpartum year, anyone was able to access the online questionnaire. Data shows that both women beyond the initial year after childbirth and men undertook the self-screening diagnosis on the website (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[11]). It is therefore highly recommended that women in their pregnancy and women having exceeded the first year postpartum may be included in screening schemes and referral pathways for further psychological support. Moreover, screening should be authorised for mothers aged under 18, for whom PPD has been found to be more prevalent (Sangsawang, Wacharasin and Sangsawang, 2019^[35]).

Transferability

This section explores the transferability of NSM and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring NSM.

Previous transfers

The NSM programme, as described above, is based exclusively in Poland. However, screening for PPD has also been implemented in many other European and OECD countries, at both national and local levels. Routine screening for depression and mental health disorders in pregnant and postpartum women has been included in national guidelines for perinatal healthcare in other OECD countries, such as Australia, New Zealand, Ireland, and Italy. However, there are still gaps in implementation that need to be addressed to achieve optimal coverage at national levels.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of NSM were identified (see Table 3.4). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 5.2. Indicators to assess the transferability of Next Stop: Mum

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Share of individuals having at least basic digital skills (%) (Eurostat, 2023 ^[36])	The intervention offers a web-based option to conduct a self-assessment on postpartum depression. Therefore, the intervention is more transferable in countries where people have at least basic digital skills.	↑ value= more transferable
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey (%) (Eurostat, 2022 ^[37])	NSM is more transferable to a context where mental health services are more accessible. Therefore, the intervention is more transferable in countries where people consult mental health professionals.	↑ value= more transferable
Share of individuals using the internet for seeking health information in the last 3 months (Eurostat, 2023 ^[38])	NSM is more transferable to a population comfortable seeking health information online.	↑ value= more transferable
<i>Sector specific context</i>		
Practicing midwives per 1 000 population (OECD, 2022 ^[39])	NSM is more transferable to countries with a high number of practicing midwives, allowing for easier access to perinatal healthcare.	↑ value= more transferable
<i>Political context</i>		
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[40])	The intervention seeks to implement postpartum depression screening and deliver medical assistance within primary healthcare settings. Therefore, the intervention is more transferable in countries that support mental health prevention and treatment in primary healthcare settings.	"Yes"= more transferable
Policies and programmes to improve mental health awareness and literacy (OECD/WHO Regional Office for Europe, 2023 ^[41])	The intervention aims to improve awareness around postpartum depression among women having recently given birth. Therefore, the intervention is more transferable in countries that support mental health awareness and literacy.	"Yes"= more transferable
Policies and programmes for integrating digital technologies and tools into mental health service delivery (OECD/WHO Regional Office for Europe, 2023 ^[42])	The intervention offers screening tools and support online. Therefore, the intervention is more transferable in countries that use digital tools into mental health services delivery.	"Yes"= more transferable
Strategy or action plan that guide implementation of the mental health policy	NSM is more transferable in countries that have strategies or action plans to guide the implementation of mental health policies and programmes.	"Yes"= more transferable

Indicator	Reasoning	Interpretation
(OECD/WHO Regional Office for Europe, 2023 ^[43])		
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[44])	NSM is a preventive programme, therefore it is more transferable to countries that allocate a higher proportion of health spending to prevention.	↑ value= more transferable
Primary healthcare expenditure as a percentage of GDP (OECD, 2024 ^[45])	NSM is a primary care intervention and countries with a larger expenditure on prevention is more likely to cover the cost of the programme.	↑ value= more transferable

Results

Results from the transferability assessment using publicly available data are summarised below (see Table 5.3 for results at the country level):

- The analysis shows that the number of midwives is amongst the highest in Poland, with 0.75 practicing midwives per 1 000 population.
- In terms of access to mental healthcare, 4% of the Polish population reported consulting mental healthcare or rehabilitative care professionals, compared to around 6% on average across OECD countries.
- The prevalence of digital tool usage and digital proficiency varies across OECD countries, with generally 40% to 80% of individuals having basic digital skills and utilising the internet for health-related information – with an average around 60%. In Poland specifically, approximately 44% of the population has basic digital skills, while over 50% use the internet for health-related inquiries.
- A vast majority of countries have national strategies to guide implementation of mental health policies (81%) and policies that improve mental health awareness and literacy, indicating that NSM would likely receive political support among potential transfer countries. Most countries also have mental health prevention policies within primary healthcare settings and policies that integrate digital technologies into mental health delivery.
- Spending on prevention across OECD countries is typically higher than in Poland (i.e. only 3 of the 39 countries analysed reported spending less on prevention than Poland). Poland's primary healthcare spending ranks near that of the OECD average, with 1.1% of GDP versus nearly 1.4% in OECD countries on average.

Table 5.3. Transferability assessment by country (OECD and non-OECD European countries) – Next Stop: Mum

A darker shade indicates *Next Stop: Mum* is more suitable for transferral in that particular country

	Basic digital skills	Self-reported consultations	Internet use for health information	Practicing midwives per 1 000 population	Prevention spending (% GDP)	Primary healthcare spending (% GDP)	Policies for promotion, prevention and treatment in primary care	Policies for integrating digital technologies	Policies for improving awareness and literacy	Strategy or action plan that guide policy implementation
Poland	44.30	4.10	52.96	0.75	0.135	1.11	Yes	Yes	Yes	Yes
Australia	n/a	n/a	n/a	0.80	0.346	1.55	Yes	Yes	Yes	Yes
Austria	64.68	7.40	64.25	0.29	1.249	1.25	No	Yes	Yes	Yes
Belgium	59.39	9.50	54.72	0.73	0.346	1.41	Yes	Yes	Yes	Yes
Bulgaria	35.52	1.50	43.14	0.47	n/a	1.12	No	No	No	Yes
Canada	n/a	n/a	72.10	n/a	0.682	1.34	n/a	n/a	Yes	No
Chile	n/a	n/a	n/a	n/a	0.312	n/a	Yes	Yes	Yes	Yes
Colombia	n/a	n/a	40.86	n/a	0.158	n/a	Yes	Yes	Yes	Yes
Costa Rica	n/a	n/a	n/a	n/a	0.059	1.12	Yes	Yes	Yes	Yes
Croatia	58.95	5.70	54.99	0.42	n/a	0.96	No	No	Yes	Yes
Cyprus	49.46	1.00	73.66	n/a	n/a	n/a	Yes	Yes	Yes	Yes
Czechia	69.11	3.90	64.15	0.41	0.771	1.12	Yes	No	Yes	n/a
Denmark	69.62	10.40	73.87	0.39	0.482	1.64	Yes	No	Yes	Yes
Estonia	62.61	8.10	63.47	0.37	0.624	1.39	Yes	Yes	Yes	Yes
Finland	81.99	9.20	82.62	0.42	0.482	1.56	Yes	Yes	Yes	Yes
France	59.67	7.20	55.15	0.35	0.676	1.54	Yes	No	Yes	Yes
Germany	52.22	10.90	46.25	0.30	0.834	1.62	Yes	Yes	Yes	No
Greece	52.40	4.10	48.67	0.27	0.37	n/a	No	No	No	Yes
Hungary	58.89	4.70	67.31	0.24	0.559	0.92	No	Yes	Yes	Yes
Iceland	n/a	12.60	71.36	0.71	0.284	1.37	Yes	Yes	Yes	Yes
Ireland	69.40	4.70	57.93	0.83	0.357	n/a	Yes	Yes	Yes	Yes
Israel	n/a	n/a	66.90	n/a	0.021	3.04	Yes	Yes	Yes	n/a
Italy	45.75	3.50	52.82	0.29	0.587	n/a	Yes	No	No	Yes
Japan	n/a	n/a	n/a	0.26	0.357	2.10	Yes	n/a	Yes	Yes
Korea	n/a	n/a	73.64	0.02	0.772	2.04	Yes	Yes	Yes	Yes

	Basic digital skills	Self-reported consultations	Internet use for health information	Practicing midwives per 1 000 population	Prevention spending (% GDP)	Primary healthcare spending (% GDP)	Policies for promotion, prevention and treatment in primary care	Policies for integrating digital technologies	Policies for improving awareness and literacy	Strategy or action plan that guide policy implementation
Latvia	45.34	4.30	52.74	0.21	0.464	2.05	Yes		Yes	Yes
Lithuania	52.91	6.00	66.66	0.31	0.435	1.43	Yes	Yes	Yes	Yes
Luxembourg	60.14	9.90	46.35	0.36	0.256	0.52	No	Yes	Yes	n/a
Malta	63.02	5.30	67.70	n/a	n/a	n/a	Yes	Yes	Yes	No
Mexico	n/a	n/a	54.17	n/a	0.179	0.98	Yes	n/a	Yes	Yes
Netherlands	82.70	9.80	78.82	0.26	0.582	1.02	No	No	Yes	n/a
New Zealand	n/a	n/a	n/a	0.51	n/a	n/a	Yes	Yes	Yes	Yes
Norway	81.09	7.00	75.02	0.56	0.268	1.11	Yes	Yes	Yes	Yes
Portugal	55.97	7.30	54.59	n/a	0.353	n/a	Yes	n/a	Yes	Yes
Romania	27.73	0.90	46.13	0.17	n/a	0.62	No	No	No	Yes
Slovak Republic	51.31	3.90	55.58	n/a	0.125	0.84	No	No	No	No
Slovenia	46.70	5.80	51.35	0.16	0.498	1.81	Yes	Yes	Yes	Yes
Spain	66.18	4.80	67.27	n/a	0.37	1.45	Yes	Yes	Yes	Yes
Sweden	66.44	11.20	69.42	0.75	0.554	1.35	Yes	Yes	Yes	Yes
Switzerland	77.52	n/a	69.39	0.34	0.333	0.92	Yes	Yes	Yes	Yes
Türkiye	33.11	6.30	56.97	n/a	n/a	n/a	Yes	Yes	Yes	Yes
United Kingdom	n/a	n/a	63.29	0.48	1.545	1.95	Yes	Yes	Yes	Yes
United States	n/a	n/a	n/a	n/a	0.838	n/a	Yes	Yes	Yes	Yes

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 3.4.

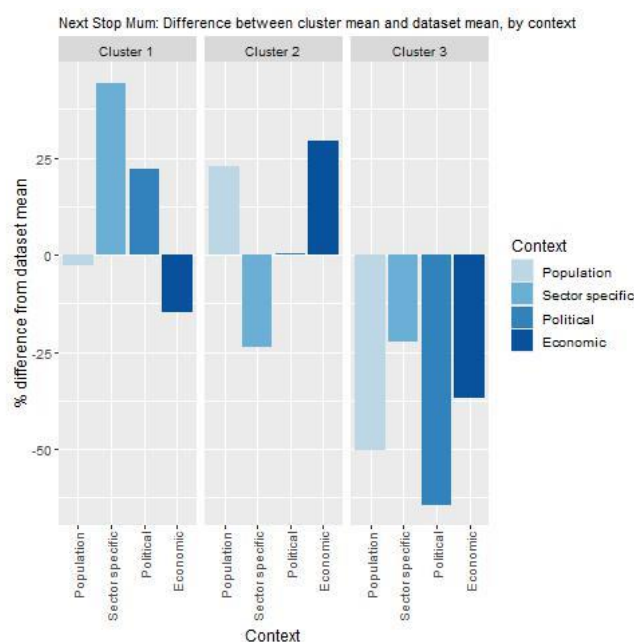
Source: Eurostat (2023^[36]), Share of individuals having at least basic digital skills (%), https://ec.europa.eu/eurostat/databrowser/view/sdg_04_70/default/table (accessed on 24 February 2025); Eurostat (2022^[37]), Self-reported consultations of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level, https://doi.org/10.2908/HLTH_EHIS_AM6E (accessed on 7 April 2024); Eurostat (2023^[38]), Individuals using the internet for seeking health-related information, <https://ec.europa.eu/eurostat/databrowser/view/tin00101/default/table?lang=en> (accessed on 24 February 2025); OECD (2022^[39]), OECD Data Explorer - Practicing midwives per 1 000 population, <https://data-explorer.oecd.org/s/2xf>; OECD/WHO Regional Office for Europe (2023^[40]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care; OECD/WHO Regional Office for Europe (2023^[41]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to improve mental health awareness and literacy; OECD/WHO Regional Office for Europe (2023^[42]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes for integrating digital technologies and tools into mental health service delivery; OECD/WHO Regional Office for Europe (2023^[43]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy.

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 3.4. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 3.8 and Table 3.6:

- Countries in cluster one, have sector specific and political arrangements in place to transfer NSM. These should however ensure that the programme is affordable and addresses mental health needs within the population. This group includes 17 countries.
- Countries in cluster two have populational and economic arrangements to support NSM. However, prior to transferring the intervention, these countries may wish to consider ensuring that the healthcare sector is ready to implement the programme, and that it aligns with political priorities. This group includes 16 countries.
- Remaining countries are in cluster three. These should consider whether the intervention aligns with political priorities and might benefit from undertaking further analyses to ensure NSM is affordable and can be implemented within existing healthcare infrastructures. This group includes six countries.

Figure 5.4. Transferability assessment using clustering – Next Stop: Mum



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.
Source: OECD analysis.

Table 5.4. Countries by cluster – Next Stop: Mum

Cluster 1	Cluster 2	Cluster 3
Australia	Austria	Bulgaria
Belgium	Czechia	Croatia
Colombia	Denmark	Greece
Costa Rica	Estonia	Italy
Cyprus	Finland	Romania
Iceland	France	Slovak Republic
Ireland	Germany	
Israel	Hungary	
Latvia	Japan	
Mexico	Korea	
Norway	Lithuania	
Poland	Luxembourg	
Portugal	Malta	
Slovenia	Netherlands	
Sweden	Spain	
Switzerland	United Kingdom	
Türkiye		

Note: Due to high levels of missing data, the following countries were omitted from the analysis: Canada, Chile, New Zealand, the United States.
Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 3.5 outlines several new indicators policymakers could consider before transferring NSM.

Box 5.5. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the maternal mortality rate related to perinatal depression?
- What are the main barriers to access perinatal mental health support?
- What is the population's attitude towards PPD screening?

Sector specific context

- Is PPD screening embedded in the usual perinatal care?
- Is there training on perinatal depression in midwifery and nursing schools?
- Are there any guidelines about PPD screening?
- How do the rates of midwives and psychologists per 1 000 inhabitants compare between rural and urban areas?
- What is professional's attitude (nurses, midwives, GP, therapists) towards PPD screening?

Political context

- Does a national plan exist to ensure systematic screening for postpartum and perinatal depression?

Economic context

- Is there a dedicated budget for perinatal mental health?

Conclusion and next steps

Next Stop: Mum is a mental health prevention programme targeting women within their last trimester of pregnancy and first year postpartum in Poland. The purpose of the programme is to train healthcare professionals (e.g. midwives and nurses) for PPD screening, inform women on PPD, screen women for the risk of PPD, and refer those with higher risks to psychological consultations as needed.

NSM has the potential to reduce the repercussions of PPD that are overlooked or not treated. NSM focusses on screening PPD and providing psychological referral as needed, thereby reducing the risk of depression in postpartum. The programme also reduces the stigma around depression during the perinatal period. It is estimated that scaling up a PPD screening programme such as NSM would be cost saving in 28% of countries studied and cost-effective in remaining countries.

The programme has a positive impact on many best practice criteria; however, further enhancements are possible. For instance, particular attention could be drawn to mental health care provision for vulnerable populations such as people living in underserved areas, ethnic minority groups, including migrants and refugees, as well as underage women.

NSM is highly transferable in 17 out of 39 EU and OECD countries, and intermediately transferable to 16 of them. The transferability analysis using clustering suggests that the reform can be readily transferred to nearly 44% of countries, which were included in the cluster of highest transferability. However, all countries have the opportunity to tailor national screening strategies for perinatal depression according to their specific needs, resources and contexts.

Box 5.6. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance screening for perinatal depression are listed below:

- Ensure effective nationwide implementation of screening for perinatal and postpartum depression, provide comprehensive training on perinatal mental health to healthcare professionals, and establish clear guidelines on screening tools and referral pathways.
- Enhance support for policies and strategies that promote mental health in the perinatal period, with a particular focus on underprivileged and underserved communities.
- Enable easy referral pathways and access to psychological support for individuals suffering from postpartum and perinatal depression.
- Promote “lessons learnt” from regions within Poland where the intervention has been carried out, as well as from countries where PPD screening has been implemented.

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Annex 5.A. Modelling assumptions for NSM

Annex Table 1.A. Parameters to model the impact of NSM

Model parameters	Next Stop: Mum model inputs
Effectiveness	33% higher chance of achieving at least 5-point reduction in PHQ-9 score at one year.
Time to maximum effectiveness	The reduction in PHQ score reaches a maximum effect at start of the intervention, with a maintained effect up to 12 months, after which it was assumed to return to 0 by 24 months.
Target population	Women aged 15-49 within their first year postpartum.
Exposure	10% of eligible patients get referred to NSM.
Per capita cost, EUR	Cost per capita: EUR 0.06.

Effectiveness

A systematic review based on six studies found that PPD screening reduces the risk of depression by 18% to 59% at follow-up (between 1.5 and 16 months across studies) compared to controls (no screening or no screening test results) (O'Connor et al., 2016^[14]). And, PPD screening programmes combined with support were associated with an increase of 33% in achieving a reduction of at least 5 points in PHQ-9 scores at one year follow up (Yawn et al., 2012^[46]).

Time to maximum effectiveness

The reduction in PHQ score reaches a maximum effect at start of the intervention, with a maintained effect up to 12 months, after which it was assumed to return to 0 by 24 months.

Target population

All adult women of reproductive age (15 to 49) within their first year postpartum are targeted by the intervention.

Exposure

Based on data from the NSM and national statistics on birth rates (Chrzan-Dętkoś, Murawska and Walczak-Kozłowska, 2022^[1]; Główny Urząd Statystyczny (Statistics Poland), n.d.^[25]), it is estimated that about 5% of eligible patients get referred to the in-person screening. When modelling the scale-up of the intervention, it is estimated that the coverage doubles and the intervention covers 10% of the eligible patients.

Cost of implementation and delivery

The total cost of the intervention is equivalent to about EUR 506 207 (PLN 2 238 291) for a duration of three years, based on the project's budget summary. These costs include project staff expenses, contracted, legal and administrative services, up to three follow-up psychological consultations for women screened with high risk of PPD, fixed assets (e.g. information technology and office equipment), website

development, as well as informational and educational material. Over the three-year period, around 5% (11 238) women in perinatal period received the in-person screening intervention and about 300 women received at least one follow-up psychological visit. It is estimated that scaling up NSM to double the intervention coverage has a yearly average cost of EUR 0.06 per capita, based on the population size in the three regions where the programme was implemented.

6 **VigilanS**

This chapter covers the case study of VigilantS, a suicide reiteration prevention programme in France. The case study includes an assessment of VigilantS against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

VigilanS: Case study overview

Description: VigilanS is a suicide reiteration prevention programme implemented at the national scale in France. It consists of post-hospital monitoring of individuals who have made a suicide attempt. The overall objective of VigilanS is to prevent suicide attempt repetition by maintaining contact with patients and improving care co-ordination in outpatient healthcare services after hospital discharge, thereby reducing the risk of relapse. The initial duration of the programme is six months, but the patient can be reintegrated for a further six months if the need arises.

Best practice assessment:

OECD best practice assessment of VigilanS

Criteria	Assessment
Effectiveness 	VigilanS reduces the risk of suicide attempt repetition by 24% within a year. It has also shown to improve healthcare co-ordination and raise awareness on suicide. By reducing the risk of suicide attempt repetition, an estimated 17 700 disability-adjusted life years (DALYs) will be gained from VigilanS by 2050 in France. Overall, self-harm cases are estimated to fall by about 13 100 between 2025 and 2050. Transferring VigilanS to OECD and EU27 countries is estimated to result in 1.42 and 1.37 DALYs gained per 100 000 people, respectively.
Efficiency 	When transferred to OECD and EU27 countries, VigilanS will result in no health expenditure savings in 26 countries and statistically significant savings in 17 countries. VigilanS would be cost-effective in nearly all countries. The reduction in self-harm resulting from VigilanS has, in turn, an impact on labour market participation and productivity, equivalent to a gain of 1.32 and 1.13 full-time equivalent workers per 100 000 working age people per year on average in OECD and EU27 countries.
Equity	VigilanS focusses on a mentally vulnerable population, targeting all patients who are discharged from hospital after a suicide attempt and who are willing to participate in the programme. VigilanS is free of charge for the user.
Evidence-base	The quality of evidence used for this case study is “strong” in areas related to data collection methods and confounders, and moderate for study design and selection bias.
Extent of coverage	Currently, VigilanS reaches approximately 46% of patients discharged from hospital following a suicide attempt, in France.

Enhancement options: To *enhance the effectiveness*, patient outreach and support can be improved by enhancing follow-up, reducing delays, increasing availability and tailoring support to patient needs. Developing training for general practitioners and establishing healthcare networks to improve patient care co-ordination would improve quality of care. To *enhance equity and to enhance the evidence-base*, it is necessary to measure the impact of the programme on the vulnerable populations that are at higher risk of suicide behaviour. To *enhance the extent of coverage*, it is essential to tailor support for vulnerable groups and prioritise implementation in regions with highest rates of suicide attempts.

Transferability: VigilanS is broadly transferable to other settings within OECD and European countries. For example, it is likely that interventions to prevent suicide attempt repetition will receive political support due to existing policies and programmes on suicide prevention.

Conclusion: VigilanS is a best practice and transferable intervention with the potential to significantly reduce the number of suicide attempt repetitions.

Intervention description

VigilanS is a suicide reiteration prevention programme. It focusses on a mentally vulnerable population, targeting hospitalised patients who have attempted suicide. The programme aims to maintain contact with patients after hospital discharge and to ensure appropriate follow-up with outpatient health services

(Box 6.1). Based in France, Vigilans was implemented in 2015 in one region, before being scaled up nationally. Today, Vigilans operates in 32 centres throughout the country. These centres have established partnerships with numerous hospitals, specifically hospital emergency, psychiatric and medicine-surgery-obstetrics departments (Broussouloux S., 2019^[1]).

Box 6.1. Suicide prevalence and risk of suicide reiteration

Suicide represents a worldwide public health concern. Each year, more than 700 000 people die by suicide worldwide (World Health Organization, 2021^[2]). With one in every 100 deaths being the result of suicide, it remains the fourth leading cause of death in the 15- to 29-year-olds. In 2020, the average suicide rate across OECD countries was 11.3 deaths per 100 000 population (OECD, 2023^[3]). In France alone, nearly 10 000 deaths by suicide and 200 000 suicide attempts were reported in 2020, representing almost 28 deaths and 550 attempts per day (Direction générale de la santé, 2023^[4]). Though numbers have been decreasing within the last decade in the European Union, the number of suicide attempts has slightly increased since the start of the COVID-19 pandemic. Direct and indirect costs related to suicide in France were estimated to add up to nearly EUR 10 billion per year, of which 1.1 billion are directly related to medical costs (Direction générale de la santé, 2023^[4]).

The likelihood of individuals who have previously attempted suicide, without resulting in death, and reiterating a suicide attempt is significant. A meta-analysis found that one in five suicide attempt survivors go on to engage in a subsequent attempt (De la Torre-Luque et al., 2023^[5]). The risk of suicide attempt repetition is particularly high within the first six months following the attempt – with three in four attempt repetitions happening within this timeframe (Direction générale de la santé, 2023^[4]). In addition, limited access to care and inadequate care continuity are identified as problems in patients who made suicide attempts. Potential reasons include psychosocial barriers, such as low perception of the need for treatment and diverse attitudes towards seeking assistance (Bruffaerts et al., 2011^[6]). This evidence highlights the importance of timely intervention and appropriate outpatient health services after hospital discharge.

Vigilans serves as a contact maintenance and reintegration system into mental health care, for a 6-month duration (Broussouloux S., 2023^[7]). The procedure for contact maintenance goes as follows:

- **On the first day** – All patients released from the hospital emergency department or inpatient care following a suicide attempt and with up to three suicide attempts, receive a resource card with information relative to the programme, including dial information for support. Both the patient's general practitioner (GP) and referring psychiatrist are then informed of their patient's entry into the programme.
- **Between day 10 and day 20** – Recruited patients receive a first phone call from the Vigilans team during this period. If they are not reachable, the team sends a postcard to the patient's postal address once a month for a duration of up to four months. The Vigilans team may also decide to reschedule one or multiple phone calls if deemed necessary. Should the patients experience a suicidal crisis, they are redirected towards an emergency consultation. Patients with first-time suicide attempt are not contacted in the first days after hospital discharge, but six months after discharge (see next section).
- **At six months** – Both individuals with first-time suicide attempt and those with repeated suicide attempts receive a phone call by the Vigilans team, six months after inclusion. To optimise phone call attendance, patients receive appointment notifications via SMS or mail before the call. If the patient's mental state has improved, they are discharged from the programme. However, if further

support is considered necessary or if a patient makes another suicide attempt, they remain in the programme for an additional six months.

A Vigilans team consists of both a co-ordination and an operational team. The co-ordination team (typically including a medical co-ordinator, an administrative assistant and a nurse) assures tasks of medical co-ordination, secretarial duties and establishing partnerships with establishments to enroll patients. The operational team consists of Vigilansors.

The Vigilansors are health professionals (e.g. nurses or psychologists) who ensure that contact is maintained and care co-ordination after hospital discharge is optimised. Vigilansors make phone calls to the patient, assess the patient's well-being, suicidal tendencies and risks (see Box 6.2), and provide guidance and support as needed. Vigilansors also take care of emailing personalised postcards to patients who are difficult to contact, particularly after three unanswered calls. Postcards are usually sent after one to five months following hospital discharge, depending on the patient's profile. Vigilansors may however take the initiative to send a postcard on top of the planned follow-up calls or at the end of a patient's monitoring period – after six months. The Vigilansors also establish links between healthcare, social and educational networks to improve the patient's healthcare pathway (Broussouloux S., 2019^[1]).

Box 6.2. Methods for clinical evaluation of suicidal risk

The Vigilans programme uses two assessment tools to measure suicidal risk and ideation. These are the Columbia-Suicide Severity Rating Scale (C-SSRS) scale and the Mini International Neuropsychiatric Interview (MINI). These tools consist of short and simple questionnaires that can be administered to patients to evaluate suicidal ideation and behaviour. These tools pose questions on suicidal thoughts, preparation and intensity of suicidal ideation, as well as on clinical status and treatment history.

Both tools were used during the follow-up phone calls carried out by Vigilansors at 10 to 20 days and six months after the first suicide attempt, in both first-time suicide attempters and repeat attempters.

Regular communication is ensured between the Vigilans team and the patient's healthcare professionals. After each phone call, a report is sent to the patient's GP and referring psychiatrist. If there are concerns about the patient's increased risk of suicide, Vigilansors can refer the patient back to their GP for further care and can reintegrate them into the monitoring system for another six months, to avoid any detrimental disruption of care. The monitoring process can be adapted to tailor the patient's needs.

OECD Best Practices Framework assessment

This section analyses Vigilans against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 3.3 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 6.3. Assessment of VigilantS

Effectiveness

- VigilantS has shown to reduce the number of suicide attempt repetitions by 24% within a year.
- The intervention has also shown to improve healthcare co-ordination and raise awareness on suicide.
- By reducing the risk of suicide attempt repetition, an estimated 17 700 disability-adjusted life years (DALYs) will be gained from VigilantS by 2050 in France. Overall, self-harm cases are estimated to fall by about 13 100 between 2025 and 2050.
- Transferring VigilantS to OECD and EU27 countries is estimated to result in 1.42 and 1.37 DALYs gained per 100 000 people, respectively.

Efficiency

- When transferred to OECD and EU27 countries, VigilantS will result in no health expenditure savings in 26 countries and statistically significant savings in 17 countries. VigilantS would be cost-effective in nearly all countries.
- The reduction in self-harm resulting from VigilantS has, in turn, an impact on labour market participation and productivity, equivalent to a gain of 1.32 and 1.13 full-time equivalent workers per 100 000 working-age people per year on average in OECD and EU27 countries.

Equity

- VigilantS focusses on a mentally vulnerable population, targeting all patients who are discharged from hospital after a suicide attempt and who are willing to participate in the programme. VigilantS is provided to the user free of cost.

Evidence-base

- VigilantS was evaluated using a non-randomised observational study, with a matched control group.
- The study used to evaluate VigilantS had a strong assessment in the domain of “Data collection methods” and “Confounders”, moderate in “Study design” and “Selection bias”, and weak in “Blinding”. The overall quality assessment of the study was considered as moderate.

Extent of coverage

- It is estimated that currently, VigilantS reaches approximately 46% of patients discharged from hospital following a suicide attempt, in France.

Effectiveness

VigilantS is a promising intervention for reducing the number of suicide attempt repetition and deaths by suicide

A study of the intervention’s effectiveness across six VigilantS centres from 2015 to 2017, has included a total of 23 146 patients, of which half received the intervention. This study shows a decrease in suicide attempt repetitions and deaths by suicide among patients in the intervention group compared to controls (patients who did not receive the intervention) (Broussouloux S., 2023^[7]). Within the 12-month follow-up, nearly 28% of participants in the intervention group had repeated a suicide attempt, compared to 43% in

the control group (Table 6.1). In light of the interviews conducted with the study's authors, the incidence risk ratio for suicide attempt reiteration has been reported as 0.76 [0.71-0.81]. This means that patients receiving Vigilans have a 24% reduction in the number of suicidal attempt repetitions compared to those who did not receive the intervention. Regarding death by suicide, the event occurred in 0.53% of participants in the intervention group, compared to 0.67% in the control group during the 12-month follow-up (Table 6.1).

Table 6.1. Study group outcomes: Suicide attempts and mortality within a year

	Intervention group Vigilans (n = 11 573)	Control group (n = 11 573)
Suicide attempt repetitions, number of cases (cumulative incidence rate at 12 months, in percentage)	3 214 (27.8%)	5 014 (43.3%)
Deaths by suicide, number of cases (cumulative incidence rate at 12 months, in percentage)	61 (0.53%)	77 (0.67%)

Source: Adapted from Broussouloux et al. (2023^[7]), "Évaluation d'efficacité de Vigilans de 2015 à 2017, dispositif de prévention de la réitération suicidaire", <https://www.santepubliquefrance.fr/maladies-et-traumatismes/sante-mentale/suicides-et-tentatives-de-suicide/documents/enquetes-etudes/evaluation-d-efficacite-de-vigilans-de-2015-a-2017-dispositif-de-prevention-de-la-reiteration-suicidaire>.

Vigilans also improves care coordination after hospital discharge and raises awareness about mental health and suicide

The programme supports patients in redirecting them to further healthcare, as well as towards the associative and social sectors. Particular attention is paid to patients with a high number of suicide attempts, who are directed to more intensive healthcare pathways.

A qualitative study was conducted in five French regions between 2016 and 2018, based on surveys within Vigilans teams, as well as on-site visits, focus groups, and documentary analyses (Broussouloux S., 2019^[1]). The Vigilans teams perceive the programme as effective in enhancing coordination and post-hospital outpatient care, as well as in improving the patients' healthcare pathway. This includes helping patients schedule appointments with healthcare professionals, establishing care plans and reviewing conditions for discharge from Vigilans. Vigilansors reported that phone calls allow communication to take place in a more trusted environment, which gives patients a sense of security and improves communication about their health status and well-being. As a consequence, Vigilansors are better able to evaluate risks of suicidal ideation and provide the necessary support.

Overall, the programme was regarded as increasing awareness on suicide and mental health in the regions of its implementation, paving the way for further action on this matter (Broussouloux S., 2019^[1]).

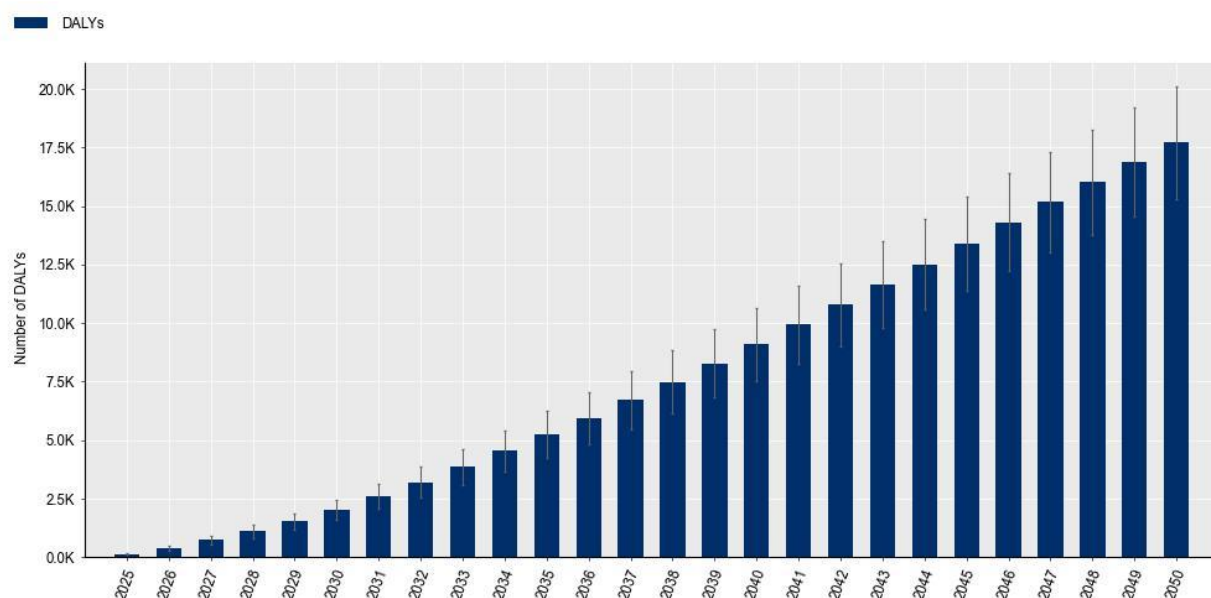
The OECD's **Strategic Public Health Planning for non-communicable diseases** (SPHeP-NCDs) microsimulation model was used to estimate the health and economic impact of expanding Vigilans across France, and across all OECD and non-OECD European countries, assuming that 60% of the target population receives the intervention. Details on the model are in Annex A, while the list of model assumptions are in Annex 6.A at the end of this Chapter.

The rest of this section presents results for France, followed by remaining OECD and non-OECD European countries.

France

The scale-up of VigilantS in France - assuming that 60% of the target population receives the intervention- is estimated to lead to a cumulative total gain of 17 700 disability-adjusted life years (DALYs) by 2050 (Figure 5.1) compared to prior the intervention.

Figure 6.1. Cumulative number of DALYs gained (2025-50) – VigilantS, France



Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

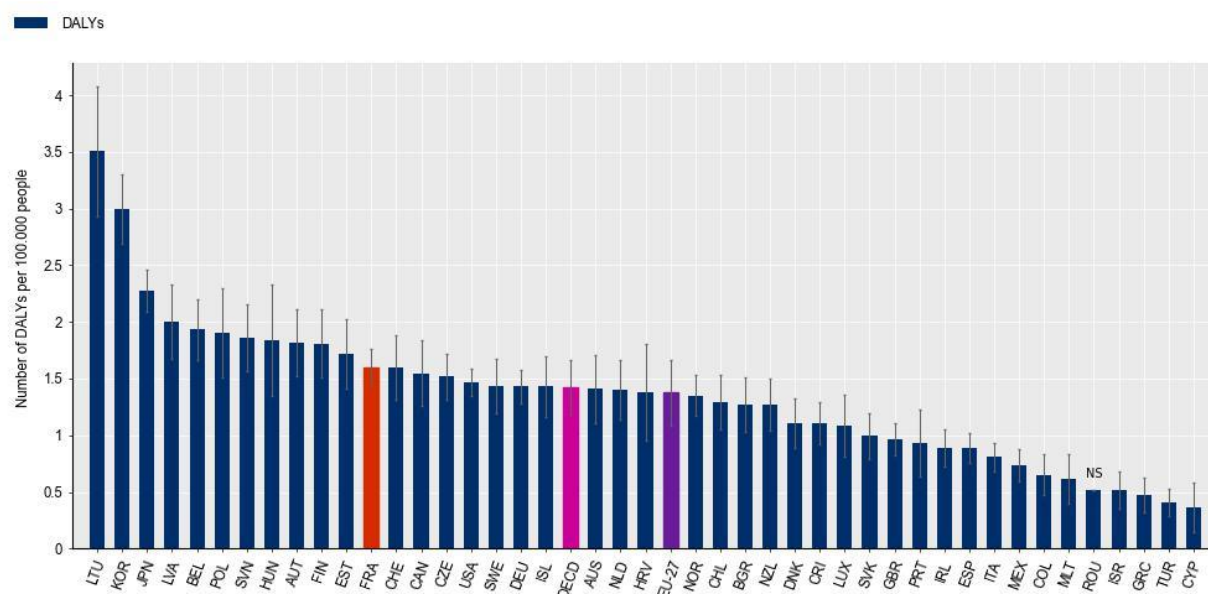
Source: OECD analyses based on the OECD SPHeP-NCDs model, 2025.

In gross terms, VigilantS is expected to have the greatest impact on self-harm¹ (including suicide). Between 2025 and 2050, the number of self-harm cases is estimated to fall by nearly 13 100 cases. Over the years, the prevalence of certain diseases is expected to increase as suicide-related deaths are avoided.

OECD and EU countries

Transferring VigilantS to OECD and EU27 countries is estimated to result in 1.42 and 1.37 DALYs gained per 100 000 people, on average per year between 2025 and 2050, respectively (ranging from 0.37 in Cyprus to 3.51 in Lithuania) (Figure 5.2). In gross terms, the intervention is estimated to reduce the number of cases of self-harm by nearly 232 540 cases across all countries, between 2025 and 2050. This represents about 1.1% of all cases of self-harm across OECD and EU27 countries.

Figure 6.2. DALYs gained annually per 100 000 people, 2025-50 – Vigilans, OECD and EU27 countries



Note: NS = non-significant. The black lines represent 95% confidence intervals.

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

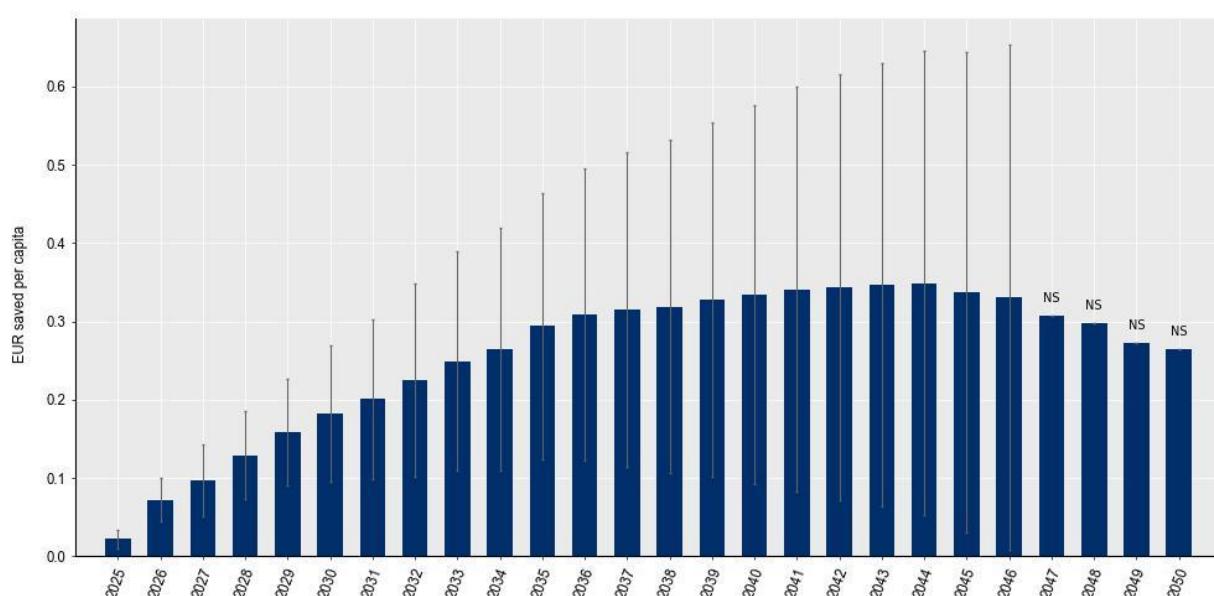
Efficiency

Similar to “Effectiveness”, this section presents results for France followed by remaining OECD and EU27 countries. It presents the potential impact of the intervention on healthcare expenditure and a cost-effectiveness analysis assuming programme costs as reported in Annex 6.A at the end of this Chapter.

France

By reducing the risk of suicide attempt repetition in persons having attempted suicide, Vigilans can reduce healthcare costs (e.g. hospitalisations after a suicide attempt). Vigilans would lead to cumulative health expenditure savings of EUR 0.35 per person by 2044 (Figure 6.3). However, on the long term, as people who received the intervention are less likely to die from suicide, they may develop chronic diseases and consume healthcare, as it is captured by the dynamics of the model (Box 6.4). Therefore, health expenditure savings are offset by the cost of treating future chronic diseases.

Figure 6.3. Cumulative health expenditure savings per person, EUR, 2025-2050 – Vigilans, France



Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

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

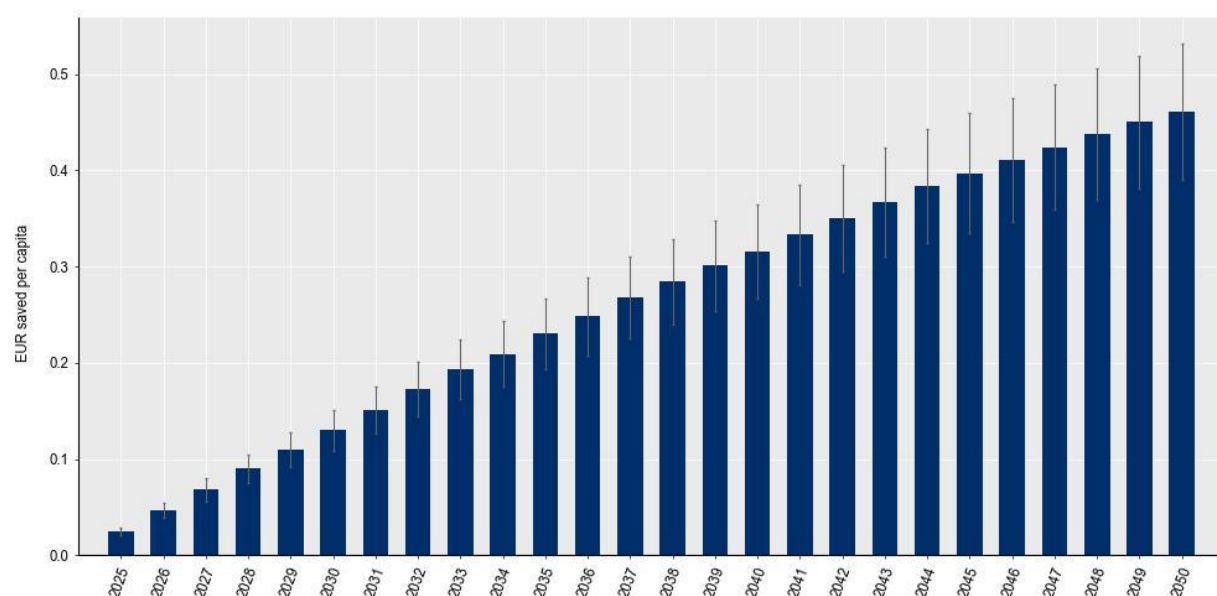
Box 6.4. The OECD model considers a dynamic approach and epidemiologic risk

Estimates derived from the OECD SPHeP-NCD model are calculated for the period 2025-2050. In the model, an individual has a certain risk of developing a disease each year. Individuals can develop different categories of diseases such as diabetes, stroke, ischaemic heart disease, cancer, depression, anxiety, dementia, musculo-skeletal disorders (e.g. low back pain, rheumatoid arthritis), chronic obstructive pulmonary diseases, cirrhosis, alcohol dependence, self-harm (e.g. suicide attempts) and injuries.

The model uses a *competing event framework*. This means that diseases and causes of death compete one against the others to determine the death of an individual. For this reason, people who do not die by suicide due to the intervention may continue to develop other chronic diseases, which represent a cost for the health system.

An analysis reveals that the savings related to self-harm alone are higher than the cost of the intervention. When considering only the costs of self-harm, it is expected that Vigilans will save up to EUR 0.46 per capita per year by 2050. By 2030, more than EUR 0.10 per capita will be saved in France (Figure 6.4). On average, this amounts EUR 0.07 per capita per year over the period 2025-2030, which is higher than the intervention cost (estimated at EUR 0.05 per capita).

Figure 6.4. Cumulative health expenditure savings from self-harm alone, per person, EUR, 2025-2050 – Vigilans, France



Note: The black lines represent 95% confidence intervals. Figures are discounted at a rate of 3%.

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

OECD and EU countries

It is estimated that transferring Vigilans to the 43 OECD and EU27 countries would result in no health expenditure savings in 26 countries since health expenditure savings are offset by the cost of treating future chronic diseases. Yet, health expenditure savings would be statistically significant in 17 countries.

Table 6.2 provides information on intervention costs, total health expenditure savings and the cost per DALY gained in local currency for OECD and EU27 countries. Vigilans is not cost saving in any country, as the reduction in health expenditure related to self-harm is outweighed by increased spending on other diseases (Box 6.4). However, in all countries with the exception of Romania, Vigilans is considered cost-effective with the cost per DALY gained below a cost-effectiveness threshold often applied in European countries (i.e. around EUR 50 000 per DALY based on (Vallejo-Torres et al., 2016^[8])).

Table 6.2. Cost effectiveness figures in local currency – Vigilans, OECD and EU27 countries

Country	Local currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Australia	AUD	0.10	1 012 641	4 852
Austria	EUR	0.05	ns	3 823
Belgium	EUR	0.05	ns	2 705
Bulgaria	BGN	0.05	ns	4 515
Canada	CAD	0.09	2 354 075	2 072
Chile	CLF	31.77	95 610 410	2 095 047
Colombia	COP	100.32	297 416 083	14 610 391
Costa Rica	CRC	24.60	12 401 365	2 007 255
Croatia	HRK	0.03	ns	2 219
Cyprus	EUR	0.04	ns	11 330

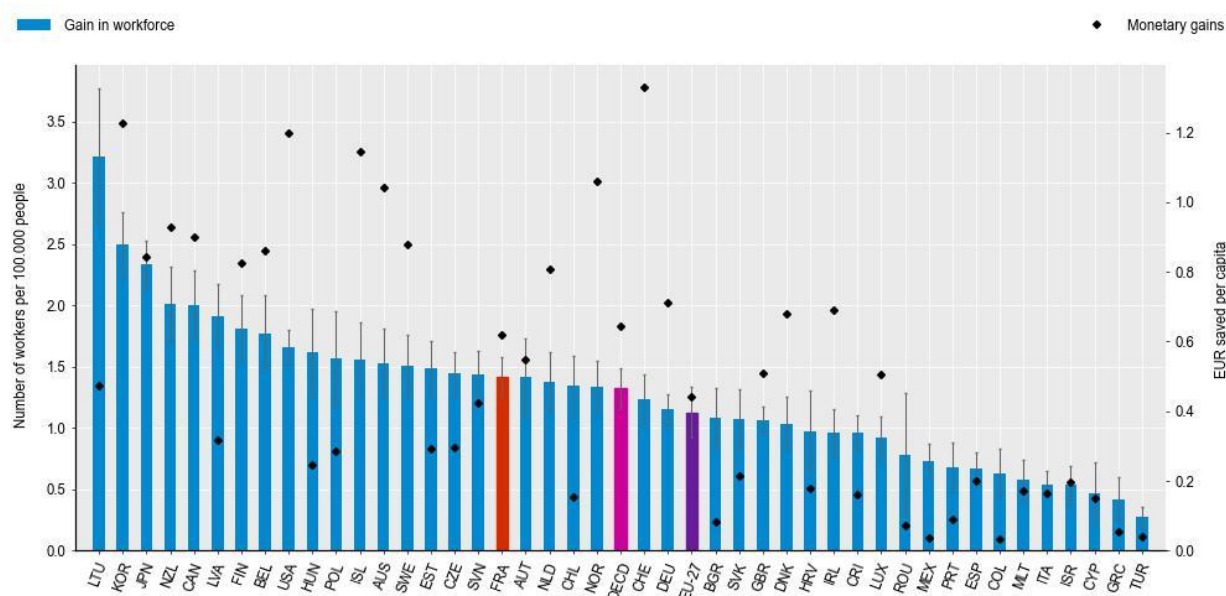
Country	Local currency	Intervention costs per capita, average per year	Total health expenditure savings, 2025-2050	Cost per DALY gained*
Czechia	CZK	0.92	ns	60 490
Denmark	DKK	0.46	ns	50 946
Estonia	EUR	0.04	4 563	2 212
Finland	EUR	0.05	117 423	2 002
France	EUR	0.05	579 429	2 603
Germany	EUR	0.05	ns	4 070
Greece	EUR	0.04	32 916	7 249
Hungary	HUF	11.70	ns	696 467
Iceland	ISK	10.32	ns	770 501
Ireland	EUR	0.05	ns	5 026
Israel	ILS	0.26	ns	49 658
Italy	EUR	0.04	ns	5 620
Japan	JPY	7.07	ns	322 217
Korea	KRW	60.48	-1 120 147 244	2 786 468
Latvia	EUR	0.04	14 358	1 436
Lithuania	EUR	0.04	ns	856
Luxembourg	EUR	0.07	ns	5 799
Malta	EUR	0.04	ns	6 170
Mexico	MXN	0.73	5 778 256	93 115
Netherlands	EUR	0.05	ns	3 489
New Zealand	NZD	0.10	275 274	4 650
Norway	NOK	0.62	ns	47 739
Poland	PLN	0.13	ns	6 482
Portugal	EUR	0.04	ns	3 870
Romania	RON	0.13	ns	Non effective**
Slovak Republic	EUR	0.04	ns	3 684
Slovenia	EUR	0.04	ns	2 004
Spain	EUR	0.04	ns	5 159
Sweden	SEK	0.62	4 792 787	13 215
Switzerland	CHE	0.08	290 979	2614
Türkiye	TRY	0.34	ns	83 969
United Kingdom	GBP	0.05	750 448	3 981
United States	USD	0.08	17 343 825	1 739

Note: * Cost per DALY gained is measured using total intervention costs less total health expenditure savings divided by total DALYs gained over the period 2025-2050. **The impact on health is non-significant. For countries presenting negative values in total health expenditure savings between 2025-2050, Vigilans leads to an increase in healthcare costs but still remains cost effective. "ns" means non significant.

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

The reduction in cases of self-harm resulting from Vigilans has, in turn, an impact on labour market participation and productivity. By reducing self-harm incidence, Vigilans is expected to lead to increases in employment and reductions in absenteeism, presenteeism, and early retirement. Converting these labour market outputs into full-time equivalent (FTE) workers, it is estimated that OECD and EU27 countries will gain 1.32 and 1.13 FTE per 100 000 working age people per year between 2025 and 2050 respectively (Figure 5.3). Country variations are mainly explained by the prevalence rates of self-harm across countries and projections of working-age population. In monetary terms, this translates into average per capita increase in labour market production of EUR 0.64 for OECD countries and EUR 0.44 for EU27 countries (Figure 5.3).

Figure 6.5. Labour market impacts, average per year, 2025-2050 – Vigilans, OECD and EU27 countries



Note: The black lines represent 95% confidence intervals.

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

Equity

VigilanS focusses on a mentally vulnerable population, targeting all patients who are discharged from hospital after a suicide attempt and who are willing to participate in the programme. VigilanS has created partnerships with public hospitals nationwide (32 hospitals, to date). The programme is accessible to the entire population without any cost, ensuring fair and equitable access. Inclusion in the programme requires patient's consent. Patients with more than three suicide attempts are, however, excluded from the programme, as their specific needs require a higher level of care. The effectiveness study found equal effectiveness of the intervention for men and women (Broussouloux S., 2023^[7]). The same study found no statistical differences between the effect on individuals who received a first phone call six months after hospital discharge (those with a first suicide attempt) and those who received a first call within three weeks (those with a history of suicide attempts).

Communication with patients is conducted by telephone and postcards, which may present limitations for patients who are difficult to reach by phone, speak a foreign language, or do not have a permanent postal address.

Evidence-based

The evidence on VigilanS effectiveness and efficiency is collected from an observational and retrospective study, including 11 573 participants who have received the intervention, matched with 11 573 patients who did not receive the intervention (for a total of 23 146 observations) (Broussouloux S., 2023^[7]). This study uses medical records from VigilanS and hospital medical-administrative databases for patient data.

The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domain of "Data collection methods" and "Confounders", moderate in "Study design" and "Selection bias", and weak in "Blinding" (see the table below) (Effective Public Health Practice Project, 1998^[9]). The overall quality assessment of the study was considered as moderate.

Table 6.3. Evidence-based assessment, Vigilans

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Very likely
	What percentage of selected individuals agreed to participate?	Can't tell
<u>Selection bias score</u>		Moderate
Study design	Indicate the study design	Observational study, with matched control group
	Was the study described as randomised?	No
<u>Study design score</u>		Moderate
Confounders	Were there important differences between groups prior to the intervention?	No
	What percentage of potential confounders were controlled for?	Matching
<u>Confounder score</u>		Strong
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	No
<u>Blinding score</u>		Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
<u>Data collection methods score</u>		Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Not applicable
	Indicate the percentage of participants who completed the study?	Not applicable
<u>Withdrawals and dropout score</u>		Not applicable

Source: Effective Public Health Practice Project (1998), "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Broussouloux et al. (2023^[7]), "Évaluation d'efficacité de Vigilans de 2015 à 2017, dispositif de prévention de la réitération suicidaire".

Extent of coverage

In 2023, about 35 200 patients received the Vigilans programme, which was implemented across all regions of continental France and in certain overseas territories. As a matter of comparison, it is estimated in 2023 that there was a total of 200 000 suicide attempts in France (Direction Générale de la Santé, 2023^[10]).

However, the size of the target group for the intervention (individuals who are hospitalised after a suicide attempt) is unclear. An analysis of hospital data showed that about 76 000 people were admitted to medical, surgical and emergency departments after a suicide attempt in 2022 (Infosuicide, n.d.^[11]). However, this estimate does not take into account patients who went to the emergency department after a suicide attempt but were not admitted, or those who were admitted to a psychiatric ward, who would be eligible for Vigilans and enrolled in the programme. This estimate also does not take into account for the possibility that individuals may have been hospitalised several times following suicide attempts within a year. Despite these limitations, and assuming the target group comprises 76 000 people in France, the programme is estimated to cover 46% of the target population.

All individuals discharged from a hospital after a suicide attempt were included in the programme, regardless of age, gender or other socio-economic factors. However, the patient's consent is required to be included in the programme. In addition, the programme does not include patients with more than three suicide attempts, as their specific needs require a higher level of care (Broussouloux S., 2019^[1]).

Policy options to enhance performance

Enhancing effectiveness

Increasing the frequency of phone calls and shortening the delay between hospital discharge and the initial follow-up call for patients with first-time suicide attempt are likely to improve the effectiveness of Vigilans. Allowing for more frequent phone calls with patients would permit to increase surveillance and improve the support to patients. Additionally, minimising the delay between hospital discharge and the initial follow-up may improve results in terms of suicide attempt repetition. In the Vigilans programme, patients with first-time suicide attempt receive their first phone call six months after hospital discharge. However, this timeframe may be too lengthy, particularly if the patient does not actively seek care on their own (Broussouloux S., 2019^[11]). As the risk of suicide attempt repetition is particularly high in the first six months after an initial attempt, research suggests that effective outpatient follow-up care during this period is crucial to reduce the risk of a repeated suicide attempt (Inagaki et al., 2019^[12]). Further research is needed to evaluate the call frequency and timeframe to optimise the effectiveness (and the efficiency) of preventive suicide monitoring.

Increasing the availability of services by extending operating hours of the Vigilansors team may increase patient reach and support. The existing operating hours for Vigilans telephone support are limited to a restricted timeframe on weekdays (Broussouloux S., 2019^[11]). This constraint imposes limitations on the accessibility of the programme's support services. Extending operational hours or alternatively, complementing the programme with dedicated suicide hotlines, could significantly increase the availability and reach of assistance for patients with suicidal behaviour.

Adapting support to patient's needs can enhance the programme's effectiveness across diverse populations. Some patients have greater needs in terms of support and guidance. This concerns patients with a history of repeated suicide attempts or with personality disorders, minors or individuals lacking social support (Broussouloux S., 2019^[11]). These patient groups may be at higher risk of repeating a suicide attempt and may require tailored support. Individuals with higher risk of suicide during hospitalisation require follow-up care that are intensive and prompt after hospital discharge (Che, Gwon and Kim, 2023^[13]).

Operational adaptations, such as face-to-face visits, may also need to be considered when approaching population groups for which phone calls may not be optimal, such as minors and elderly patients.

Improving quality of care by developing training and establishing guidelines for GPs in suicide prevention. The Vigilans programme allows GPs to be aware about their patients' mental status by receiving health reports and communicating with the monitoring team for further insights. These interactions play a crucial role in improving the support and quality of care offered to patients and could be strengthened by providing training and establishing guidelines for GPs on suicide prevention (Carrigan et al., 2003^[14]), (Broussouloux S., 2019^[11]).

Establishing healthcare networks to facilitate co-ordination among healthcare professionals and ensure time-efficient care for patients. Establishing timely and effective co-ordination between the suicide monitoring team, social services and health and mental health professionals, to co-ordinate on patient care and follow-up, would contribute to enhancing the quality of care of patients. This has the potential to increase the effectiveness of the programme, particularly when the monitoring team and the co-ordinating professionals operate from the same premises (Broussouloux S., 2019^[11]).

Ensuring sufficient human resources depending on regional needs. To improve co-ordination and quality of care, programmes like Vigilans must ensure sufficient human resources to overcome time and resource constraints. To ensure this, conducting regular territorial assessments of suicidal attempts is essential to better estimate local needs and allocate sufficient human resources accordingly.

Enhancing efficiency

Policies that boost effectiveness will have a positive impact on efficiency (see Enhancing effectiveness). In addition, Vigilans could enhance its efficiency with the following recommendations:

- Improving coverage in increasing patient uptake of the programme in regions where patient uptake is low and through the co-ordination with primary healthcare services.
- Providing patients with the choice of a digital follow-up, as an alternative to postcards.
- Adapt the frequency of follow-up based on identified risk markers (e.g. psychiatric comorbidity, recurrence, age).

Enhancing equity

Stratifying patient data to measure the impact of Vigilans on vulnerable populations and priority groups can improve equity impact. Although Vigilans is accessible to all populations without distinction, the programme effectiveness has not been evaluated on different population groups. To enhance Vigilans equity impacts, it would be essential to monitor the programme uptake and outcomes by breaking down the data by different population groups, to the extent permitted by national regulations and authorisations for demographic data collection. Groups of interest are those at higher risk of suicidal ideation, including youth, women, LGBTQ+ individuals, Indigenous communities, individuals with substance abuse disorders, individuals with a history of self-harm, or experiencing financial hardship (e.g. unemployment and housing insecurity) (Mao et al., 2025^[15]).

Providing support in multiple languages can improve equity. Language barriers often impede access to healthcare. Addressing this barrier by offering support in the most commonly used languages, can improve inclusivity and coverage of non-native speakers that represent a particularly vulnerable group.

Enhancing the evidence-base

Improving the programme's evaluation quality by controlling for variables related to socio-economic factors and outside care. Controlling for a range of confounding factors allows to obtain more robust results and draw less biased conclusions. The study has controlled for a variety of confounders, including year and region of inclusion, sex, age group, date of suicide attempt, hospitalisation motive, and history of suicide attempts. Accounting for further variables such as minority group, socio-economic status and external mental health interventions, would allow to better measure the impact of the programme on different subgroups and would mitigate treatment bias.

Enhancing extent of coverage

A comprehensive and adaptive approach is needed to boost the uptake of Vigilans among individuals with suicidal ideation. Vigilans has expanded its coverage to the national level in France. The programme is available to all patients having been to the hospital after a suicide attempt, without any distinction. Some vulnerable groups may however need adjustments in the support offered by the programme, this concerns, for example, minors, older people, those from minority groups, persons with personality disorders and individuals with history of recurrent suicide attempts (Broussouloux S., 2019^[1]). Furthermore, a dedicated support system for patients who have attempted suicide more than three times could provide more frequent check-ins and additional assistance to help access appropriate psychological or psychiatric care.

Efforts to implement post-hospital monitoring and support programmes such as Vigilans, should prioritise regions with the highest rates of suicide attempts. This approach would require making regional assessments of suicidal tendencies and identifying areas with the greatest needs.

Transferability

This section explores the transferability of VigilantS and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring VigilantS.

Previous transfers

VigilantS has not yet been transferred to other countries. However, some OECD countries, such as Australia and Spain (Catalonia), have adopted suicide prevention programmes similar to VigilantS, that provide follow-up support after a suicide attempt (Martin et al., 2023^[16]; CoDiRISC^[17]). Other countries, such as Denmark, Finland and Norway have implemented specialised outpatient programmes for individuals having attempted suicide (e.g. psychosocial therapy) (Nordic Council of Ministers^[18]).

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of VigilantS were identified (see Table 3.4). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 6.4. Indicators to assess the transferability of VigilantS

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey (%) (Eurostat, 2022 ^[19])	VigilantS is conducted by psychologists and mental health nurses. Therefore, the intervention is more transferable in countries where people consult mental health professionals.	↑ value= more transferable
<i>Sector specific context</i>		
Healthcare Access and Quality Index (HAG Index) (IHME, 2017 ^[20])	VigilantS is more transferable in a context where access to mental health care is facilitated and where the unmet need for mental health care is lower.	↑ value= more transferable
Psychologists per 1 000 population (OECD, 2021 ^[21])	A high or sufficient number of psychologists working enables better access to mental health programmes such as VigilantS due to higher human resources and will reduce waiting time and improve geographical access, as well as quality of care.	↑ value= more transferable
Mental health nurses (including professionals) per 1 000 population (OECD, 2021 ^[21])	As above	↑ value= more transferable
<i>Political context</i>		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[22])	The implementation of a suicide prevention programme such as VigilantS requires clinical practice guidelines. Therefore, the intervention is more transferable in countries that have strategies or action plans to guide the implementation of mental health policies and programmes.	“Yes”= more transferable
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[23])	The intervention aims to provide guidance and mental health support in primary healthcare settings. Therefore, the intervention is more transferable in countries that support mental health prevention in primary healthcare settings.	“Yes”= more transferable

Indicator	Reasoning	Interpretation
Policies and programmes that support suicide prevention (WHO, 2024 ^[24]) (OECD/WHO Regional Office for Europe, 2023 ^[25])	The intervention aims to prevent suicide attempt repetition. Therefore, the intervention is more transferable in countries that have policies and programmes that support suicide prevention.	"Yes"= more transferable
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[26])	The intervention places a stronger emphasis on prevention, therefore, it is likely to be more successful in countries that allocate a higher proportion of health spending to prevention.	↑ value= more transferable

Results

Results from the transferability assessment using publicly available data are summarised below (see Table 6.5 for results at the country level):

- The analysis shows that the number of psychologists in France is similar or lower than in many OECD countries. On average, there are 0.53 and 0.49 psychologists per 1 000 population in OECD and EU countries respectively, while France matches the EU average with 0.49 psychologists per 1 000 population. France however presents a high rate of mental health nurses – nearly 1 per 1 000 population. In comparison, OECD and EU countries have 0.52 and 0.42 mental health nurses for 1 000 inhabitants, respectively.
- In terms of access to mental health care, over 7% of the French population reported consulting mental health care or rehabilitative care professionals, compared to around 6% on average across OECD countries. The Healthcare Access and Quality Index demonstrates high results in most countries, ranging over 80 for more than 70% of OECD countries.
- The vast majority of countries have national strategies and programmes for suicide prevention (90%) and for guidance in implementing mental health policies (81%), indicating that Vigilans would likely receive political support among potential transfer countries. Most countries also have mental health prevention policies within primary healthcare settings.
- Spending on prevention across OECD countries is typically lower than in France (i.e. only 7 of the 43 countries analysed spent more on prevention than France). Given that Vigilans is a preventive intervention, these results may indicate a potential affordability issue in many countries.

Table 6.5. Transferability assessment by country (OECD and non-OECD European countries) – Vigilans

A darker shade indicates Vigilans is more suitable for transferral in that particular country

	Self-reported consultations	Psychologists per 1 000 population	Mental health nurses per 1 000 population	Healthcare Access and Quality Index	Prevention spending (% GDP)	Policies supporting suicide prevention	Strategy or action plan that guide policy implementation	Policies for promotion, prevention and treatment in primary care
France	7.20	0.49	0.98	87.90	0.68	Yes	Yes	Yes
Australia	n/a	1.03	0.91	89.80	0.35	Yes	Yes	Yes
Austria	7.40	1.18	n/a	88.20	1.25	Yes	Yes	No
Belgium	9.50	0.10	1.26	87.90	0.35	Yes	Yes	Yes
Bulgaria	1.50	n/a	n/a	71.40	n/a	Yes	Yes	No
Canada	n/a	0.49	0.69	87.60	0.68	Yes	No	n/a
Chile	n/a	n/a	n/a	76.00	0.31	Yes	Yes	Yes
Colombia	n/a	n/a	n/a	67.80	0.16	Yes	Yes	Yes
Costa Rica	n/a	n/a	n/a	72.90	0.06	Yes	Yes	Yes
Croatia	5.70	n/a	n/a	81.60	n/a	n/a	Yes	No
Cyprus	1.00	n/a	n/a	85.30	n/a	Yes	Yes	Yes
Czechia	3.90	0.03	0.31	84.80	0.77	Yes	n/a	Yes
Denmark	10.40	1.62	n/a	85.70	0.48	Yes	Yes	Yes
Estonia	8.10	0.06	0.23	81.40	0.62	Yes	Yes	Yes
Finland	9.20	1.09	n/a	89.60	0.48	Yes	Yes	Yes
Germany	10.90	0.50	n/a	86.40	0.83	Yes	No	Yes
Greece	4.10	0.09	0.13	87.00	0.37	No	Yes	No
Hungary	4.70	0.02	0.34	79.60	0.56	Yes	Yes	No
Iceland	12.60	1.37	n/a	93.60	0.28	Yes	Yes	Yes
Ireland	4.70	n/a	n/a	88.40	0.36	Yes	Yes	Yes
Israel	n/a	0.88	n/a	85.50	0.02	Yes	n/a	Yes
Italy	3.50	0.04	0.23	88.70	0.59	No	Yes	Yes
Japan	n/a	0.03	0.84	89.00	0.36	Yes	Yes	Yes
Korea	n/a	0.02	0.14	85.80	0.77	Yes	Yes	Yes
Latvia	4.30	0.67	0.23	77.70	0.46	Yes	Yes	Yes
Lithuania	6.00	0.16	0.50	76.60	0.44	Yes	Yes	Yes

	Self-reported consultations	Psychologists per 1 000 population	Mental health nurses per 1 000 population	Healthcare Access and Quality Index	Prevention spending (% GDP)	Policies supporting suicide prevention	Strategy or action plan that guide policy implementation	Policies for promotion, prevention and treatment in primary care
Luxembourg	9.90	0.59	n/a	89.30	0.26	Yes	n/a	No
Malta	5.30	n/a	n/a	85.10	n/a	Yes	No	Yes
Mexico	n/a	n/a	n/a	62.60	0.18	Yes	Yes	Yes
Netherlands	9.80	0.94	n/a	89.50	0.58	Yes	n/a	No
New Zealand	n/a	0.86	0.75	86.20	n/a	Yes	Yes	Yes
Norway	7.00	1.40	0.66	90.50	0.27	Yes	Yes	Yes
Poland	4.10	0.16	0.31	79.60	0.14	Yes	Yes	Yes
Portugal	7.30	n/a	n/a	84.50	0.35	Yes	Yes	Yes
Romania	0.90	n/a	n/a	74.40	n/a	No	Yes	No
Slovak Republic	3.90	n/a	n/a	78.60	0.13	Yes	No	No
Slovenia	5.80	0.09	0.36	87.40	0.50	Yes	Yes	Yes
Spain	4.80	0.55	0.03	89.60	0.37	Yes	Yes	Yes
Sweden	11.20	0.99	0.51	90.50	0.55	Yes	Yes	Yes
Switzerland	n/a	0.26	n/a	91.80	0.33	Yes	Yes	Yes
Türkiye	6.30	0.03	1.50	76.20	n/a	Yes	Yes	Yes
United Kingdom	n/a	0.36	0.53	84.60	1.55	Yes	Yes	Yes
United States	n/a	0.30	0.04	81.30	0.84	Yes	Yes	Yes

Note: n/a = data was not available. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details can be found in Table 3.4.

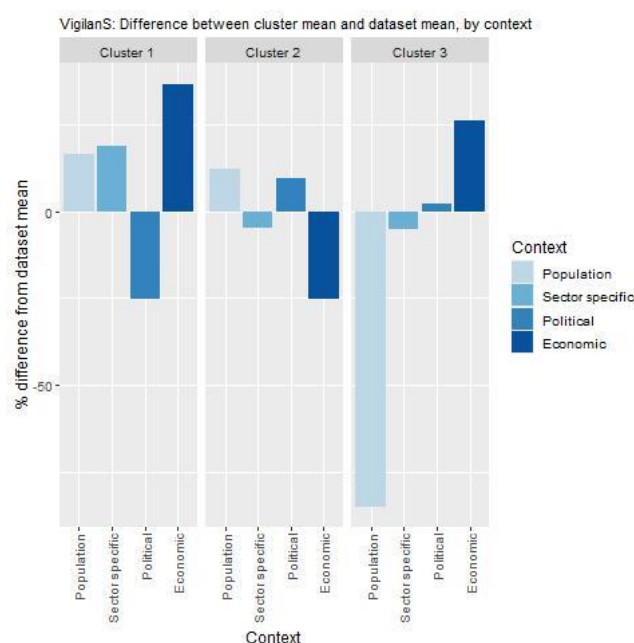
Source: Eurostat (2022^[19]), *Self-reported consultations of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level*, https://doi.org/10.2908/HLTH_EHIS_AM6E (accessed on 7 April 2024); IHME (2017^[20]), *Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990–2015*, <https://ghdx.healthdata.org/record/ihme-data/gbd-2015-healthcare-access-and-quality-index-1990-2015> (accessed on 7 April 2024); OECD (2021^[21]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>; OECD/WHO Regional Office for Europe (OECD/WHO Regional Office for Europe, 2023^[22]), *Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy*; OECD/WHO Regional Office for Europe (2023^[23]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care*; OECD/WHO Regional Office for Europe (2023^[25]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes that support suicide prevention*.

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 3.4. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 6.6 and Table 3.6:

- Countries in cluster one, including France, have populational, sector specific and economic arrangements in place to transfer *VigilanS*. These countries however may wish to ensure that the intervention aligns with political priorities. Overall, they are less likely to experience issues associated with implementing and operating the programme in their local context. This group includes nine countries.
- Countries in cluster two have populational and political arrangements to support *VigilanS*. Prior to transferring the intervention, however, these countries may wish to consider ensuring that the sector is ready to implement the programme and ensure long-term affordability by increasing spending on prevention. This group includes 21 countries.
- Countries in cluster three have political and economic arrangements to transfer *VigilanS*. These countries may wish to undertake further analysis to ensure the programme can be implemented within the existing healthcare infrastructures. This group includes 12 countries.

Figure 6.6. Transferability assessment using clustering – VigilanS



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 6.6. Countries by cluster – Vigilans

Cluster 1	Cluster 2	Cluster 3
Austria	Belgium	Australia
Canada	Chile	Bulgaria
Czechia	Colombia	Cyprus
France	Costa Rica	Israel
Germany	Denmark	Italy
Luxembourg	Estonia	Japan
Malta	Finland	Korea
Netherlands	Greece	New Zealand
Slovak Republic	Hungary	Romania
	Iceland	Switzerland
	Ireland	United Kingdom
	Latvia	United States
	Lithuania	
	Mexico	
	Norway	
	Poland	
	Portugal	
	Slovenia	
	Spain	
	Sweden	
	Türkiye	

Note: Due to high levels of missing data, the following country was omitted from the analysis: Croatia.

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 3.5 outlines several new indicators policymakers could consider before transferring Vigilans.

Box 6.5. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of mental health literacy within the population (e.g. awareness and attitudes) especially about suicidality?
- What are the main barriers to access mental health care?

Sector specific context

- Do patients already receive psychological support or guidance at hospital discharge following a suicide attempt?

Political context

- Are there existing programmes for the prevention of suicide attempt repetition?
- Have these interventions received political support from key decision makers?
- Have these interventions received financial commitment from key decision makers?

Economic context

- Are there any financial schemes in place to support vulnerable population groups in accessing mental health care?
- What is the share of healthcare expenditure allocated to mental health prevention programmes?
- Is there a dedicated funding budget for suicide prevention?

Conclusion and next steps

VigilanS is a national suicide prevention programme based in France targeting individuals having attempted suicide. The purpose of VigilanS is to prevent suicide attempt repetition in individuals discharged from the hospital following a suicide attempt. The programme offers support in maintaining contact with patients and providing guidance for further care.

The support provided by VigilanS has led to reductions in suicidal behaviour. VigilanS has shown to significantly improve patient mental health, in decreasing the number of suicide attempt repetitions by 24%. The intervention is estimated to be cost effective in nearly all countries.

The programme would benefit from enhancing strategies to effectively reach and support vulnerable groups. An assessment of VigilanS' performance against the best practice criteria highlighted potential areas for improvement. These include, but are not limited to, enhancing outreach efforts and availability for patients, adapting contact maintenance strategies to better support vulnerable and hard-to-reach groups, and addressing barriers in access that exacerbate inequalities.

VigilanS is highly transferable in nine out of 42 EU and OECD countries, and intermediately transferable to an additional 21 of them. The transferability analysis using clustering suggests that this programme can be readily transferred to 21% of countries, which were included in the cluster of highest transferability. However, all countries have the opportunity to implement suicide prevention strategies according to their specific needs, resources and contexts.

Box 6.6 outlines next steps for policymakers and funding agencies.

Box 6.6. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance VigilanS are listed below:

- To improve the overall effectiveness of the programme, consider strategies that aim to improve outreach to vulnerable populations, reduce delay between outreach efforts, provide long-term support and establish healthcare networks to facilitate co-ordination among healthcare professionals.
- To support further data collection such as patient health outcomes associated with VigilanS, along with data monitoring on suicidal behaviour, and assessment of regional needs for suicide prevention. And encourage analyses stratified by population groups (e.g. minors; older people, minority groups, those with history of suicidal behaviour) in order to tailor the programme to vulnerable groups.

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Annex 6.A. Modelling assumptions for Vigilans

Model parameters	VigilanS model inputs
Effectiveness	The number of suicidal reiterations is 24% lower in patients receiving Vigilans (IRR (suicidal reiteration) = 0.76 [0.71;0.81] (Broussouloux S., 2023 ^[7])). 38% of self-harm cases in IHME data are assumed to correspond to suicide attempts (Duarte et al., 2020 ^[27]). A suicide attempt leads to around six months of absenteeism (Segar et al., 2024 ^[28]).
Time to maximise effectiveness	Maximum effect at six months, with maintained effect up to 3 years. Based on similar studies, it is estimated that the effect will be maintained up to 3 years, before returning to baseline levels at five years.
Target population	All individuals having undergone hospitalisation or having sought emergency services within a hospital following a suicide attempt.
Exposure	60% of the target population receive Vigilans.
Per capita cost, EUR	Average yearly cost per participant: EUR 235 Cost per capita: EUR 0.05

Effectiveness

VigilanS is expected to reduce the number of suicidal reiterations by 24% in patients receiving the programme, compared to a business-as-usual scenario (IRR (suicidal reiteration) = 0.76 [0.71;0.81], p-value<0.00 001) (Broussouloux S., 2023^[7]). To obtain effectiveness results on self-harm across countries, IHME data was used (IHME, 2024^[29]). It is assumed that 38% of self-harm cases correspond to suicide attempts (Duarte et al., 2020^[27]).

To estimate the impact of the programme on labour market participation, it is assumed that a suicide attempt leads to approximately six months of absenteeism, based on data from Segar et al. (2024) on the average cost of suicide attempt and death by suicide in France, combined with the average annual gross salary in France (Segar et al., 2024^[28]).

The costs of self-harm and death included in the model are based on previous analyses (OECD, 2019^[30]).

Time to maximise effectiveness

Results from the study show, that the maximum impact on suicide reiteration reduction is observed at six months, with a maintained effect up to 12 months. Based on similar studies, the effect of the intervention is estimated to last up to three years, and then decrease linearly to reach baseline levels at five years (Lahoz, Hvid and Wang, 2016^[31]).

Target population

For Vigilans, the inclusion criteria are:

- Individuals who have been hospitalised following a suicide attempt.
- Individuals who have sought emergency services within a hospital following a suicide attempt.
- Individuals with over three suicide attempts are excluded from the programme.

The model assumption relies on IHME self-harm data. Not all people will self-harm have a suicide attempts. According to the literature, 38% of people with self-harm have a suicide attempt (Duarte et al., 2020^[27]).

Also, it is estimated that 61% (100%-39%) of them have one suicide attempt (Léon, Roscoät and Beck, 2023^[32]). Finally, all suicide attempts do not lead to hospitalisation. 58% of suicide attempts lead to hospital of which 89% were hospitalised at least one night (Léon, Roscoät and Beck, 2023^[32]). Therefore, in the model, 12% of people with self-harm were estimated to be eligible (target) to the programme ($38\% \times (1-39\%) \times 58\% \times 89\% = 12\%$).

Exposure

As described in the main text, the programme is estimated to cover 46% of the target population. In the model, it is estimated that the coverage is boosted by a third to reach 60% of the target (national coverage target for Vigilans).

Cost of implementation

Funding of the Vigilans programme is mainly provided by the regional health agencies (Agences Régionales de Santé) and ranged from EUR 165 000 to EUR 486 000 per region in 2018 (Broussouloux S., 2019^[1]). On average, over the six study regions, it is estimated that Vigilans costs EUR 235 per participant per year (Broussouloux S., 2023^[7]). Costs related to possible additional consultations with mental health professionals -beyond the support provided within the programme- are not included in the programme cost and assumed to be covered by the health system.

Notes

¹ Self-harm is defined as deliberate bodily damage inflicted on oneself resulting in death or injury (Institute for Health Metrics and Evaluation (IHME), 2021^[33]).

7 Belgian Mental Health Reform

This chapter covers the case study of the Belgian Mental Health reform. The case study includes an assessment of the Belgian Mental Health reform against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

Belgian Mental Health Reform: Case study overview

Description: The Belgian Mental Health Reform has led to a nationwide transformation in the provision of mental health care. Launched in 2009, it is divided into five action pillars that promote better and equitable access to mental health care and enhance organisation of mental health care services prioritising outpatient care. The reform has created over 30 multidisciplinary professional networks across the country for both children and adults. The reform provides both front-line and specialised psychological care tailored to the intensity of care required, ensuring the co-ordination of services across multiple sectors and improving outreach to the population groups. The Belgian reform is a best practice transferred to countries within the EU-funded Joint Action ImpleMENTAL to improve mental health in Europe.

Best practice assessment:

OECD best practice assessment of the Belgian Mental Health Reform

Criteria	Assessment
Effectiveness 	The reform is associated with a 10% decrease in overall mental health disorders. Patients' resilience has improved. Patients have nearly 40% less days of incapacity and over 30% less days of reduced functioning. Absenteeism is reduced, with days lost reduced by 60% after six months.
Efficiency	The budget for Belgium's front-line mental health care scheme is estimated at EUR 165 million per year (or EUR 1 122 per treated patient per year). The associated reduction in absenteeism is equivalent to economic savings of EUR 85.3 million per year.
Equity	The reimbursement of up to eight psychological sessions per year and outreach efforts improve access to mental health care for people of all socio-economic backgrounds. Despite improved access to mental health care, patients' resilience and days of reduced functioning have improved little among individuals with vulnerabilities
Evidence-base	An observational study was conducted on 2 750 patients to evaluate the effectiveness and efficiency of the front-line healthcare scheme. The overall study quality assessment was considered moderate, with a strong data collection method and moderate quality regarding patient retention, confounders and study design.
Extent of coverage 	The front-line mental health care scheme covers 147 000 patients per year, covering about 6% of people with mental health issues in the country.

Enhancement options: *To enhance effectiveness*, particular attention should be drawn to improving care referral and further developing collaboration between networks. *To enhance equity*, it is crucial to ensure an equitable distribution of the financial resources of the networks in line with the disparities and needs of the population. Furthermore, it is essential to understand the reasons for the lower impact on the most vulnerable groups and to prioritise these groups for additional assistance to improve their outcomes. *To enhance the evidence-base*, the evaluation of the reform can be improved by extending data collection and by including indicators on patient outcomes and experiences and educational and occupational outcomes where relevant. *To enhance coverage*, policies should be developed to further address geographical disparities to accessing mental health care, as well as to improve public communication on mental health care coverage. Finally, strategies that improve patient adherence to mental health care in the short and medium term would enhance the coverage and effectiveness of the front-line mental health care scheme.

Transferability: The reform is broadly transferable to other settings within OECD and European countries. For example, it is likely that such a mental health scheme will receive political support due to existing policies and programmes that integrate mental health in primary healthcare settings. However, some countries may face challenges regarding political priorities and the affordability of implementing the reform.

Conclusion: The Belgian Mental Health Reform has the potential to significantly reduce the incidence of mental health disorders and to improve outcomes related to work productivity.

Intervention description

The Belgian mental health reform encompasses a range of national policy changes resulting in structural transformations in the healthcare organisation to improve access to mental health care for the population. The reform was initiated in 2009 with the introduction of a new legislative framework governing hospitals and care institutions. This enabled a partial reallocation of the budget for hospital funding, ensuring the allocation of resources for the provision of mental health care.

The reform has introduced a global change in the healthcare provision model involving hospitals and community services. It enhances co-operation and intersectionality in healthcare to improve mental health care provision and quality. The new Belgian model aligns with an international vision of enabling more patient-centred and personalised care in mental health, through improved access and adaptability. It also enhances patient outreach with the objective of ensuring that patients remain within their personal and social surroundings, by establishing individualised and timely therapeutic pathways. The reform has facilitated the development of professional networks, based on multidisciplinary, intersectionality and on flexible intervention methods (Box 7.1). The reform is driven by the following principles:

- Deinstitutionalisation, in which outpatient care is prioritised over inpatient care;
- Intensification of healthcare programmes to reduce the length of hospital stays;
- Inclusion through an improvement of rehabilitative care and the reintegration of patients within society;
- Intersectionality based on co-operation involving different institutions and professionals beyond the medical sector; and
- Decategorisation of the previous system in creating circuits and networks between sectors.

Box 7.1. Mental health care networks and partnerships

The mental health networks have been established through collaboration with partners from various sectors, both within and outside the healthcare profession, in order to enhance access to mental health care and facilitate communication among professionals. The networks and partnerships are designed to implement community-oriented care and provide better guidance for patients seeking psychological care, while ensuring continuity of care. Front-line mental health practitioners (e.g. psychologists and educational therapists) often liaise with other psychologists, psychiatrists or general practitioners. Communication can also extend to professionals from other fields, including psychomotor therapists, physiotherapists, family planning centres, and more. Overall partnerships are continuously evolving, involving general healthcare services, vocational reintegration environments, youth support services, social services and the education sector, among others (Jansen et al., 2023^[1]). The allocation of resources in each network is determined by the healthcare needs of the population in the respective territories.

Since the start of the reform, 32 regional mental health networks have been established across Belgium. The networks are structured as follows: 20 are allocated for individuals aged 15 and over, 11 networks for children and adults under 24 years, and a subsequent network operates for both children and adults. The networks are working in collaboration to implement the reform.

The reform is structured around five strategic pillars, although this chapter focusses on the evaluation of the first pillar particularly. The **first pillar** aims to increase the prevention and promotion of mental health, including early detection, screening and diagnosis of mental health disorders, through better co-operation between medical centres, general practitioners, and other existing front-line care services (Jacob and Lucassen, 2011^[2]). This pillar involves the creation of a community-based **front-line mental health care scheme that is affordable, accessible and in proximity to all**. Key initiatives include policies such as the reimbursement of both low-threshold and specialised psychological care, covering up to eight and 20 psychological sessions per patient per year, respectively. Additionally, the previous requirement for a medical prescription (referral) to access mental health care has been removed, enabling direct and timely access to psychological care. However, patients can still be referred to a psychologist by their general practitioner. The reform has enhanced the effectiveness of referral, by streamlining clinical assessments to evaluate the patients' mental health condition, facilitating appropriate referral to either front-line or specialised mental health care based on the required intensity of care. The first pillar plays an important role in alleviating the burden on mental health care and psychiatric services. It mainly addresses **mild to moderate clinical issues** that reflect temporary situations, which are the most common among patients seeking mental health care (Jansen et al., 2023^[1]). These issues include, for instance, anxiety, depression, burnout, behavioural problems, grief, addictions, and relationship difficulties.

The **four remaining pillars** seek to improve (2) access to intensive outpatient care using mobile units, (3) rehabilitative care, (4) social inclusion and reintegration, and (5) residential treatment units for intensive and chronic care provision. These initiatives adopt a targeted approach to mental health care, addressing specific needs within the community. To support individuals with acute and chronic mental health conditions, mobile teams have been established to improve access to intensive outpatient care, as an alternative to hospitalisation, when feasible. For patients needing supervised intensive residential care, residential treatment units provide necessary support during emergencies or when patients require assistance and intensive supported housing. Additionally, programmes have been developed to support patients in their rehabilitation and reintegration into society, focussing on autonomy, social skills, and professional development. Lastly, the reform includes the development of residential care facilities, offering housing for dependent patients suffering from chronic psychiatric disorders who have limited autonomy and face challenges in social integration.

OECD Best Practices Framework assessment

This section analyses the Belgian Mental Health Reform against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 3.3 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 7.2. Assessment of the Belgian Mental Health Reform

Effectiveness

- The reform is associated with a 10% decrease in overall mental health disorders after six months.
- Patients' resilience scores have increased by 10% after six months. Days with incapacity have reduced by 40%, and days with reduced functioning by over 30%.
- Absenteeism from work was reduced by 60%. Days of absence were reduced from five to two days per month, after six months.
- Access to mental health care was facilitated with the reimbursement of up to eight psychological sessions per year and direct access to psychological care without prescription.

Efficiency

- The budget for Belgium's front-line mental health care scheme is estimated at EUR 165 million per year, equivalent to an average cost of EUR 1 122 per treated patient or EUR 14 per capita per year.
- Reduced absenteeism is associated with economic savings equivalent to EUR 85.3 million per year. Savings related to presenteeism are potentially higher than that of absenteeism.

Equity

- One in four adults benefiting from the front-line mental health care scheme belongs to a potentially socially vulnerable group.
- The introduction of the reimbursement of psychological consultations helps overcome the financial barrier to access to mental health care.
- Despite improved access to mental health care, patients' resilience and days of reduced functioning have improved little among socially vulnerable groups.

Evidence-base

- An observational study was conducted on 2 750 patients to evaluate the effectiveness and efficiency of the front-line healthcare scheme. The study had a "strong" data collection method and performed moderately in areas such as patient retention, confounders and study design. However, the overall quality of assessment was considered moderate.

Extent of coverage

- The front-line mental health care scheme covers around 147 000 patients per year, representing 1.3% of the entire population and 6% of individuals with mental health issues in the country.
- Adherence to psychological sessions decreases by a third after six months. Patients tend to dropout of psychological treatment: after completing the eight reimbursed sessions per year, only 10% to 40% of patients continue seeking mental health care.

Effectiveness

A study published in 2023 (EPCAP 2) presents an evaluation of the outcomes of 2 750 patients benefiting from the front-line or specialised mental health care scheme, which provides psychological support tailored to the required intensity of care (Jansen et al., 2023^[1]). Data collected include the patient's clinical profile and previous access to care, using a range of assessment tools (Box 7.3). Patient data were collected at three, six and 12 months following inclusion, although data at 12 months are not available at the time of writing this report (Jansen et al., 2023^[1]). The measured outcomes were related to clinical diagnosis of mental disorder, quality of life, work absenteeism and psychological resilience (which is defined as the capacity to respond to stress, personal competence, perseverance and adaptability).

Box 7.3. Data collection tools

Study participants were given a set of different standardised and valid questionnaires assessing mental health status, healthcare utilisation, well-being, and demographics.

Psychiatric disorders and mental health problems were measured with the Composite International Diagnostic Interview (CIDI-3.0), the WHO's World Mental Health survey and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Psychological crisis and suicidality were measured through the Crisis Triage Rating Scale (CTRS) and the Columbia Suicidal Severity Rating Scale respectively. The CIDI-3.0 questionnaire also assesses healthcare utilisation, measured by at least one contact with a healthcare professional for mental health in the previous year.

Quality of life and functional limitations associated with mental health were evaluated with the Sheehan Disability Scale and a shortened version of the WHO Disablement Assessment Scale. Well-being was self-assessed with the help of the OECD's Well-Being Core Set and the WHO-5 items. Patients' resilience was measured with the Connor-Davidson scale, which is based on factors such as capacity to adapt to difficult situations, reaction towards stress, personal efficacy and stability, and social support (Connor and Davidson, 2003^[3]). Patients' motivation for change was measured with the 12-item Readiness to Change Questionnaire (RCQ), comprising items on stages of change, such as precontemplation, contemplation and action.

Sociodemographic variables such as age, gender, work and living conditions, marital status, and educational level were collected as well, in a standardised manner.

Participants were divided into three age groups: youth (11-17 years), adults (18-64 years) and older people (65 years and over). Questionnaires were standardised for each age group. Patients aged 65 and over were presented with the same questionnaires as adults, along with two additional surveys addressing psychosocial well-being: the Severity of Dependence Scale (SDS) and the Loneliness scale.

Source: Jansen et al. (2023^[1]), "Eerstelijnspsychologische zorg in België - EPCAP-studie".

The Belgian mental health reform improves population mental health status, increases resilience, and reduces the number of days with incapacity and absence from work

Front-line mental health scheme is associated with a reduction of the prevalence of mental health disorders. The 2023 EPCAP study shows a nearly 10% reduction in the prevalence of mental health disorders among patients receiving front-line care after six months following the intervention, although a control group was not included (Jansen et al., 2023^[1]). The improvement rate varied by mental disorder

type, with major depressive episodes showing the greatest reduction. At three months, the rate was 68% lower, and at six months, it was 75% lower. Patients with mental health disorders that severely impact daily functioning, also saw significant improvement, with a 33% reduction of disorders at three months, and a 60% reduction at six months.

Results show that patient's resilience scores increased by 5% and 10%, at three and six months respectively. The average resilience score went from 4.2 (out of 8) points at the start of treatment, to 4.4 at three months and 4.6 at six months.

Belgium's front-line mental health care scheme is also associated with a decrease in the number of days with incapacity and with reduced functioning, and a reduction in absenteeism at work. The number of days with incapacity were reduced from eight days to five days per month, corresponding to a nearly 40% decrease at three months, and remained stable at six months. Similarly, the number of days with reduced functioning decreased from 12 days to 9 days per month after three months, and to 8 days after six months. Absenteeism from work significantly decreased from five days per month at the starting point, to two days per month after six months.

Belgium's mental health care scheme improves patients' access to mental health care. The EPCAP report notes that the reform has removed the financial barrier to access by reimbursing psychological sessions and allowing direct access without the requirement of a medical prescription (Jansen et al., 2023^[1]). Specifically, nearly 40% of patients benefiting from the new scheme indicated that they had previously refrained from seeking mental health care due to financial reasons when the consultations were not reimbursed. Besides, one in two patients benefiting from the new scheme, reported that the scheme served as their first point of contact with mental health care services. Patients also waited less time to seek psychological care, as the admission process has become faster and more fluid since the beginning of the reform.

The EPCAP report also underlines that overall, the reform has led to better co-operation between healthcare professionals and has improved social acceptance towards mental health care.

Efficiency

The total cost of the reform is estimated at EUR 342 million per year, with nearly half of this annual budget allocated to the front-line scheme (EUR 165 million, equivalent to EUR 1 122 per treated patient and EUR 14 per capita¹). Within the front-line scheme, over 50% of the budget is allocated to care for adults and around 30% to children and adolescents. The remaining 20% of the budget is allocated to the implementation of the front-line care, including training of professionals, communication strategies and scientific studies. The remaining budget is distributed to the other four pillars, as follows: EUR 45 million is allocated to mobile teams, over EUR 76 million to institutions and over EUR 65 million to cross-sector projects.

The reform is estimated to have a positive impact on costs in the labour market, with less absenteeism and higher productivity. The EPCAP report pointed out that among patients benefiting from the front-line mental health care scheme, 60% were professionally active, representing 90 000 individuals per year. The reform was associated with an average reduction of three days of absenteeism at six months, equivalent to economic savings of EUR 948 per treated patient. In total, absenteeism-related costs are estimated around EUR 85.3 million per year (Jansen et al., 2023^[1]). Savings related to presenteeism – that is reduced productivity while at work – are potentially higher than those due to absenteeism. A study found that the productivity losses due to NCD-related presenteeism tend to be two to three times higher than that due to absenteeism, in 12 OECD and G20 countries (Rasmussen, Sweeny and Sheehan, 2016^[4]).

Equity

Belgium’s front-line mental health care scheme effectively reaches vulnerable populations, facilitating access to healthcare. The EPCAP study shows that more than one in four adults benefiting from the scheme belong to a potentially socially vulnerable group. This includes single parents (10.5%), individuals with low socio-economic status (9.8%), patients with severe physical health problems (5.5%), non-nationals (5.0%), unemployed people (3.5%), young parents (0.6%) and patients aged 75 and over (0.4%). The main barriers to mental health care include cost and distance. Before the reform, financial barriers accounted for up to 40% of reasons reported by patients for delaying seeking mental health care (Jansen et al., 2023^[1]). The introduction of the reimbursement for psychological consultations helped overcome the financial barrier to access mental health care. Another barrier that the reform addresses, is about the distance to mental health facilities. The reform successfully improves physical or remote access to mental health care by developing teleconsultation services and outreach venues (locations close to patients) that improve proximity with patients. Home-based and remote sessions represent 25% of all sessions. The EPCAP study shows that around one in six sessions takes place in outreach venues, and this proportion increases to one in four sessions for patients facing vulnerabilities.

Despite improved access to mental health care, patients’ resilience and days of reduced functioning have improved little among individuals with vulnerabilities. Patients’ resilience scores (measuring the ability to respond to stress, personal competence, perseverance and adaptability) have remained relatively unchanged six months after enrolment in the scheme, for patients aged 75 and over, as well as those who are unemployed and those with low socio-economic status. Similarly, the number of days of reduced functioning remained high for patients with low socio-economic status and those with a long-term condition (Jansen et al., 2023^[1]).

Evidence-base

The evidence on the Belgian Mental Health reform is mainly collected from the observational EPCAP study, evaluating the effectiveness and efficiency of the reform through qualitative and quantitative methods (Jansen et al., 2023^[1]). The data were collected between 2020 and 2023, in 31 mental health care networks for both adults and children, including in total 2 750 patients receiving front-line care, and 483 healthcare professionals. This study relies on a before-after comparison, limiting the evaluation about the causal impact of the reform.

The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domain of “Data collection methods”, moderate in “Study Design” and “Confounders”, and weak in “Selection Bias” and “Withdrawals and Dropouts” (see the table below) (Effective Public Health Practice Project, 1998^[5]).

Table 7.1. Evidence base assessment, The Belgian Reform

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Yes
	What percentage of selected individuals agreed to participate?	Less than 60%
	<u>Selection bias score</u>	Weak
Study design	Indicate the study design	Observational study
	Was the study described as randomised?	No
	<u>Study design score</u>	Moderate
Confounders	Were there important differences between groups prior to the intervention?	Not applicable
	What percentage of potential confounders were controlled for?	Weighting

Assessment category	Question	Rating
<u>Confounder score</u>		Moderate
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Yes
<u>Blinding score</u>		Not applicable
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
<u>Data collection methods score</u>		Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	Less than 60%
<u>Withdrawals and dropout score</u>		Weak

Source: Effective Public Health Practice Project (1998), "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Jansen et al. (2023_[1]), "Eerstelijnspsychologische zorg in België - EPCAP-studie".

Extent of coverage

The reform's front-line mental health care scheme covers adults, as well as children and adolescents, experiencing mental health issues and in need of mental health care. It covers around 147 000 patients per year, representing 1.3% of the entire Belgian population in 2023. Providing that in 2019, 25% of the Belgian population experienced mild or moderate mental health issue (OECD analysis based on the European Health Interview Survey 2019, see Chapter 2), the reform covers around 6% of people in needs of mental health support. In 2023, nearly 850 000 psychological sessions were delivered to patients, corresponding to around six sessions per patient.

Adherence to treatment slightly decreases with time, with 8 in 10 patients adhering at three months and two in three patients adhering at six months following the start of treatment (Jansen et al., 2023_[1]). Once exceeding the limit of reimbursed sessions, only 10% to 40% of patients persist in attending mental health care sessions, demonstrating the importance of the reimbursement of sessions in fostering the continuity of mental health care.

Policy options to enhance performance

This section outlines policy options to enhance the performance of the Belgian Mental Health reform against the five best practice criteria.

Enhancing effectiveness

The Belgian Mental Health Reform aims to improve access to mental health care for the entire population by offering patients a healthcare scheme that provides affordable and easily accessible mental health services. Individual needs are assessed through streamlined diagnosis, followed by direct referral to front-line and specialised care for further treatment with a healthcare professional. Improvements can however be made to further enhance the effectiveness of the reform.

Improving diagnosis and patient pathway allocation by using tailored clinical tools and assessments. Challenges have been identified by healthcare professionals in areas of diagnosis and care attribution. Patients are not always referred to the most appropriate professional to meet their needs, depending on the intensity of their disorders. The effectiveness of the referral can be enhanced by using clinical instruments and questionnaires adapted to a variety of mental health disorders, to enable more accurate diagnosis. This would lead to improved allocation towards the suitable care pathway (either front-

line or specialised mental health care, type of therapy, etc) (Jansen et al., 2023^[1]). These clinical instruments should effectively assess patient needs and objectives, while also facilitating the comprehension on the clinical diagnosis.

Improving network collaboration for better quality of care. Findings from the EPCAP study indicate that enhancing organisation and coherence within networks can enhance the successful execution of the reform (Jansen et al., 2023^[1]). Ensuring clear criteria to evaluate practices (for diagnosis and therapy) within networks and ensuring their uniformity across regions is crucial. The performance of networks can be improved by carrying out regular assessments and establishing clear guidelines for network co-ordination. Moreover, strengthening existing network collaboration and fostering the exchange of best practices among co-ordinators and healthcare professionals can lead to better care quality and delivery.

Enhancing population mental health literacy for improving ability to seek care and adhere to prescribed therapies. Health literacy refers to “an individual’s knowledge, motivation and skills to access, understand, evaluate and apply health information” (Moreira, 2018^[6]). Individuals that are health literate will more likely seek mental health care and adhere to the medical recommendations they receive, thus improving the effectiveness of the reform.

Enhancing efficiency

Policies that boost effectiveness and coverage without significant increases in costs will have a positive impact on efficiency. For instance, enhancement options development under effectiveness and extend of coverage would help to increase efficiency.

Enhancing equity

Although the reform targets the whole community, vulnerable groups may experience greater barriers to access to mental health care. To maximise levels of healthcare utilisation, policymakers should consider the options listed below.

Ensure an equitable distribution of the financial resources of the networks in line with the disparities and needs of the population. The EPCAP study report emphasises the importance of integrating considerations for vulnerability and precariousness at regional and local levels (Jansen et al., 2023^[1]). The allocation of financial resources within the network should therefore consider the specific characteristics of communities, regions, and networks, in terms of vulnerabilities and inequalities, guided by the principle of solidarity.

Implementing strategies to increase affordability of psychological sessions in the long run. The Belgian reimbursement plan covers up to eight individual psychological sessions, or up to five group sessions, per year. The study shows that affordability represents a financial barrier in patients seeking mental health care and that half of patients do not continue treatment with their assigned healthcare professional beyond the reimbursed sessions. To enhance continuity of care and equitable access, it is essential to develop strategies to promote long-term affordability, particularly for patients with a lower socio-economic status.

Improving outreach efforts. Further development of field interventions and outreach efforts, notably by involving mobile ambulatory teams, is crucial for effectively reaching and assisting vulnerable populations. The study indicates that outreach efforts are more successful in delivering care to vulnerable patients compared to other populations (Jansen et al., 2023^[1]). It is recommended to conduct situational analyses and local needs assessments for optimising outreach activities. Furthermore, regional co-ordinators can better address challenges faced by specific priority groups (such as older people and non-native speakers) by collecting data on their healthcare utilisation and identifying barriers to mental health care access. Regional co-ordinators can tailor the healthcare scheme to align with local and cultural needs of

communities, and foster collaboration with community stakeholders to enhance outreach efforts towards priority groups.

Enhancing the evidence-base

To strengthen the evidence-base, it is important to collect data on mental health outcomes (by symptom severity) and to extend indicators to measure educational and occupational outcomes where relevant. Data on patient outcomes and experiences would help monitor trends in mental health care utilisation and the quality of care. It is also essential to analyse data over longer periods to provide insights into the long-term impact of the reform.

Enhancing extent of coverage

Coverage of the intervention can be enhanced by addressing the known barriers to seeking professional help for mental health issues.

Addressing geographical disparities in access to mental health care. Mental health care services should be provided remotely by using teleconsultation services and further developing mobile outreach efforts. This allows for individuals to access support and counselling when facing geographical or scheduling barriers. Moreover, it is crucial to promote e-interventions and psychological self-help programmes, as research shows that these serve as stepping stones to further treatment (Eilert et al., 2021^[7]). Finally, access can be improved through the continued development of partnerships with sectors such as healthcare institutions, social services, education and socio-professional reintegration sectors.

Increasing communication. Improving communication on access to mental health care can improve coverage at local levels. Effective communication campaigns can ensure that the information reaches individuals in need of mental health care and can therefore optimise coverage. Mental health awareness and information campaigns also play a role in destigmatizing mental health disorders, which remains a barrier to pursuing mental health care (Latha et al., 2020^[8]).

Introducing strategies to nudge patients towards adherence. Patient adherence to mental health consultations was reported as insufficient, with frequent absenteeism and high dropout rates (Jansen et al., 2023^[1]). About 18% of patients terminated their psychological follow-up before the end of the reimbursed sessions. To optimise patient adherence to consultations, it is advisable to implement strategies that encourage patients to actively participate in their mental health care journey. This could result in better patient outcomes and improve the programme's effectiveness. Strategies that previously showed to be effective, include appointment reminders and actively engaging patients in their treatment process by providing informative briefs explaining the programme, the fee system, and providing encouragement (Reda, Rowett and Makhoul, 2001^[9]).

Transferability

This section explores the transferability of the Belgian Mental Health Reform and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring the Belgian Mental Health Reform.

Previous transfers

The Belgian Mental Health reform is one of the two best practices identified and transferred to 14 European countries, as part of the 2022-2024 EU-funded Joint Action ImpleMENTAL (JA-ImpleMENTAL, n.d.^[10]). The Joint Action ImpleMENTAL supports countries in the implementation process, such as assessing the

situation and needs in the target countries, establishing local networks for mental health, sharing knowledge, setting achievable goals, fostering stakeholder engagement and advocacy, and building capacity for mental health care services.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of the Belgian mental health reform were identified (see Table 3.4). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 7.2. Indicators to assess the transferability of The Belgian Reform

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey (%) (Eurostat, 2022 ^[11])	The Mental Health Reform is more transferable to a population that already seeks mental health care.	↑ value= more transferable
<i>Sector specific context</i>		
Healthcare Access and Quality Index (IHME, 2017 ^[12])	The Mental Health Reform is more transferable in a context where access to mental health care is facilitated.	↑ value= more transferable
Psychologists per 1 000 population (OECD, 2021 ^[13])	The Mental Health Reform is more transferable to countries with a high number of practicing psychologists, allowing for easier access to psychological care.	↑ value= more transferable
Mental health that can be accessed directly, without referral (OECD, 2021 ^[13])	The Mental Health Reform is more transferable in countries where mental health services are accessible without previous referral.	“Yes”= more transferable
<i>Political context</i>		
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[14])	The reform seeks to integrate mental health care within primary healthcare settings. Therefore, the intervention is more transferable in countries that support mental health prevention and treatment in primary healthcare settings.	“Yes”= more transferable
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[15])	The implementation of front-line mental health care and psychological screening requires clinical practice guidelines, based on scientific consensus. Therefore, the intervention is more transferable in countries that have strategies or action plans to guide the implementation of mental health policies and programmes.	“Yes”= more transferable
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[16])	The reform places a strong emphasis on prevention, therefore, it is likely to be more successful in countries that allocate a higher proportion of health spending on prevention.	↑ value= more transferable
Primary healthcare expenditure as a percentage of GDP (OECD, 2024 ^[17])	The reform seeks to integrate mental health prevention within primary healthcare settings, therefore, it is likely to be more successful in countries that allocate a higher proportion of health spending to primary care.	↑ value= more transferable

Results

Results from the transferability assessment using publicly available data are summarised below (see Table 7.3 for results at the country level):

- In terms of access to mental health care, 9.5% of the Belgian population reported consulting mental health care or rehabilitative care professionals, compared to around 6% on average across OECD countries. Belgium performs well in the Healthcare Access and Quality Index, with a rate higher than the OECD average. More than two-thirds of OECD countries have a score over 80%.
- The analysis shows that the number of psychologists is higher in most countries compared to Belgium. As in Belgium, patients can access mental health care without the need of a referral in most OECD countries.
- Spending on prevention is typically higher in the studied countries than in Belgium (i.e. only 11 of the 43 countries analysed spent less on prevention than Belgium). Belgium's expenditure on primary healthcare aligns with the OECD average, which typically lies around 1.4% of the gross domestic product (GDP).
- A majority of countries have strategies or action plans to guide implementation of mental health policies and around 80% of them have policies or programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare – including Belgium.

Table 7.3. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates the Belgian Mental Health Reform is more suitable for transferral in that particular country.

	Self-reported consultations	Healthcare access and quality index	Psychologists per 1 000 population	Direct access without referral	Prevention spending (% GDP)	Primary healthcare spending (% GDP)	Policies for promotion, prevention and treatment in primary care	Strategy or action plan that guide policy implementation
Belgium	9.50	87.90	0.10	Yes	0.346	1.41	Yes	Yes
Australia	n/a	89.80	1.03	Yes	0.346	1.55	Yes	Yes
Austria	7.40	88.20	1.18	Yes	1.249	1.25	No	Yes
Bulgaria	1.50	71.40	n/a	n/a	n/a	1.12	No	Yes
Canada	n/a	87.60	0.49	Yes	0.682	1.34	n/a	No
Chile	n/a	76.00	n/a	n/a	0.312	n/a	Yes	Yes
Colombia	n/a	67.80	n/a	n/a	0.158	n/a	Yes	Yes
Costa Rica	n/a	72.90	n/a	n/a	0.059	1.12	Yes	Yes
Croatia	5.70	81.60	n/a	n/a	n/a	0.96	No	Yes
Cyprus	1.00	85.30	n/a	n/a	n/a	n/a	Yes	Yes
Czechia	3.90	84.80	0.03	Yes	0.771	1.12	Yes	n/a
Denmark	10.40	85.70	1.62	Yes	0.482	1.64	Yes	Yes
Estonia	8.10	81.40	0.06	Yes	0.624	1.39	Yes	Yes
Finland	9.20	89.60	1.09	n/a	0.482	1.56	Yes	Yes
France	7.20	87.90	0.49	n/a	0.676	1.54	Yes	Yes
Germany	10.90	86.40	0.50	n/a	0.834	1.62	Yes	No
Greece	4.10	87.00	0.09	Yes	0.37	n/a	No	Yes
Hungary	4.70	79.60	0.02	n/a	0.559	0.92	No	Yes
Iceland	12.60	93.60	1.37	Yes	0.284	1.37	Yes	Yes
Ireland	4.70	88.40	n/a	Yes	0.357	n/a	Yes	Yes
Israel	n/a	85.50	0.88	Yes	0.021	3.04	Yes	n/a
Italy	3.50	88.70	0.04	Yes	0.587	n/a	Yes	Yes
Japan	n/a	89.00	0.03	Yes	0.357	2.10	Yes	Yes
Korea	n/a	85.80	0.02	Yes	0.772	2.04	Yes	Yes
Latvia	4.30	77.70	0.67	Yes	0.464	2.05	Yes	Yes
Lithuania	6.00	76.60	0.16	Yes	0.435	1.43	Yes	Yes
Luxembourg	9.90	89.30	0.59	Yes	0.256	0.52	No	n/a
Malta	5.30	85.10	n/a	n/a	n/a	n/a	Yes	No

	Self-reported consultations	Healthcare access and quality index	Psychologists per 1 000 population	Direct access without referral	Prevention spending (% GDP)	Primary healthcare spending (% GDP)	Policies for promotion, prevention and treatment in primary care	Strategy or action plan that guide policy implementation
Mexico	n/a	62.60	n/a	n/a	0.179	0.98	Yes	Yes
Netherlands	9.80	89.50	0.94	Yes	0.582	1.02	No	n/a
New Zealand	n/a	86.20	0.86	Yes	n/a	n/a	Yes	Yes
Norway	7.00	90.50	1.40	Yes	0.268	1.11	Yes	Yes
Poland	4.10	79.60	0.16	Yes	0.135	1.11	Yes	Yes
Portugal	7.30	84.50	n/a	No	0.353	n/a	Yes	Yes
Romania	0.90	74.40	n/a	n/a	n/a	0.62	No	Yes
Slovak Republic	3.90	78.60	n/a	n/a	0.125	0.84	No	No
Slovenia	5.80	87.40	0.09	Yes	0.498	1.81	Yes	Yes
Spain	4.80	89.60	0.55	n/a	0.37	1.45	Yes	Yes
Sweden	11.20	90.50	0.99	n/a	0.554	1.35	Yes	Yes
Switzerland	n/a	91.80	0.26	Yes	0.333	0.92	Yes	Yes
Türkiye	6.30	76.20	0.03	Yes	n/a	n/a	Yes	Yes
United Kingdom	n/a	84.60	0.36	Yes	1.545	1.95	Yes	Yes
United States	n/a	81.30	0.30	n/a	0.838	n/a	Yes	Yes

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 3.4.

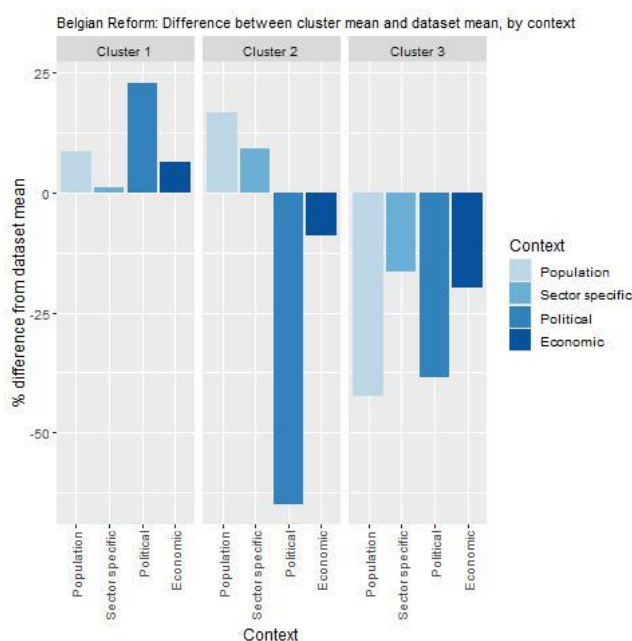
Source: Eurostat (2022^[11]), Self-reported consultation of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level, https://doi.org/10.2908/HLTH_EHIS_AM6E; IHME (2017^[12]), *Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990-2015*, <https://ghdx.healthdata.org/record/ihme-data/gbd-2015-healthcare-access-and-quality-index-1990-2015>; OECD/WHO Regional Office for Europe (2023^[14]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care; OECD/WHO Regional Office for Europe (2023^[15]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy; OECD (2024^[16]), OECD Data Explorer - Prevention spending as a percentage of GDP, <http://data-explorer.oecd.org/s/1nl> (accessed on 7 April 2024); OECD (2024^[17]), OECD Data Explorer - Primary health care expenditure as a percentage of GDP, <http://data-explorer.oecd.org/s/1nl> (accessed on 11 April 2025).

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 3.4. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 3.8 and Table 3.6:

- Countries in cluster one, including Belgium, have populational, sector specific, political, and economic arrangements in place to transfer the *Mental Health Reform*. Overall, these countries are less likely to experience issues associated with implementing the reform in their local context. This group includes 27 countries.
- Countries in cluster two have populational and sector specific arrangements to support the reform. Prior to transferring the practice, however, these countries may wish to consider ensuring that the implementation is affordable and that it aligns with political priorities. This group includes six countries.
- Countries in the remaining cluster may wish to undertake further analysis to ensure the programme is affordable, aligns with political priorities, and can be implemented within the existing healthcare infrastructures. This group includes six countries.

Figure 7.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 7.4. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia	Canada	Austria
Belgium	Czechia	Bulgaria
Costa Rica	Germany	Croatia
Denmark	Luxembourg	Greece
Estonia	Netherlands	Hungary
Finland	Slovak Republic	Romania
France		
Iceland		
Ireland		
Israel		
Italy		
Japan		
Korea		
Latvia		
Lithuania		
Mexico		
New Zealand		
Norway		
Poland		
Portugal		
Slovenia		
Spain		
Sweden		
Switzerland		
Türkiye		
United Kingdom		
United States		

Note: Due to high levels of missing data, the following countries were omitted from the analysis: Colombia, Chile, Cyprus, Malta.

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 3.5 outlines several new indicators policymakers could consider before transferring the Mental Health Reform.

Box 7.4. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of mental health literacy in the population?
- What are the main barriers to accessing mental health care?
- What percentage of the population is aware of the steps necessary to access mental health care services?
- What percentage of the population is satisfied with the mental health services provided to them?

Sector specific context

- What is the average delay to access mental health care?
- What is the rate of educational therapists per 100 000 inhabitants?
- How does access to mental health care differ regionally?

Political context

- Are there intersectoral partnerships aimed at improving access to mental health care?
- What type of mental health care is covered by the national medical insurance?

Economic context

- What is the spending on mental health prevention as a percentage of health expenditure?
- What fraction of total mental health expenditure constitutes out-of-pocket costs?

Conclusion and next steps

The Belgian Mental Health Reform is a mental health prevention programme targeting individuals with mild to severe mental health issues. The purpose of the reform is to improve access and quality of mental health care services in Belgium, in restructuring the care delivery system, developing outpatient care and establishing networks for intersectoral collaboration.

The reform has resulted in improvements in mental health outcomes and productivity. Among individuals who have received front-line and specialised care through the mental health reform, there has been notable progress in reducing the prevalence of mental health disorders and mitigating workforce impairment, linked to incapacity and absenteeism. Reduced absenteeism is then associated with economic savings.

The reform has improved access to mental health care. The front-line care scheme has effectively reached vulnerable groups and facilitated access to mental health care by addressing financial and geographical barriers. Improvements can however be made in long-term affordability strategies and initiatives that address regional needs to enhance outreach efforts.

The Belgian Mental Health reform is highly transferable in nearly 70% of OECD and EU countries with available data (27 out of 39 countries), and intermediately transferable to six countries. All countries have the opportunity to tailor mental health prevention strategies according to their specific needs, resources

and contexts. This also applies to certain countries that may encounter challenges related to political priorities and the affordability of implementing the reform.

Box 7.5 outlines next steps for policymakers and funding agencies.

Box 7.5. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance the Belgian Mental Health Reform are listed below:

- Consider policies that aim to improve affordability of mental health care in the long term.
- Establish efficient communication strategies, to raise awareness among the population about mental health care access.
- Improve the clinical guidelines for healthcare professionals, to facilitate diagnosis and patient care attribution.
- Continue collecting patient data on health outcomes, experience and healthcare utilisation, as well as healthcare provider feedback regarding experiences, perspectives and challenges encountered within the healthcare framework.

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Notes

¹ According to recent demographic data, Belgium’s population stands at 11 697 557 inhabitants on 1 January 2023. <https://statbel.fgov.be/en/themes/population/structure-population>.

8

SUPRA, Suicide Prevention Austria

This chapter covers the case study of Suicide Prevention Austria (SUPRA), a national strategy for suicide prevention in Austria. The case study includes an assessment of SUPRA against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

Suicide Prevention Austria (SUPRA): Case study overview

Description:

SUPRA is a national strategy for suicide prevention. SUPRA tackles multiple risk factors for suicide and introduces protective factors. This case study focusses on three key components of SUPRA: gatekeeper programmes (e.g. front-line workers trained to listen to people at risk of suicide and provide essential support), safeguarding hotspots for suicide attempts (e.g. bridges and railways), and reducing access to means of suicide (e.g. firearms and substances). SUPRA is a best practice transferred to countries within the EU-funded Joint Action ImMeNTAL to improve mental health in Europe.

Best practice assessment:

OECD best practice assessment of Suicide Prevention Austria

Criteria	Assessment
Effectiveness 	Currently there are no available data on the global effectiveness of SUPRA or on the effectiveness of its components in the Austrian setting. Broader research backs up the effectiveness measures included in SUPRA: • Gatekeeper programmes for suicide prevention have shown positive effects overall, but the quality of evidence is relatively low. • Safeguarding hotspots for suicide attempts is a highly effective measure for suicide prevention, reducing suicides by 93% compared to before the introduction of the intervention. • Interventions requiring safe storage for firearms and restricting access to lethal doses of medication are associated with a 13% and 22% reduction in suicide rates.
Efficiency	Currently there are no data on the cost-effectiveness of SUPRA or of its components. Broader research signals positive economic effects of some suicide prevention actions included in SUPRA: • Gatekeeper programmes are cost-saving in the United States. • Interventions safeguarding hotspots shows a return-on-investment of EUR 2.40 for every EUR 1 invested. • Interventions banning dangerous pesticides can prevent up to 28 000 suicides at a cost of EUR 0.006 per capita.
Equity	SUPRA has potential to improve health equity because it supports groups at higher risk of suicide which often encompass lower income, socially isolated, minority, and disadvantaged social groups.
Evidence-base	Data to assess the impacts and efficiency of SUPRA is not systematically collected. An analysis of other national suicide prevention strategies in Australia, Finland, Norway and Sweden, shows that they are effective at reducing overall suicide rates and suicide rates among specific age groups.
Extent of coverage 	SUPRA is tailored to cover the whole population, individuals with risk factors of increased likelihood of suicide, and people with suicidal behaviours which maximises the extent of population coverage.

Enhancement options: *To enhance its effectiveness*, SUPRA should integrate broader social policy addressing structural causes of psychological distress (e.g. social safety nets). *To enhance its evidence-base*, SUPRA should systematically collect data on the effectiveness, costs, and uptake of individual programme actions, and on intermediate outcomes, such as changes in awareness, attitude, stigma, and access to treatment. *To enhance equity impacts*, it is recommended to monitor the uptake of programme components by specific population groups (e.g. unemployed people, youth, and minority groups).

Transferability: A high-level transferability analysis using clustering suggests that 39 out of 42 EU/OECD countries considered would present many of the characteristics needed to ensure a successful transferability of SUPRA.

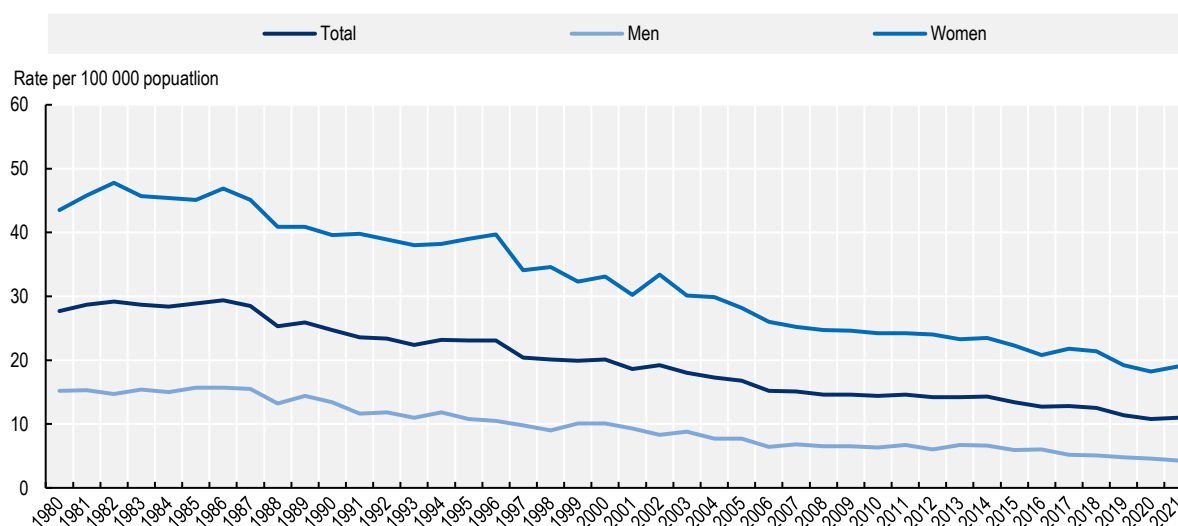
Conclusion: SUPRA presents a promising approach to articulate different dimensions of suicide prevention involving diverse stakeholders. Research suggests that most components of SUPRA are likely to be effective and efficient means to tackle suicide, yet SUPRA could benefit from a stronger monitoring and evaluation framework to measure its impacts with more accuracy.

Intervention description

Suicide Prevention Austria (SUPRA) -Suizidpräventionsprogramm- is a multilevel suicide prevention programme addressing several risk factors for suicide. SUPRA was first launched in 2012 as an initiative of the Austrian Ministry of Health to articulate existing suicide prevention actions at the national and sub-national levels, to introduce new actions, and to further improve their reach and effectiveness. SUPRA actions are multiple and can be independent from each other. They span across several areas, including co-ordination schemes between Austrian national and sub-national governments, enhanced access to mental health support and treatment, restricted access to means of suicide, mental health and suicide prevention literacy, media guidelines for communication on suicide, and inclusion of suicide prevention in other health promotion actions.

SUPRA seeks to further decrease the suicide rate in Austria. The suicide rate in Austria had been following a downwards trend since 1986, which stabilised during the 2008 crisis. Since then, the suicide rate has stagnated around 13 suicides¹ per 100 000 inhabitants in 2019, with a total of 1 113 people dying by suicide across the country in 2019 (Figure 8.1). Rates of suicide increase with age. Risk of suicide in the age groups 75 to 79, and 85 to 89, are twice and four times as high, respectively, as for the general population. More than a fourth of suicide victims in Austria are male, and suicide remains the most frequent cause of death for middle-aged people, and the second most frequent in the age group 15 to 29 years old (BMSGPK, 2019^[1]). Currently, there are no reliable data on suicide attempts given that many cases are not documented or do not result in contact with the healthcare services. Since 2022, Austria includes assisted suicide in its suicide statistics, which limits comparison over time (BMSGPK, 2023^[2]).

Figure 8.1. Suicide rates in Austria have been declining since the 1980s but stabilised since 2008



Source: OECD Health Statistics, 2024, <http://dx.doi.org/10.1787/health-data-en>.

SUPRA's most noteworthy innovation is its co-ordination strategy, integrating evidence-based suicide prevention actions under a detailed implementation framework. SUPRA first outlined a "starting package" of priority actions for suicide prevention that were already in place or that could be implemented easily in the short term (e.g. over the next two years). These included, among others, setting up a national co-ordination centre for suicide prevention, integrating a network of phone-based and online-based support and information services such as websites and hotlines. In 2019, a full starting package and longer-term implementation concept linking 70 actions to 18 operative goals and 6 strategic goals for suicide

prevention was presented to further support the implementation of SUPRA across the entire country (Grabenhofer-Eggerth et al., 2022^[3]). Between 20% to 30% of the actions foreseen in SUPRA's starting package have been implemented in Austria by June 2023.

SUPRA has six strategic goals, including multiple actions (Table 8.1). The strategic goals serve as the overarching framework guiding targeted operational goals and specific actions. For example, the strategic goal of “Coordination and organisation” is supported by the operational goal of “embedding suicide prevention into national and sub-national structures”, exemplified by the establishment of the SUPRA federal co-ordination centre. Similarly, the strategic goal of “Support and treatment” is operationalised through the implementation of a “Train-the-trainer” gatekeeper program, expanding the availability of frontline support. Each operational goal is directly tied to actionable measures, such as safeguarding suicide hotspots to restrict access to means, awarding the Papageno media prize to raise awareness, and integrating suicide prevention into school-based programmes to align with broader health promotion efforts. Together, these interconnected goals and actions ensure a cohesive and evidence-based approach to reducing suicidality.

Table 8.1. SUPRA's starting package for suicide prevention proposes a wide range of measures

Strategic goals	Selected operational goals	Selected actions	Description
Coordination and organisation	Suicide prevention in Austria is organisationally embedded and co-ordinated	Create the SUPRA federal co-ordination centre	The SUPRA federal co-ordination centre established in 2 012 continues to orientate national and sub-national efforts in suicide prevention.
Support and treatment	People at risk of suicide receive appropriate support and treatment	Implement the “Train-the-trainer” gatekeeper programme.	A programme to train instructors who in turn educate Gatekeepers for suicide prevention. The goal is to increase the availability of front-line support for people at risk of suicide.
Restriction of access to means of suicide	Suicide means are as difficult as possible to reach	Extend and create standards on weapons security; safeguard hotspots for suicide attempts.	Provide comment and feedback on regulatory initiatives that modify the accessibility of means of suicide and suicide hotspots.
Awareness and knowledge	The general population is knowledgeable and aware of suicidality	Award journalists with Papageno media prize	A prize for journalistic content that contributes to create awareness around suicide and prevent copycat suicides.
Embedment in prevention and health promotion activities	Suicide as a topic is integrated into health promotion, addiction, and violence prevention measures	Integrate suicide prevention modules into school-based violence and substance use prevention programmes	Seizing the opportunity to cover suicide as an issue in ongoing programmes tailored to children and adolescents.
Quality assurance and expertise	Suicide prevention is quality-assured on the basis of scientific expertise.	Set up and maintenance of a suicide database integrating best practices for suicidality surveillance.	Improve the quality of data available on suicidality to better measure the impact of SUPRA measures.

Note: This table does not comprise all the operative goals and actions included within SUPRA. SUPRA's handbooks offers a full account.

Source: Grabenhofer-Eggerth et al., (2022^[3]), SUPRA Handbook; an experience-based document for implementing a national suicide prevention programme.

SUPRA measures are classified as universal, selective, and indicated prevention, depending on the public they are addressed to. Universal health promotion targets the whole population or community; selective prevention is focussed on groups at higher risk of suicide, such as youth, LGBTQI+ individuals, and people in precarious living situations; and indicated prevention is tailored to those having shown suicidal behaviours. Table 8.2 describes them in detail.

Table 8.2. Suicide prevention strategies target the whole population, individuals at risk, or people having showed signs of suicidal behaviour

Type of prevention	Aim	Examples
Universal prevention	Aimed at the general population to raise awareness, reduce stigma, and promote mental health and well-being.	Public education campaigns, promoting responsible media reporting on suicide, enhancing access to mental health services, and implementing policies to reduce access to means of suicide (such as restricting access to lethal means).
Selective prevention	Aimed at individuals or groups with risk factors or vulnerabilities that increase their likelihood of suicidal behaviour.	Programmes targeted at youth, LGBTQ+ individuals, Indigenous communities, individuals with substance abuse disorders, individuals with a history of self-harm, etc. These programmes may involve early identification and intervention, community-based support services, and mental health promotion activities tailored to the specific needs of these groups.
Indicated prevention	Aimed at individuals who have already shown signs of suicidal behaviour or are experiencing significant distress.	Suicide risk assessment and management in healthcare settings, crisis intervention services (such as hotlines and crisis centres), psychotherapy, pharmacotherapy, and intensive follow-up care for individuals discharged from psychiatric facilities after a suicide attempt.

Source: WHO, (2021^[4]) *LIVE LIFE: an implementation guide for suicide prevention in countries*. <https://www.who.int/publications/i/item/9789240026629>

How SUPRA contributes to suicide prevention

Suicide occurs in a complex social and psychological context. No single factor can be signaled as a main determinant of suicidal behaviour, but it is acknowledged that people undergoing major personal crises such as losing close relationships or jobs, enduring long-lasting suffering, abuse, or pain, and in general being subject to high levels of deprivation, disadvantage, and negative life events are at increased risk of suicide (Kabir, Wayland and Maple, 2023^[5]). This entails that suicide prevention strategies and programmes should encompass the wide contexts in which people live – including workplace, education and leisure – rather than focussing exclusively on the clinical aspects of mental health (O'Connor et al., 2023^[6]).

This case study focusses on three components of SUPRA: gatekeeper programmes, restricting access to means of suicide and safeguarding of hotspots for suicide attempts, which are evidence-based suicide prevention programmes. The following sections briefly describe these interventions and explain how they have been implemented within the framework of SUPRA.

Gatekeeper programmes for suicide prevention

Gatekeepers for suicide prevention are individuals who provide front-line support to individuals at risk of suicide, delivering or arranging essential suicide prevention interventions. The Gatekeepers are often front-line workers more likely to interact with individuals at risk of suicide due to their professional or social activities, such as labour market service employees, teachers, police, doctors, or volunteers. Gatekeepers are trained to show willingness to listen to people at risk of suicide, demonstrate that they understand their distress, and offer support around suicidality. Didactic methods include role-play, case-discussion, group-reflection and discussion, and presentation of slides (Plöderl et al., 2023^[7]). SUPRA's working group seeks to train as many Gatekeepers as possible. Gatekeepers must be trained by a certified Gatekeeper instructor, who received specialised education through a tailored “train-the-trainer” educational programme. The training concept was developed by a working group of the Austrian Society for Suicide Prevention (Österreichischen Gesellschaft für Suizidprävention) in co-operation with SUPRA under the leadership of qualified health professionals (BMSGPK, 2019^[11]).

Restricting access to means of suicide (e.g. firearms, lethal substances)

SUPRA proposes a variety of approaches to reduce access to objects and substances that might be used to attempt and commit suicide. The most frequent means of suicide in Austria in 2023 were hanging (42%), firearms (18%) and poisoning (13%). Changes in weapons legislation and standards for accessing potentially lethal substances (such as pesticides) can reduce the availability of suicide means and reduce the overall opportunities for committing or attempting suicide. For instance, the Austrian weapons law of 2018 introduces a mandatory psychological assessment for people intending to buy firearms (BMSGPK, 2019^[1]; ÖGS, 2018^[8]).

Safeguarding hotspots for suicide

Bridges, highways, railway lines, metro platforms and other physical places are often used to commit suicide and suicidal attempts. These places are secured by installing physical barriers that eliminate or reduce the likelihood of people accessing climbing over, therefore reducing the opportunities to commit or attempt suicide. Since 2016, the Institute for Suicide Prevention Graz, in collaboration with the Austrian Motorway and Expressway Financing Corporation (ASFINAG), has initiated a project to enhance the safety of hotspot bridges. All bridges within the ASFINAG network, identified by the Austrian Federal Ministry of the Interior (BMI), have been evaluated by the respective motorway authorities. Six of these bridges have been classified as hotspots according to the Swiss model (Bundesamt für Strassen-ASTRA), accounting for factors such as frequency of suicidal events and the accessibility and visibility of the place. Two of these hotspots have already undergone structural modifications such as the elevation of railings and the safeguarding of bridgeheads. Additionally, some bridges have been equipped with information boards displaying a telephone counselling number. ASFINAG employees have also received suicide prevention training. The long-term plan is to implement this programme across Austria (BMSGPK, 2019^[1]).

OECD Best Practices Framework assessment

This section analyses SUPRA against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 8.1 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 8.1. Assessment of SUPRA

Effectiveness

- Currently there are no available data on the global effectiveness of SUPRA or on the effectiveness of its components in the Austrian setting. Broader research backs up the effectiveness measures included in SUPRA:
- Gatekeeper programmes for suicide prevention have shown positive effects overall, but the quality of evidence is relatively low.
- Safeguarding hotspots for suicide attempts is a highly effective measure for suicide prevention, reducing suicides by about 93% compared to before the introduction of the intervention.
- Interventions requiring safe storage for firearms and restricting access to lethal doses of medication are associated with a 13% and 22% reduction in suicides.

Efficiency

- Currently there are no data on the cost-effectiveness of SUPRA or of its individual components. Broader research signals positive economic effects of specific suicide prevention measures:
- Gatekeeper programmes are cost-saving in the United States.
- Interventions to make suicide hotspots safer show a return-on-investment of EUR 2.40 for every EUR 1 invested.
- Interventions banning dangerous pesticides can prevent up to 28 000 suicides at a cost of EUR 0.006 capita.

Equity

- SUPRA has potential to improve health equity because it supports groups at higher risk of suicide which often encompass lower income, socially isolated, and unfairly disadvantaged social groups.

Evidence-base

- Data to assess the impacts and efficiency of SUPRA is not systematically gathered. An analysis of other national suicide prevention strategies in Australia, Finland, Norway and Sweden, show that they are effective at reducing overall suicide rates and suicide rates among specific age groups.

Extent of coverage

- The multilevel nature of SUPRA encompassing universal, selective, and indicated prevention makes it particularly suitable to tackle health and social inequalities around suicide.

Effectiveness

Three SUPRA components are examined herein, based on their promising effectiveness. This section presents a summary of the research around the effectiveness of gatekeeper programmes, programmes to secure hotspots for suicide, and programmes restricting access to means of suicide. As evidence of effectiveness is not available in Austria, the evidence is collected from other settings.

Gatekeeper programme

Gatekeeper programmes improve people's knowledge, skills, and confidence in helping individuals at risk of suicide, although there is no evidence for a causal link with reduced suicide rate. Gatekeeper programmes offer training to identify people at risk of suicide and refer them to appropriate services (Hawgood et al., 2022^[9]). Evidence of the causal link between gatekeeper programmes and reduced suicide rates is modest. Some systematic reviews have found overall positive effect on relevant suicidal behaviours. However, the quality of evidence is either low or unclear and demands careful interpretation. A quantitative summary was not calculated given the heterogeneity between the measured outcomes (Yonemoto et al., 2019^[10]).

Safeguarding hotspots for suicide attempts

Safeguarding hotspots is very effective at reducing suicide rates. Safeguarding hotspots for suicide attempts includes installing fences and safety nets, among others. These measures are implemented in places that have been previously used to commit suicide, such as highways, buildings, and bridges. The interventions either prevent people from climbing over or protect them from falls. A systematic review on interventions to reduce suicides at hotspots suggests that physically safeguarding hotspots is associated with a reduction in the incidence rate of suicides by approximately 93% (incidence rate ratio 0.07, 95% CI 0.02-0.19; $p < 0.001$) – 14 times lower than the incidence rate before the intervention- (Pirkis et al., 2015^[11]). A national survey in Switzerland compared the effectiveness of suicide prevention measures implemented on bridges and other high structures. Comparing scenarios before and after the intervention, the study found that both barriers and safety nets were effective, with a mean suicide reduction of 68.7% for barriers and 77.1% for safety nets (Hemmer, Meier and Reisch, 2017^[12]). There is relatively strong evidence that safeguarding hotspots averts suicide without substitution effects (Pirkis et al., 2015^[11]; Cox et al., 2013^[13]).

Restricting access to means of suicide

Restricting access to firearms and potentially lethal substances prevents suicide. Making the means of suicide less deadly or less available, reduce fatal attempts and help reduce suicide rates (Barber and Miller, 2014^[14]). A study from the United States, where gun ownership is highly prevalent, shows that policies requiring safe storage of firearms are associated with a 13.1% (95% Confidence interval: 2.7%-22.3%) reduction in adolescent firearm suicide (Kivisto et al., 2021^[15]). Similarly, restricting access to lethal doses of medication (e.g. analgesics) was associated with a 22% reduction in suicides compared to rates before restriction policies were introduced (Hawton et al., 2004^[16]). Decreasing the lethality of means available is of special relevance, considering that 90% of people who attempt suicide do not die in the attempt (Owens, Horrocks and House, 2002^[17]). Restricting access to means of suicide works by delaying attempts – increasing the likelihood that the triggering events will pass – and substituting means for less lethal ones allows people to receive help and support (Barber and Miller, 2014^[14]).

Efficiency

Data on the global costs of SUPRA are not readily available. SUPRA components are delivered by different national and sub-national stakeholders, and there are no readily available data on the global costs of SUPRA. However, there is some evidence on the cost-effectiveness of selected components of SUPRA. Evaluations of interventions containing a gatekeeper programme demonstrated to be cost-saving in the United States (Le et al., 2021^[18]). Interventions to install barriers at multiple bridge sites across Australia were cost-saving with a return of USD 2.40 for every USD 1 (EUR 2.40 for every EUR 1) invested over 10 years (Bandara et al., 2022^[19]). A modelling study estimated that banning highly hazardous pesticides across 14 studied countries could result in about 28 000 fewer suicide deaths each year at an annual cost

of USD 0.007 (EUR 0.006) per capita (Lee et al., 2021^[20]). The cost-effectiveness of multicomponent suicide prevention strategies such as SUPRA have been evaluated in other settings. In a Canadian study, the incremental cost-effectiveness rate associated with the implementation of suicide prevention programmes reached on average CAD 3 979 (EUR 2 806) per life year saved (Vasiliadis, Lesage and Seguin, 2015^[21]).

Equity

To date, there are no data on the equity impacts of SUPRA. Suicidality impacts men and women in noticeably different ways. While women are more likely to attempt suicide than men, death by suicide is more frequent among men, probably because of their likelihood to choose more deadly means (Sher, 2021^[22]). Additional sources also signal that suicide is more likely among ethnic and racial minorities, and lower socio-economic groups (World Health Organization, 2014^[23]). SUPRA is tailored to cover both the whole population, individuals with risk factors of increased likelihood of suicide behaviour, or people with suicidal behaviour. Its actions focus on universal, selective, and indicated prevention according to the risk of suicidality of individuals. Tailored prevention is likely to reduce health inequalities among social groups.

Evidence-base

SUPRA relies on evidence-based interventions but it does not systematically assess their effectiveness in the Austrian context. National programmes for suicide prevention were evaluated in other settings. A research article investigating the effectiveness of national suicide prevention programmes in Australia, Finland, Norway and Sweden, shows a reduction in suicide rates post-implementation, particularly among men aged 25-64 and women aged 45-64. However, the authors highlight important limitations of the study, including not being able to isolate the effects of individual components of the programmes and the lack of control for confounding variables such as access to healthcare, economic conditions, or social change which might affect suicide rates (Lewitzka et al., 2019^[24]).

Extent of coverage

SUPRA actions are rolled out at the national and sub-national level. They intend to cover the whole Austrian population, while more tailored actions target individuals with risk factors of increased likelihood of suicide, and people with suicidal behaviour. However, to date there are no specific data on the level of implementation of the different measures and thus the share of the population effectively covered by SUPRA actions is unclear.

Policy options to enhance performance

Recommendations to improve SUPRA's performance across OECD's Best Practice Assessment Framework would demand a sounder monitoring and evaluation framework for SUPRA, encompassing data on the effectiveness, costs, coverage, and uptake of individual components of the programme. Additionally, data about intermediate outcomes relevant to suicide prevention, such as changes in awareness, attitude, stigma, broader mental health and well-being, and access to treatment could provide a more nuanced picture of the impacts of SUPRA. This considered, the following recommendations broadly apply to national suicide prevention strategies, and some dimensions relate specifically to SUPRA.

Enhancing effectiveness

SUPRA can enhance its effectiveness by tackling the social determinants of psychological distress and improving individual coping and social-emotional skills. Social and economic crises often lead to increased

suicide rates (Chang et al., 2013^[25]). To prevent suicide, it is important to have sound social security systems in place that can mitigate the impact of negative life events on people's psychological distress (e.g. social safety nets). Moreover, providing education and social-emotional skills to help individuals cope with life's challenges in a positive and constructive manner is shown to improve overall mental health and is likely to have a positive impact on reducing suicide rates.

Enhancing equity

SUPRA can enhance equity impacts by disaggregating data by different population groups. SUPRA's structure is well-suited to tackle health inequalities around suicide. To enhance SUPRA's equity impacts, it would be essential to monitor the SUPRA actions by breaking down the data by different population groups. Groups of interest are those at higher risk of suicidal ideation, including individuals undergoing life crises (such as losing a family member, their job, or becoming displaced), youth, minority groups such as LGBTQI+, and indigenous communities, individuals in precarious living situations and lower income groups.

Enhancing the evidence-base

SUPRA can enhance its evidence-base by systematically collecting and monitoring key outcome measures. Currently SUPRA does not systematically collect data on its individual components, such as cost, effectiveness, uptake and coverage. Collecting these data, within the framework of an appropriate monitoring and evaluation framework, would contribute to consolidate the evidence for the effectiveness of SUPRA and pin-point areas for potential improvement. Monitoring intermediate outcomes would also be relevant. Some research suggests that including intermediate outcomes such as changes in awareness, attitude, stigma, and access to treatment, might provide a more nuanced picture of the impacts of suicide prevention programmes (Arensman et al., 2010^[26]).

Enhancing extent of coverage

SUPRA intends to be an encompassing strategy for suicide prevention covering the entire population with actions targeting individuals, families, communities, and sub-groups with different risk profiles. Carefully monitoring the levels of uptake of SUPRA actions at the national and sub-national level can provide a clearer picture of its current reach and serve to enhance its extent of coverage.

Transferability

This section explores the transferability of SUPRA. It is divided into three sub-sections: 1) notes on current efforts for transferring SUPRA to other settings; 2) transferability assessment using publicly available data, and; 3) considerations for policymakers interested in introducing a national suicide prevention strategy similar to the one presented in this case study.

Previous transfers

SUPRA has been identified as a best practice model for suicide prevention in Europe. SUPRA is being disseminated to other countries as part of the European Union Joint Action ImpleMENTAL, aimed at implementing mental health best practices across member countries. Austria has produced a Handbook (Grabenhofer-Eggerth et al., 2022^[3]) to guide countries interested in integrating components of SUPRA in their own national suicide prevention strategies. By March 2024, 17 European countries initiated pilots of SUPRA in their national setting, as part of collaborative work of Joint Action ImpleMENTAL for Suicide Prevention (JA-ImpleMENTAL, 2023^[27]). Measures chosen under the six strategic areas have been

prioritised based on the country needs. A total of over 140 measures were implemented across the countries participating in the project.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by an analysis of the results.

Methodological framework

Table 8.3 presents a selection of high-level indicators to assess the transferability of SUPRA to other OECD and non-OECD European countries. Variables were selected considering data availability and content relevance. Jurisdictions considering the transfer of SUPRA should carefully consider their local context, needs, and resources.

Table 8.3. Indicators to assess the transferability of SUPRA

Indicator	Description	Interpretation
Population context		
Self-reported consultations – proportion of people having consulted a psychologist, psychotherapist or psychiatrist during the 12 months prior to the survey) (Eurostat, 2022 ^[28])	SUPRA is more transferable to a context where mental health services are more accessible. Therefore, the intervention is more transferable in countries where people consult mental health professionals.	↑ value = more transferable
Sector specific context		
Healthcare Access and Quality Index (IHME, 2017 ^[29])	SUPRA is more transferable in a context where access to mental health care is facilitated and where the unmet need for mental health care is lower.	↑ value = more transferable
Political context		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[30])	SUPRA is more transferable in a context where mental health is explicitly included within the policy agenda.	“Yes” = more transferable
Policies and programmes to improve mental health awareness and literacy (OECD/WHO Regional Office for Europe, 2023 ^[31])	Raising awareness about suicidality is a component of SUPRA. Jurisdictions having already a policy on mental health awareness and literacy might be more receptive of the SUPRA model.	“Yes” = more transferable
Policies and programmes to support mental health in educational settings (OECD/WHO Regional Office for Europe, 2023 ^[32])	SUPRA integrates suicide prevention into existing school-based programmes around substance use and mental health. Jurisdictions already implementing such programmes could more easily follow a similar approach.	“Yes” = more transferable
Policies and programmes that support suicide prevention (OECD/WHO Regional Office for Europe, 2023 ^[33])	SUPRA aims to prevent suicide attempts. Therefore, the intervention is more transferable in countries that have policies and programmes that support suicide prevention.	“Yes” = more transferable
Economic context		
Prevention spending as a share of current health expenditure (OECD, 2022 ^[34])	Jurisdictions allocating a higher share of their resources to health promotion and prevention are more likely to successfully adopt a programme like SUPRA.	↑ value = more transferable

Results

Main results from the transferability assessment are summarised below:

- In Austria, a higher share of adults reported having consulted a mental health or rehabilitative professional, compared to potential transfer countries – 7% compared to 5.9% in the median in OECD and EU countries.
- A higher healthcare access and quality index is correlated with higher accessibility of mental health services. The index for Austria is higher than the median across OECD and EU countries

(88.2 versus 85.8), suggesting that countries with a higher index have a more favourable sector-specific context to implement SUPRA.

- c) As in Austria, a vast majority (90%) of countries have strategy or action plan that guide implementation of the mental health policy. This result suggests that SUPRA would likely receive political support among most potential transfer countries.
- d) Mental health awareness and literacy policies are in place in 88% of countries, including Austria. Increasing awareness around mental health issues and suicide are goals of SUPRA actions, therefore policy supporting these objectives enhances the transferability of SUPRA.
- e) As in Austria, a large proportion (90%) of countries reported having policies to support mental health in educational settings. As SUPRA integrates suicide prevention into existing school-based health promotion programmes, this result suggests that SUPRA would likely receive political support among most potential transfer countries.
- f) As in Austria, a vast majority (93%) of countries have suicide prevention policies in place. This provides further evidence of SUPRA's transferability, given it aligns with national strategy in most countries.
- g) Austria spends a higher proportion of current health expenditure on preventive care, compared to other countries (10% vs. 4.42% for the median in OECD and EU countries). Countries with higher spending would likely have economic support for the transfer of SUPRA.

Table 8.4. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates SUPRA is more suitable for transferral in that particular country.

Country	Self-reported consultations	Healthcare access and quality index	Policies supporting suicide prevention	Strategy or action plan that guide implementation	Policies for improving awareness and literacy	Policies supporting mental health in educational settings	Prevention spending (% health expenditure)
Austria	7.4	88.2	Yes	Yes	Yes	Yes	10.3
Australia	n/a	89.8	Yes	Yes	Yes	Yes	3.2
Belgium	9.5	87.9	Yes	Yes	Yes	Yes	3.1
Bulgaria	1.5	71.4	Yes	Yes	No	No	3.2
Canada	n/a	87.6	Yes	No	Yes	Yes	6.1
Chile	n/a	76.0	Yes	Yes	Yes	Yes	3.4
Colombia	n/a	67.8	Yes	Yes	Yes	Yes	2.1
Costa Rica	n/a	72.9	Yes	Yes	Yes	No	0.8
Croatia	5.7	81.6	n/a	Yes	Yes	Yes	4.4
Cyprus	1.0	85.3	Yes	Yes	Yes	Yes	2.2
Czechia	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Denmark	10.4	85.7	Yes	Yes	Yes	Yes	5.1
Estonia	8.1	81.4	Yes	Yes	Yes	Yes	8.3
Finland	9.2	89.6	Yes	Yes	Yes	Yes	4.7
France	7.2	87.9	Yes	Yes	Yes	Yes	5.5
Germany	10.9	86.4	Yes	No	Yes	Yes	6.4
Greece	4.1	87.0	No	Yes	No	Yes	4.0
Hungary	4.7	79.6	Yes	Yes	Yes	Yes	7.6
Iceland	12.6	93.6	Yes	Yes	Yes	Yes	3.3
Ireland	4.7	88.4	Yes	Yes	Yes	Yes	5.9
Israel	n/a	85.5	Yes	n/a	Yes	Yes	0.3
Italy	3.5	88.7	No	Yes	No	No	6.5
Japan	n/a	89.0	Yes	Yes	Yes	Yes	3.2
Korea	n/a	85.8	Yes	Yes	Yes	Yes	7.9
Latvia	4.3	77.7	Yes	Yes	Yes	Yes	5.1
Lithuania	6.0	76.6	Yes	Yes	Yes	Yes	5.6
Luxembourg	9.9	89.3	Yes	n/a	Yes	Yes	4.7
Malta	5.3	85.1	Yes	No	Yes	Yes	1.5
Mexico	n/a	62.6	Yes	Yes	Yes	Yes	2.9
Netherlands	9.8	89.5	Yes	n/a	Yes	Yes	9.6
New Zealand	n/a	86.2	Yes	Yes	Yes	Yes	n/a
Norway	7.0	90.5	Yes	Yes	Yes	Yes	2.7
Poland	4.1	79.6	Yes	Yes	Yes	n/a	2.1
Portugal	7.3	84.5	Yes	Yes	Yes	n/a	3.2
Romania	0.9	74.4	No	Yes	No	No	3.7
Slovak Republic	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Slovenia	5.8	87.4	Yes	Yes	Yes	Yes	5.3
Spain	4.8	89.6	Yes	Yes	Yes	Yes	3.4
Sweden	11.2	90.5	Yes	Yes	Yes	Yes	4.9
Switzerland	n/a	91.8	Yes	Yes	Yes	Yes	2.8
Türkiye	6.3	76.2	Yes	Yes	Yes	Yes	n/a
United Kingdom	n/a	84.6	Yes	Yes	Yes	Yes	12.5
United States	n/a	81.3	Yes	Yes	Yes	Yes	4.8

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 8.3.

Source: IHME (2017^[29]), *Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990–2015*, <https://ghdx.healthdata.org/record/ihme-data/gbd-2015-healthcare-access-and-quality-index-1990-2015> (accessed on 7 April 2024); Eurostat (2022^[28]), *Self-reported consultations of mental healthcare or rehabilitative care professionals by sex, age and educational attainment level*, https://doi.org/10.2908/HLTH_EHIS_AM6E (accessed on 7 April 2024); OECD/WHO Regional Office for Europe (2023^[30]), *Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy*; *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to improve mental health awareness and literacy*; OECD/WHO Regional Office for Europe (2023^[32]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support mental health in educational settings*; OECD/WHO Regional Office for Europe (2023^[31]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes that support suicide prevention*; OECD (2022^[34]), *OECD Data Explorer - Prevention spending as a percentage of current health expenditure*, <http://data-explorer.oecd.org/s/1nl> (accessed on 11 April 2025).

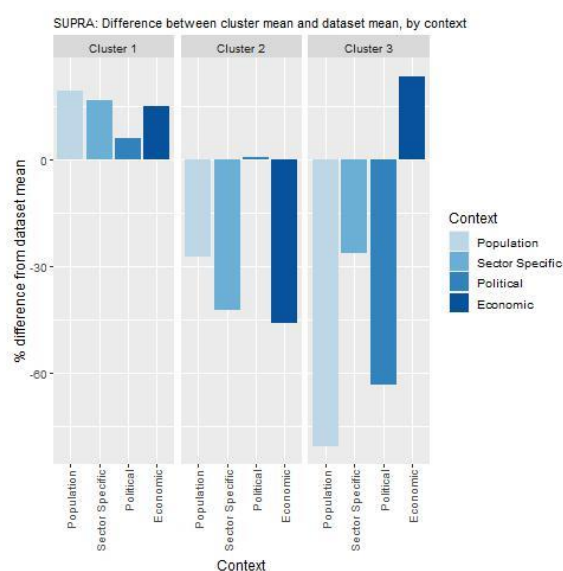
To consolidate findings from the transferability assessment above, countries have been clustered into three groups, based on indicators reported in Table 8.4. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the cluster are below with further details in Figure 8.2 and Table 8.5:

- Countries in cluster one have population, sector-specific, political, and economic conditions in place that would support the introduction of a suicide prevention programme. This cluster comprises 30 countries, including Austria.
- Countries in cluster two have some degree of political support for the introduction of suicide prevention programmes akin to SUPRA. Ensuring that the population is favourable to take part in these initiatives and that the resources allocated to prevention policies are sufficient might favour the transferring SUPRA. The existence of other suicide prevention policies might also improve transferability for this cluster. This group includes 10 countries.
- Countries in cluster three meet economic conditions supportive of SUPRA. Considering the circumstances pertaining the rest of the dimensions would be necessary to ensure that SUPRA is transferrable for this cluster. This group includes three countries.

For further details on the methodological approach used, please refer to Annex A. Figure 8.2 presents a graphical representation of clusters, and Table 8.5 a list of countries per cluster.

Figure 8.2. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Table 8.5. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia Austria Belgium Canada Croatia Cyprus Czechia Denmark Estonia Finland France Germany Greece Iceland Ireland Israel Japan Korea Luxembourg Malta Netherlands New Zealand Norway Portugal Slovenia Spain Sweden Switzerland United Kingdom United States	Chile Colombia Costa Rica Hungary Latvia Lithuania Mexico Poland Slovak Republic Türkiye	Bulgaria Italy Romania

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of SUPRA. Box 8.2 outlines several new indicators policymakers could consider before transferring SUPRA.

Box 8.2. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect and consider information for the following indicators:

Population context

- What is the level of mental health literacy within the population (e.g. awareness and attitudes) especially about suicidality?
- What are the main barriers to access to mental health care services?

Sector specific context

- Which actions for suicide prevention are already in place?
- Is a gatekeeper programme in place to train front-line workers to listen to people at risk of suicide and provide essential assistance?
- Is there a programme for social-emotional skills training in education?

Political context

- Is there regulation on access to means of suicide, including safeguarding hotspots, and restricting access to firearms and potentially lethal medications?
- Have these interventions received political support from key decision makers?
- Have these interventions received financial commitment from key decision makers?

Economic context

- Are there dedicated funding packages or budget for suicide prevention?

Conclusion and next steps

SUPRA is a national strategy for suicide prevention. It is composed by 70 actions to tackle risk factors for suicide and introduce protective factors. This case study highlights gatekeeper programmes, safeguarding hotspots for suicide attempts, and reducing access to means of suicide as promising components of SUPRA that can be integrated in other national suicide prevention strategies.

The components of SUPRA are highly effective to reduce suicide rates. Safeguarding suicide hotspots and reducing access to means of suicide are two components of SUPRA having the largest impact on suicide prevention. A systematic review on interventions to reduce suicides at hotspots suggests that physically safeguarding hotspots is associated with a reduction in the incidence rate of suicide by approximately 93%. Restricting access to lethal doses of medication was associated with a 22% reduction in suicides compared to rates before restriction policies were introduced. Safeguarding hotspots has been associated positive returns on investment. SUPRA does not yet have cost-effectiveness assessments of the programme altogether or of its components.

Suicide disproportionately affects disadvantaged social groups; the multilevel structure of SUPRA addresses inequalities. SUPRA actions target both the general public, minorities (such as the

unemployed and other people at disadvantage), people showing suicidal behaviours, and those directly in contact with them. This structure is likely to have a positive effect in reaching the groups most affected by suicidality and reducing inequalities.

SUPRA would benefit from a stronger monitoring and evaluation framework. Specifically, to enhance its evidence-base, SUPRA should systematically collect data on the effectiveness, costs, and uptake of individual programme actions, and on intermediate outcomes, such as changes in awareness, attitude, stigma, and access to treatment. To enhance equity impacts, monitoring the programme uptake by specific population groups would be essential.

SUPRA is highly transferable to 30 OECD and EU countries and intermediately transferable to 10 other countries. The transferability analysis using clustering suggests that SUPRA can be readily transferred to 70% of countries, which were included in the cluster of highest transferability. Besides, 23% of countries were included in the cluster of intermediate transferability. However, all countries can engage in suicide prevention adapting actions and strategies to their specific needs, resources, and contexts. Box 8.3 outlines next steps for policymakers and funding agencies.

Box 8.3. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance the impact of SUPRA:

- Develop and implement a comprehensive monitoring and evaluation framework for SUPRA.
- Carry out cost-effectiveness assessments of individual actions within SUPRA.
- Disseminate results of impact and cost-effectiveness assessment among the broader public, funders, decision makers and other key stakeholders.

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Notes

¹ Age- and sex-standardised rate.

9

Mental Health First Aid

This chapter covers the case study of Mental Health First Aid (MHFA), a training programme that teaches people how to help someone experiencing a mental health problem or a crisis. The case study includes an assessment of MHFA against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to OECD and EU27 countries.

Mental Health First Aid: Case study overview

Description: Mental Health First Aid (MHFA) is a training programme that teaches people how to recognise, understand and help someone who may be experiencing mental health problems. The aim of the programme is to improve mental health literacy, reduce stigma, and increase confidence in helping someone experiencing mental distress or crisis. MHFA training is aimed at the general public, but several course options are available to train adults to deliver MHFA to youth and other specific groups. The programme is applicable in a variety of settings and can be embedded in the community, workplace, tertiary institutions and schools.

Best practice assessment:

OECD best practice assessment of Mental Health First Aid

Criteria	Assessment
Effectiveness	MHFA is effective in increasing mental health literacy, knowledge, helping-behaviour and confidence in helping people with mental health problems, with evidence also suggesting a reduction in stigmatising attitudes.
Efficiency	Economic evaluations of MHFA are not readily available. The estimated cost per person for the training course is between EUR 250 and EUR 380.
Equity	Different versions of the programme are available, including for adults and youth, and MHFA training can be embedded in the community, workplaces, tertiary institutions and schools.
Evidence-base 	The evidence-base for MHFA is broad and includes several randomised controlled trials (RCTs), systematic reviews and meta-analyses.
Extent of coverage	More than 6 million people have been trained in MHFA and it operates in 29 countries, with 67 000 accredited instructors.

Enhancement options: To *enhance effectiveness* of MHFA, further research is needed to assess the impact of MHFA on people experiencing mental distress who have received help from MHFAiders®. Continuous learning and a clear definition and guidelines for the role of MHFAiders® can also enhance the effectiveness of the programme. To *enhance efficiency*, a budget should be allocated for MHFA training for frontline workers in public services, such as police officers, hospital staff and teachers. To *enhance extent of coverage* it is necessary to increase communication efforts and address the stigma associated with mental health, as well as partnering with organisations across various sectors.

Transferability: MHFA originated in Australia and has been adopted worldwide. It is now used in 29 countries (including 19 OECD and EU countries).

Conclusion: MHFA is effective in increasing mental health knowledge, helping-behaviour and confidence in helping people with mental health problems. Evidence also suggests that MHFA courses can reduce stigmatising attitudes.

Intervention description

Mental Health First Aid (MHFA) is a training programme that teaches people how to identify, understand and help someone who may be experiencing mental health problems. It aims to improve mental health literacy, reduce stigma, increase confidence and increase helping behaviours related to mental health issues (Kitchener and Jorm, 2002^[1]). The MHFA strategies are aimed at the general public and the goal is to increase the participants knowledge about mental health in general and for common disorders, such as depression, anxiety, substance use, suicidal behaviours, self-harm and psychosis. Another goal is to reduce the stigma around mental disorders by addressing negative attitudes that negatively affect

supportive and help-seeking behaviours (Hadlaczky et al., 2014^[2]). MHFA adopts a familiar model from physical first aid training, which is well-established for handling injuries and emergencies, applying it to mental health situations.

The standard MHFA training is a 12-hour course and is designed for adults to give them the skills, knowledge and confidence to understand and respond to someone experiencing a mental health problem or crisis, whether it is a family member, a colleague or another adult. The MHFA training is typically delivered through face-to-face courses, although alternative options include a combination of in-person and online learning, as well as exclusively online formats. The training programme follows the “ALGEE” action plan consisting of five steps/skills (Kitchener and Jorm, 2008^[3]; Morgan, Ross and Reavley, 2018^[4]):

1. Approach the person, assess and assist with any crisis
2. Listen and communicate non-judgementally
3. Give support and information
4. Encourage individuals to get appropriate professional help
5. Encourage other supports

Mental Health First Aiders® (MHFAiders®) are people who have completed a MHFA course. MHFAiders® are equipped with the knowledge, confidence, and skills to provide mental health first aid assistance to people experiencing mental health problems. Specifically, they are trained to recognise clusters of symptoms of different mental disorders and mental health crises, provide initial support, and direct the individual to suitable treatment and other supportive help (Morgan, Ross and Reavley, 2018^[4]). MHFAiders® are not mental health professionals but are trained to provide initial support until professional help arrives or the crisis is resolved, similar to how physical first aiders provide immediate assistance before professional medical help is available (MHFA Australia, n.d.^[5]).

MHFA was originally developed in Australia in 2000 and has since been implemented globally. The programme operates in more than 29 countries (including 19 OECD and EU countries) worldwide and more than 6 million people have been trained in MHFA. MHFA offers several versions of the programme to meet the needs of different groups (such as youth, teens, older people, veterans, suicidal people, people with gambling problems) and to fit to specific contexts (such as the workplace) (Box 9.1).

Box 9.1. MHFA at the workplace

The workplace is an important setting for health promotion and disease prevention, including early intervention and support for people experiencing or living with mental health problems (OECD, 2022^[6]). Poor mental health in the workplace has been linked to absenteeism and presenteeism, leading to reduced performance and productivity at work and an increased risk of unemployment (Tóth et al., 2023^[7]; OECD, 2022^[6]). Mental health related stigma has been identified as one of the main barriers to seeking help. Interventions aimed at reducing mental health stigma, such as MHFA, can lead to improvements in employees’ knowledge and supportive behaviour towards people with mental health problems (Tóth et al., 2023^[7]).

MHFA training provides employees with the essential skills to recognise signs of mental health problems, initiate conversations about mental health, and provide help to colleagues in need. These are skills that anyone in the workplace can learn and are an important strategy for promoting early help-seeking. MHFA training at the workplace is an important part of building more mentally healthy workplaces where employees feel supported, valued, and confident in to talk openly about mental health (MHFA Australia, n.d.^[8]).

MHFA at the workplace trains employees to recognise and respond to colleagues who are experiencing mental health problems or crises. The benefits of implementing MHFA training in the workplace include (MHFA Australia, n.d.^[8]):

- Improve employee engagement and well-being
- Improve overall performance and productivity
- Attract and retain employees

Implementing MHFA in the workplace can help to improve the well-being of employees. As more workplaces adopt MHFA training, it can also reduce the stigma surrounding mental health and promote a more inclusive and supportive working environment.

OECD Best Practices Framework assessment

This section analyses Mental Health First Aid against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 9.2 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 9.2. Assessment of Mental Health First Aid

Effectiveness

- There is strong evidence that MHFA leads to improvements in mental health knowledge (effect size $d = 0.63$).
- MHFA is effective in improving confidence in helping people with mental health problems (effect size $d = 0.58$) and the intentions to provide mental health first aid (effect size $d = 0.75$) after the intervention.
- Evidence suggests that MHFA can reduce stigmatising attitudes up to six months following the intervention, but the long-term effects (i.e. after 12 months) are uncertain.

Efficiency

- Economic evaluations of MHFA are not readily available.
- The cost of MHFA varies according to location, type of course and the instructor. The estimated cost per person for the training course is between EUR 250 and EUR 380.

Equity

- Various versions of the programme are available, including programmes for the adult population and for the youth population.
- MHFA training can be embedded in a variety of settings, including the community, workplaces, tertiary institutions and schools.

Evidence-base

- The evidence-base for MHFA is well-established, with several randomised controlled trials (RCTs), systematic reviews and meta-analyses.
- An RCT was used to assess the impact of MHFA and the evidence was rated as strong in several areas.

Extent of coverage

- More than 6 million people have been trained in MHFA and it operates in 29 countries.
- MHFA have more than 67 000 accredited instructors worldwide.

Note: d refers to Cohen's d effect size and is generally interpreted as small (0.20), medium (0.50) and large (0.80).

Effectiveness

MHFA is effective in increasing the participants mental health knowledge

Research has extensively explored the impact of MHFA on improving participant's knowledge and understanding of mental health, with strong evidence showing significant improvements in mental health knowledge. A Swedish randomised controlled trial (RCT) study found that the intervention group that received MHFA training, **improved their knowledge about mental disorders and how to act and behave when in contact with affected individuals**, as compared to controls with an effect size of $d^1 = 0.63$ (Svensson and Hansson, 2014_[9]). A meta-analysis based on 15 relevant studies found MHFA to be effective in increasing participants **knowledge regarding mental health** with a mean effect size of Glass's delta $\Delta = 0.56$ (95% CI ranged from 0.38 to 0.74). The effect was regarded as highly robust with a moderately high effect size (Hadlaczky et al., 2014_[2]). These findings are confirmed in a more recent systematic review and meta-analysis based on 18 studies with a total of 5 936 participants, that show improvements in three measures of mental health knowledge (Morgan, Ross and Reavley, 2018_[4]). First, beliefs about effective treatments for mental health problems improved significantly at post-intervention (Cohen's effect size $d = 0.45$) and up to 6-months follow-up ($d = 0.19$). Second, for accurate identification of mental health problems, small non-significant improvements were observed at post-intervention ($d = 0.22$), increasing to moderately significant improvements at 6-month follow-up ($d = 0.52$). Third, for MHFA knowledge, a moderate-to-large significant improvement was found at post-intervention ($d = 0.72$). The effect was reduced at 6-month follow-up ($d = 0.54$) and at 12-month follow-up ($d = 0.31$).

MHFA is increasing participants helping behaviour and their confidence in helping people with mental health problems

MHFA is effective in improving participants' helping behaviour towards people with mental health problems. A Swedish RCT study found that the intervention group improved their **readiness to provide help in a mental health crisis situation** compared to the control group who did not receive the training, with an effect size of $d = 0.22$ (Svensson and Hansson, 2014_[9]). They also showed improved **confidence in providing help** compared to controls, with an effect size of $d = 0.32$. After two years of follow-up, the results showed that the MHFA training still had a notable impact on the awareness of mental health and its treatment, and that it led to a change in behaviour in terms of willingness to engage more with people with mental health problems (Svensson and Hansson, 2014_[9]).

MHFA leads to improvements in **confidence in helping a person with a mental health problem**. Moderate significant improvements were found at post-intervention ($d = 0.58$) and at follow-up at 6-months ($d = 0.46$), while the effects beyond 6-months were small ($d = 0.21$) (Morgan, Ross and Reavley, 2018_[4]). Furthermore, **moderate to large effects were observed on the intentions to provide mental health first aid at post-intervention** ($d = 0.75$) and at 6-month follow-up ($d = 0.55$). Similar effects were also found in a meta-analysis based on nine studies, which found that MHFA is effective in increasing help-providing behaviour, with a mean effect size of Glass's $\Delta = 0.25$ (CI95% ranged from 0.12 to 0.38) (Hadlaczky et al., 2014_[2]).

Evidence suggests that MHFA courses can reduce stigmatising attitudes, but the long-term effect is uncertain

A meta-analysis based on 14 studies found that the participation in an MHFA course was effective in **decreasing negative attitudes towards people with mental health problems**. A very robust moderate effect was found (Glass's $\Delta = 0.28$, 95% CI ranged from 0.22 to 0.35) with a highly significant difference between individuals in the control and intervention groups and in the pre-post measures (Hadlaczky et al., 2014^[2]). Furthermore, evidence shows small reductions in stigmatising attitudes at post-intervention ($d = 0.14$) and at six-months follow-up ($d = 0.14$), while a very small non-significant effect was observed at 12-month follow up ($d = 0.08$) (Morgan, Ross and Reavley, 2018^[4]).

Efficiency

Economic evaluations of MHFA are not readily available. The cost of MHFA varies according to location, type of course and the instructor. Available information from MHFA England values the course at GDP 325 (EUR 380) per person, offering four sessions of 3 hours and 45 minutes over two weeks, with a limited number of 16 people per course (MHFA England, n.d.^[10]). In France, the cost of the MHFA course is EUR 250. This includes 14 hours of training, which can be delivered either face-to-face or remotely (Premiers Secours en Santé Mental France, n.d.^[11]).

Equity

The MHFA programme promotes equity in mental health support by offering various versions of the programme targeting different groups. This ensures a widespread accessibility and relevance of the programme. The standard version of the MHFA programme focusses on mental health problems in the adult population and is suitable for anyone over the age of 18 (Hadlaczky et al., 2014^[2]). Youth MHFA is a different version of the programme designed to teach families, parents, teachers, peers, neighbours, and school staff, how to help young people (aged 12-18) who are experiencing mental health or addiction problems or are in crisis.

MHFA is applicable in a variety of settings and the training can be embedded in the community, workplace, tertiary institutions and schools. In Australia, a specialised course trains adults to deliver MHFA specifically for Aboriginal and Torres Strait Islander communities, and is available in both adult and youth versions, enhancing the cultural sensitivity and inclusivity of the programme. Several course options are available, including training to support someone experiencing a gambling problem, someone with non-suicidal self-harm and someone with suicidal thoughts and behaviours (MHFA Australia, n.d.^[12]).

Evidence-based

Results for the effectiveness of MHFA is based on data from RCTs, as well as systematic reviews and meta-analyses. For the purpose of this case study, the study by Svensson and Hansson (2014^[9]) was used to assess the evidence-base. This study was selected because it is a peer-reviewed journal article with an RCT design, and it evaluates MHFA in an OECD and EU country (Sweden).

The *Quality Assessment Tool for Quantitative Studies* rates the quality of the evidence as strong in several domains (see Table 9.1). The study was rated as “strong” for study design and adjusting for confounders and “moderate” for selection bias. Blinding was rated as “weak” as blinding of participants was difficult due to the nature of the study. Data collection was also rated as “weak” because validity and reliability for the data collection tools were not reported.

Table 9.1. Evidence base assessment, Mental Health First Aid

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Somewhat likely
	What percentage of selected individuals agreed to participate?	60-79% agreement
	<u>Selection bias score</u>	Moderate
Study design	Indicate the study design	Randomised controlled trial
	Was the study described as randomised?	Yes
	<u>Study design score</u>	Strong
Confounders	Were there important differences between groups prior to the intervention?	No
	What percentage of potential confounders were controlled for?	Can't tell
	<u>Confounder score</u>	Strong
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Can't tell
	Were the study participants aware of the research question?	Yes
	<u>Blinding score</u>	Weak
Data collection methods	Were data collection tools shown to be valid?	Can't tell
	Were data collection tools shown to be reliable?	Can't tell
	<u>Data collection methods score</u>	Weak
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	60-79%
	<u>Withdrawals and dropout score</u>	Moderate

Source: Effective Public Health Practice Project (1998^[13]) "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Svenson & Hansson (2014^[9]) "Effectiveness of mental health first aid training in Sweden. A randomized controlled trial with a six-month and two-year follow-up", <https://doi.org/10.1371/journal.pone.0100911>.

Extent of coverage

MHFA was originally developed in Australia in 2000 and has then been transferred to multiple countries. More than 6 million people have been trained in MHFA and the programme is currently being delivered in 29 countries worldwide (including 19 OECD and EU countries). More than 67 000 people are accredited as MHFA instructors worldwide (MHFA International, n.d.^[14]).

Policy options to enhance performance

Enhancing effectiveness

Further research is needed to assess the benefits of MHFA on individuals who received assistance from MHFAiders®. The current evidence clearly shows that MHFA improves the capacities of MHFAiders® such as participants' knowledge, attitudes and behaviours, and it appears to be a promising public health tool for tackling the stigma associated with people with mental disorders and suicidality (Hadlaczky et al., 2014^[2]). However, there is an evidence gap of the MHFA impact on people who experienced mental distress and crises and who received help from MHFAiders®. Further research should focus on collecting data on the recipients of MHFA support (Morgan, Ross and Reavley, 2018^[4]; Maslowski et al., 2018^[15]). Evaluations could include for instance the time of recovery, impact on social and occupational functioning, and satisfaction.

Fostering an environment of continuous learning is essential to enhance the effectiveness of MHFA. Ideally, MHFAiders® should receive regular updates on the latest mental health research and practice.

Understanding and skills can be deepened through specialised training targeted at specific mental health conditions or populations. MHFAiders® could benefit from support mechanisms, such as supervision or peer groups, where they can discuss challenges and ensure that they remain effective and confident in their role.

Enhancing efficiency

Efficiency is calculated by obtaining information on effectiveness and expressing it in relation to inputs used. Therefore, policies to boost effectiveness without significant increases in costs will have a positive impact on efficiency.

Enhancing equity

Increasing the accessibility of the MHFA training programme to diverse communities will enhance equity. Involving leaders and organisations in the design and the delivery of the programme will help ensure that MHFA training meets the specific needs of diverse communities and workplaces, making the programme more equitable.

Enhancing the evidence-base

A longer evaluation period would help to improve the evidence base. There is a lack of evidence about the long-term impact of MHFA, particularly beyond six months. Therefore, future research should focus on examining the sustainability of MHFA training (Morgan, Ross and Reavley, 2018^[4]).

Enhancing extent of coverage

To enhance the reach and enrolment in MHFA training, it is necessary to increase communication efforts and to address the stigma surrounding mental health. Effective communication strategies should emphasise the benefits of MHFA, such as how it increases mental health knowledge and how it can help build a more mentally healthy workplace. Mental health stigma can be addressed by promoting the positive outcomes of MHFA training. To increase the uptake, organisations can encourage individuals to participate in the programme.

Forming partnerships with organisations across various sectors can enhance the extent of coverage for MHFA. By extending the reach of the programme and collaborating with new educational institutions, corporations, healthcare providers and community organisations, MHFA can be integrated into new locations. This broadens the reach of the programme and ensures that more people in different settings and environments receive the training.

Allocating a budget for MHFA training for frontline workers in public services, such as teachers, social service providers and religious services, can enhance the extent of coverage of MHFA. Providing MHFA training to key groups who are most likely to be in regular contact with people experiencing mental health problems or crises can maximise the reach and impact of MHFA. Training these workers can help build a more resilient public service workforce that is better prepared to manage stress and trauma.

Transferability

This section explores the transferability of MHFA and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring MHFA.

Previous transfers

MHFA originated in Australia, where it was developed in 2000. Since then, the programme has been adopted worldwide and is now used in 29 countries (including 19 OECD and EU countries). Countries like Australia, Canada, France, Sweden, the United Kingdom and the United States, have adapted MHFA for their populations, showing how flexible the programme is.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results. In order to assess the transferability of the MHFA programme, this case study will draw on the Swedish programme, which has been studied by Svensson and Hansson (2014^[9]).

Methodological framework

A few indicators to assess the transferability of MHFA were identified (see Table 9.2). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. The assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 9.2. Indicators to assess the transferability of Mental Health First Aid

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Share of individuals volunteering time to an organisation in the past month (%) (Gallup, 2023 ^[16])	MHFA aims to train people to listen and help someone in mental distress or crises, and will be more transferrable in countries where volunteering and community engagement is high.	↑ value = more transferable
<i>Political context</i>		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[17])	MHFA is more transferable in countries that have a strategy or action plan in place to guide the implementation of mental health policy	Yes = more transferable
Policies and programmes to improve mental health awareness and literacy (OECD/WHO Regional Office for Europe, 2023 ^[18])	MHFA aims to improve mental health literacy and awareness in the general population and will be more transferable to countries that support mental health awareness and literacy	Yes = more transferable
Policies and programmes to address stigma and discrimination (OECD/WHO Regional Office for Europe, 2023 ^[19])	MHFA aims to decrease stigmatising and negative attitudes surrounding mental health problems and will be more transferable to countries that have policies in place to address stigma and discrimination.	Yes = more transferable
<i>Economic context</i>		
Prevention spending as a percentage of current health expenditure (OECD, 2022 ^[20])	MHFA is a preventive programme, therefore it is more transferable to countries that allocate a higher proportion of health spending to prevention.	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below:

- In Sweden, the proportion of people who had volunteered in the last month was 16%, suggesting that countries with a higher proportion will have an enabling environment for the transfer of MHFA.
- As in Sweden, the vast majority of countries (90%) have a strategy or action plan to guide the implementation of mental health policy. This suggests that MHFA would be likely to receive political support in most potential transfer countries.

- c) Mental health awareness and literacy policies are implemented or underway in 88% of countries (38 out of 43), including in Sweden. MHFA aims to increase mental health awareness and literacy, and policies that support these aims enhance the transferability of MHFA.
- d) The majority of countries (83%) have policies and programmes in place to address stigma and discrimination, including Sweden. MHFA aim to reduce stigma, and countries with policies that support this have a better potential for transferability.
- e) Sweden spends 4.93% of current health expenditure on preventive care, compared with the median of 4.42% in OECD and EU countries. Countries with a higher spending on prevention are more likely to have economic support for the transfer of MHFA.

Table 9.3. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates MHFA is more suitable for transferral in that particular country

Country	Volunteering	Strategy or action plan that guide policy implementation	Policies for improving awareness and literacy	Policies addressing stigma and discrimination	Prevention spending (% health expenditure)
Sweden	0.16	Yes	Yes	Yes	4.93
Australia	0.34	Yes	Yes	Yes	3.24
Austria	0.24	Yes	Yes	No	10.33
Belgium	0.26	Yes	Yes	Yes	3.13
Bulgaria	0.06	Yes	No	No	3.25
Canada	0.34	No	Yes	Yes	6.11
Chile	0.17	Yes	Yes	Yes	3.35
Colombia	0.21	Yes	Yes	Yes	2.05
Costa Rica	0.22	Yes	Yes	Yes	0.78
Croatia	0.11	Yes	Yes	Yes	4.43
Cyprus	0.23	Yes	Yes	Yes	2.19
Czechia	0.24	n/a	Yes	Yes	8.12
Denmark	0.25	Yes	Yes	Yes	5.08
Estonia	0.20	Yes	Yes	No	8.30
Finland	0.24	Yes	Yes	No	4.70
France	0.30	Yes	Yes	Yes	5.49
Germany	0.27	No	Yes	Yes	6.45
Greece	0.20	Yes	No	Yes	4.04
Hungary	0.17	Yes	Yes	Yes	7.58
Iceland	0.25	Yes	Yes	Yes	3.31
Ireland	0.29	Yes	Yes	Yes	5.89
Israel	0.28	n/a	Yes	Yes	0.27
Italy	0.19	Yes	No	No	6.52
Japan	0.19	Yes	Yes	Yes	3.24
Korea	0.20	Yes	Yes	Yes	7.95
Latvia	0.12	Yes	Yes	Yes	5.13
Lithuania	0.11	Yes	Yes	Yes	5.56
Luxembourg	0.31	n/a	Yes	Yes	4.70
Malta	0.31	No	Yes	Yes	1.45
Mexico	0.20	Yes	Yes	Yes	2.95
Netherlands	0.32	n/a	Yes	Yes	9.59
New Zealand	0.34	Yes	Yes	Yes	n/a
Norway	0.31	Yes	Yes	Yes	2.70
Poland	0.07	Yes	Yes	Yes	2.10
Portugal	0.13	Yes	Yes	Yes	3.17
Romania	0.06	Yes	No	No	3.73
Slovak Republic	0.17	No	No	No	1.61
Slovenia	0.27	Yes	Yes	Yes	5.26
Spain	0.19	Yes	Yes	Yes	3.45
Switzerland	0.27	Yes	Yes	Yes	2.82
Türkiye	0.10	Yes	Yes	Yes	n/a
United Kingdom	0.26	Yes	Yes	Yes	12.49
United States	0.39	Yes	Yes	Yes	4.83

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 9.3.

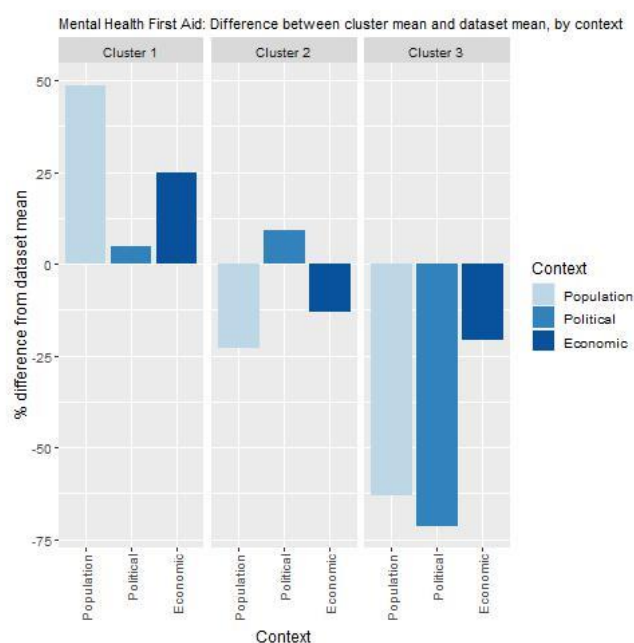
Source: OECD/WHO Regional Office for Europe (2023^[17]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy; OECD/WHO Regional Office for Europe (2023^[18]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to improve mental health awareness and literacy; OECD/WHO Regional Office for Europe (2023^[19]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to address stigma and discrimination; OECD (2022^[20]), OECD Data Explorer - Prevention spending as a percentage of current health expenditure, <http://data-explorer.oecd.org/s/1nl> (accessed on 11 April 2025).

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 9.2. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 9.1 and Table 9.4:

- Countries in cluster one have population, political and economic arrangements in place to facilitate the transfer of MHFA and therefore have conditions in place to readily transfer MHFA to their local context. Countries in this cluster are considered to be less likely to encounter issues in implementing and operating MHFA in their local context. This group includes 16 countries.
- Countries in cluster two have political arrangements in place to transfer MHFA, but they may not have the population context and economic feasibility to support the transfer of MHFA. Compared to cluster one, countries in cluster two have lower levels of volunteering and community engagement, and lower spending on prevention than in cluster one. This group includes 23 countries.
- Countries in cluster three do not have conditions in place regarding population, political and economic contexts to support the transfer of MHFA. This cluster has a small number (four) of countries. Countries in cluster three may have relatively lower levels of volunteering and community engagement. They may not have an action plan that guides the implementation of mental health policy, or programmes to increase mental health literacy and address stigma. Spending on prevention is relatively lower than in cluster one.

Figure 9.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 9.4. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia	Belgium	Bulgaria
Austria	Chile	Italy
Canada	Colombia	Romania
Czechia	Costa Rica	Slovak Republic
France	Croatia	
Germany	Cyprus	
Ireland	Denmark	
Israel	Estonia	
Luxembourg	Finland	
Malta	Greece	
Netherlands	Hungary	
New Zealand	Iceland	
Norway	Japan	
Slovenia	Korea	
United Kingdom	Latvia	
United States	Lithuania	
	Mexico	
	Poland	
	Portugal	
	Spain	
	Sweden	
	Switzerland	
	Türkiye	

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 9.3 outlines several new indicators policymakers could consider before transferring MHFA.

Box 9.3. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of mental health literacy in the population?
- What is the level of stigma associated with mental illness?

Sector specific context

- What is the share of workers who receive health-related trainings?

Political context

- Has the intervention received political support from key decision makers?
- Has the intervention received commitment from key decision makers?

Economic context

- Are there government-led financial incentives for promoting mental health in specific contexts (e.g. at the workplace)?

Conclusion and next steps

MHFA is a training programme that teaches people how to recognise, understand and help someone who may be experiencing mental health problems and is aimed at the general public. The programme aims to improve mental health literacy, reduce stigma, increase confidence and increase helping behaviours related to mental health issues. The programme is applicable in a variety of settings and can be embedded in the community, workplace, tertiary institutions and schools.

MHFA has been effective in increasing mental health knowledge, helping-behaviour and confidence in helping people with mental health problems. Evidence suggests that MHFA courses can reduce stigmatising attitudes, although the long-term effect is uncertain. Several course options are available to train adults to deliver MHFA to youth or other specific groups, such as training to support people with gambling problems, non-suicidal self-harm and people with suicidal thoughts. Economic evaluations of MHFA are not readily available, however evidence shows that the training course costs between EUR 250 and EUR 380.

MHFA originated in Australia and has been adopted worldwide. It now exists in 29 countries (including 19 OECD and EU countries). More than 6 million people have been trained in MHFA and the programme has 67 000 accredited instructors. The transferability analysis using clustering suggests that MHFA can be readily transferred to 37% of countries, which were included in the cluster of highest transferability. Besides, 53% of countries were included in the cluster of intermediate transferability.

Box 9.4 outlines next steps for policymakers and funding agencies.

Box 9.4. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance MHFA are listed below:

- Ensure funding to continue the implementation of the programme as well as for future scale-up and transfer efforts.
- Support further research on the effectiveness of MHFA, in particular on the benefits for individuals who received assistance from MHFAiders®.
- Promote “lessons learnt” from countries and regions that have transferred MHFA to their local setting.

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Notes

¹ *d* refers to Cohen’s *d* effect size and is generally interpreted as small (0.20), medium (0.50) and large (0.80).

10 @ease

This chapter covers the case study of @ease, a youth mental health initiative based on peer support in the Netherlands. The case study includes an assessment of @ease against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

@ease: Case study overview

Description: @ease is a youth mental health initiative providing peer-based accessible support to increase mental health resilience and prevent worsening of psychological distress and symptoms. Fifteen @ease centres are available in 12 municipalities in the Netherlands. Volunteer young adult peers, including those with lived experience, serve as counsellors to young people that might walk in or have booked an appointment, at no cost and without referral. Youth peers operating in these non-clinical environments are trained in active listening, solution-focussed strategies and motivational interviewing, and are supervised by a healthcare professional on site.

Best practice assessment:

OECD best practice assessment of @ease

Criteria	Assessment
Effectiveness	Psychological distress and functioning improve over time for young people returning to @ease after a first visit. @ease returnees do also seem more likely to receive mental health support in the past three months, and less likely to be absent from school, although with less certainty.
Efficiency 	@ease relies mostly on voluntary work, which reduces the cost of the intervention.
Equity	@ease reaches young people in vulnerable circumstances, but to a limited extent. Only a small share of young people who seek @ease are not in employment or education or training, in an unstable housing situation or of a gender minority.
Evidence-base	Although @ease has a routine outcome monitoring in place, the studies produced with these data face important limitations such as absence of a control group, (potentially) high missing data, and self-selection into monitoring.
Extent of coverage	@ease succeeds in removing barriers on access to mental health support, covering a group of people with high distress and suicidal ideation, and who often did not receive formal mental health care in the recent past.

Enhancement options: *To enhance effectiveness of @ease*, efforts should be conducted to increase the return rate and continuity of support. *To enhance equity*, efforts should focus on increasing the representation of traditionally underserved groups such as gender/sexual and ethnic minorities. This can be done through increased dissemination in respective social circles, recruiting peers from these groups which can act as ambassadors and provide linguistically and culturally adapted support, and setting up new @ease centres in strategic locations. *To enhance the evidence-base*, better data collection is essential to assess @ease results. Conducting a controlled study and a cost-effectiveness evaluation are highly recommended. *To enhance the extent of coverage*, it is important to diversify the communication channels (e.g. telephone, videoconference) and increase opening hours.

Transferability: A high-level transferability analysis using clustering suggests that 18 of the 38 countries included in the analysis would present many of the characteristics needed to ensure a successful transferability of @ease.

Conclusion: @ease centres provide an innovative form of youth mental health support based on trained volunteer peers, easily and freely accessed by young people, and have the potential to improve their psychological distress and functioning. Enhancements in the continuity of support, uptake by traditionally underserved groups and data collection would maximise the potential of @ease and favour its establishment as a key intervention for youth mental health.

1. At the time of writing this report funding had been attributed to study both the comparative effectiveness and the cost-effectiveness of @ease but the studies were still in the preparation phase.

Intervention description

Youth is a critical life-phase for mental health and for the onset of mental disorders (Kessler et al., 2007^[1]; Solmi et al., 2022^[2]). Mental disorders are the main cause of disability among adolescents and young adults in high-income countries (Gore et al., 2011^[3]; Erskine et al., 2015^[4]), with suicide being the fourth leading cause of death for those aged 15-29 years old (WHO, 2021^[5]). Still, a large part of young people experiencing mental health problems do not receive formal support (De Graaf, Ten Have and van Dorsselaer, 2010^[6]; Slade, Teeson and Burgess, 2009^[7]). Several factors contribute to this treatment gap, even in countries with well-established child and adolescent mental health services (CAMHS). These barriers arise at the individual level, for example due to stigma, lack of mental health literacy or concerns with privacy and confidentiality (Corry and Leavey, 2017^[8]; MacDonald et al., 2021^[9]), as well as the service level, for example complex referral processes and waiting lists, or the disconnection between CAMHS and adult mental health services (AMHS) that hinders care continuation into adulthood (Appleton et al., 2021^[10]; Gerritsen et al., 2022^[11]; Signorini et al., 2018^[12]).

The treatment gap and the mismatch between services available and young people's needs have motivated the development of several initiatives aimed at improving access and appropriateness of care for youth. In the Netherlands, @ease was founded in 2017, and the first centre applying the @ease method opened in 2018, in Maastricht.

Origin and mission

@ease is a Dutch initiative designed to reach young people in need of mental support, with the objectives of increasing mental health resilience and thereby the chance of positive development, as well as preventing aggravation of emerging or existing mental health and developmental problems (Leijdesdorff et al., 2022^[13]). The initiative follows from a Foundation with the same name and consists of a set of walk-in centres targeting young people aged 12 to 25. The centres are characterised by being youth-friendly and embedded in a non-clinical environment, where an intervention according to the @ease method is delivered by youth peers with on-site professional supervision (Boonstra et al., 2023^[14]).

@ease was founded in 2017, and the first centre opened in 2018. Today, the programme counts 15 centres across 12 municipalities: Maastricht, Amsterdam, Heerlen, Rotterdam, Leiden, Groningen, Leeuwarden, Haarlem, Zwolle, Eindhoven, Roermond, Apeldoorn. (Boonstra et al., 2023^[14]; @ease, n.d.^[15]).

Intervention

@ease can be characterised as low-barrier support provided by trained peers. It is free and requires no referral, no appointment, no intake session and no clinical diagnosis or even identification of the young person, which can remain anonymous if they prefer. Young people in need of support can walk into the @ease centre and seek help from trained peers, which do usually work in pairs. During their time with the peers, young people can discuss a multitude of topics that range from their mental health to their physical health, but also sexual, financial, vocational, and social problems (Boonstra et al., 2023^[14]).

The intervention consists of peer-to-peer conversations based on the principles of active listening and counselling, provided by trained youth peers, including experts by experience. @ease's motivational and solution-focussed working method aims at activating visitors' (social) participation, in terms of opportunities and through alternate coping strategies (Boonstra et al., 2024^[16]). Peers are volunteers aged 18 to approximately 30, who apply to @ease, and are screened by location managers to assess their motivation, past conduct, lived experience, and conditions to deal with visitor problems and complex situations. Following the screening, peers undertake a 2-day training that is solution-focussed and covers techniques of active listening and motivational interviewing (Slot and van Aken, 2010^[17]; Spanjaard and Slot, 2015^[18]). The training also includes elements of the suicide prevention training offered by the national Dutch suicide

prevention centre 113 (<https://www.113.nl/english>), to support peers in dealing with young people's suicidal thoughts and crisis situations. During an initial period following the training, peers are monitored to determine their suitability to the programme and commitment to the role (Leijdesdorff et al., 2022^[13]). Reinforced training is offered along the programme.

Young people in need of support can access @ease centres by walking in unannounced during opening hours or by scheduling an appointment, either online (chat) or by telephone. There are no financial costs to the young people, no referral requirements, waiting lists, or intake/admission procedures that could discourage and delay access to support. There is also no limit to the number of visits per person. The young person is the one to decide if and when visiting again, without the need of announcement. This also means that there is not necessarily a trajectory of consecutive sessions with the same peer. The content of the counselling and the peer may vary at every visit and the topics can be situational: what is required at that time is determined in each visit. During the COVID-19 pandemic, @ease launched an online chat to enable remote conversations. The online chat tool is still available today during the opening hours of @ease locations.

The peer-led conversation is tailored to the need of the visitor, providing either early intervention, first support and facilitation of further help-seeking, offering support during waiting time for formal care, or complementing or bridging care provided by a practitioner (in parallel) (Leijdesdorff et al., 2022^[13]).

Organisational structure

Each @ease location operates on one to three afternoons a week, with three to five peers working in the centre. Depending on locations and volunteers, peers work on average two afternoons per month. Peers are often experts by experience, ranging from experience of psychological distress, family problems, and other challenges experienced by youth, to a diagnosed mental disorder and an experience of formal mental health care. Supervision of young peers in each centre is done by a healthcare professional: most often a psychologist or a social worker, but possibly also a psychiatry resident, behavioural scientist, or a specialised nurse. The supervision consists of preliminary discussions with the peers of potentially complex situations and mandatory discussions following each individual conversation, in which the peers and the professional evaluate the session together. If needed, the professional can join the session to support the peer in interacting with the visitor (Leijdesdorff et al., 2022^[13]).

Each team also has access to on-call psychiatric support, which can be activated by the on-site healthcare professional. One psychiatrist per region would be available during @ease centres' opening hours for telephone consultations and referrals to the crisis intervention team, if needed (Leijdesdorff et al., 2022^[13]; Boonstra et al., 2023^[14]). Last, each centre is managed by a site manager, who takes care of logistical aspects such as organising the peers' schedule and registration.

Premises where @ease centres are located vary by the municipality, and are decided together with local stakeholders, based on needs but also considering easy access by foot or public transport (i.e. central in the city). Example of locations include public libraries, youth centres, private buildings (renting small workspaces) and study-café.

Monitoring and evaluation

Routine outcome monitoring is part of @ease design and is conducted by collecting data at the end of each visit on a tablet device, provided that the visitor consents. Data collection starts with the presentation of an informed consent form which outlines the research purposes, confirms that the participation is not mandatory, and that the data collection can be stopped at any moment. For those that do not object (passive informed consent), the questionnaire consists of a first part answered by the visitor, with questions about demographic characteristics, access to @ease and validated measures of psychosocial distress and quality of life. A second part of the questionnaire is then completed by the peers that provided the support,

collecting data on suicidal ideation, need for referral and social functioning. Table 10.1 describes the information collected in more detail. When data from a first visit has already been collected, only part of the questionnaire needs to be answered in follow-up visits. Furthermore, each consent form also asked visitors about the possibility of receiving follow-up questionnaires, by text or email, at three, six and 12 months after their last visit to the site (Boonstra et al., 2023^[14]).

Table 10.1. Information collected as part of @ease routine outcome monitoring

1st visit	Subsequent visits	Follow-up via email / text	Information collected	Description
			Self-rated:	
X			Demographics and background information	Age; Gender; Country of Birth; Highest education; Parental mental illness
X			@ease questions	Counselling topic/reasons for visiting @ease: "my feelings", "social relationships", "education/work", "drugs/alcohol", "physical health" or "sexuality"; How one found @ease
X	X	X	Current situation	Living situation; Occupation; Educational status
X	X	X	Past 3 months ¹	School absenteeism: number of days skipping school in the last three months. Mental health support: number of days of support from a school-based adviser, mentor, therapist, community worker or other professional.
X	X	X	Satisfaction with @ease counselling	Satisfaction with conversation on a scale from 1 to 5, with 1 being "very unsatisfied" and 5 "very satisfied"
X	X	X	Psychological Distress: CORE-10	CORE-10 is measure of psychological distress consisting of short, acceptable and feasible 10-item questionnaire with total score ranging from 0 to 40 (higher score for higher distress). It assesses the presence and severity of common mental health problems in the context of primary healthcare. Scores of 11 or higher denote a clinically significant level of psychological distress.
X	X	X	Quality of life: EQ-5D-5L	EuroQoL EQ-5D-5L comprises five dimensions that concern quality of life: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has five levels, ranging from "no problems" to "not able to perform a certain activity". It has been shown to reflect the impact of common mild to moderate mental health conditions on quality of life and discriminate between subgroups in terms of severity.
X			Peer-rated:	
X	X		Suicide	Suicidal ideation Peers ask whether the young person thinks about killing themselves: "No", "Yes, sometimes there are short periods in which they think about this", "Yes, there are periods that last for a while in which they think about this" or "Yes, long periods in which they think about this". Suicidal plans Peers ask whether young people has specific thoughts about the way they could kill themselves: "Yes" or "No"
X	X		Plans for after the @ease conversation	Based on the conversation or a direct question to the visitor, the peer registers whether the visitor plans to visit 1) General practitioner 2) Psychologist 3) Other support 4) None
X	X		Social and Occupational Functioning (SOFAS)	The Social and Occupational Functioning Assessment Scale consists of one score between 0 and 100 (superior functioning), rated by the practitioner/peer. It has high intraclass correlation (ICC) although this varies depending on the applicant (e.g. nurses ICC is 1.0). SOFAS is also used by headspace Australia and is argued to provide crucial information for evaluating and improving early care for young people.

Notes: According to the protocol paper (Boonstra et al., 2023^[14]) the collection of past mental health support was restricted to healthcare, and guided by the question "During the last three months, how often did you go to a healthcare professional for mental health issues or addiction problems?". Furthermore, the school absenteeism was instead named Truancy. In (Boonstra et al., 2024^[16]), the authors justify that "truancy might also be a less accurate term at tertiary education levels if attendance is less often or not mandatory, or when the education largely consists of self-study".

Source: Adapted from Leijdesdorff et al. (2022^[13]), "Who is @ease? Visitors' characteristics and working method of professionally supported peer-to-peer youth walk-in centres, anonymous and free of charge", <https://doi.org/10.1111/eip.13294>, Boonstra et al. (2023^[14]), "@ease peer-to-peer youth walk-in centres in The Netherlands: A protocol for evaluating longitudinal outcomes, follow-up results and cost-of-illness", <https://doi.org/10.1111/eip.13443> and Boonstra et al. (2024^[16]), "Evaluating changes in functioning and psychological distress in visitors of the @ease youth mental health walk-in centres", <https://doi.org/10.1192/bj0.2024.58>.

OECD Best Practices Framework assessment

This section analyses @ease against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 10.1 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 10.1. Assessment of @ease

Effectiveness

- Psychological distress and functioning improve over time for young people returning to @ease after a first visit. Positive changes over time are also observed for @ease returnees on the likelihood of receiving mental health support in the past three months, and on school absenteeism, although with less certainty. These findings only represent visitors coming back to the @ease centre and willing to complete the questionnaires and therefore not generalizable to all @ease users.

Efficiency

- @ease relies mostly on voluntary work, which reduces the cost of the intervention.

Equity

- @ease reaches young people in vulnerable circumstances, but to a limited extent. The analysis of visitor demographics shows that only a small share of young people who seek @ease are not in employment or education, in an unstable housing situation or of a gender minority.

Evidence-base

- Although @ease routinely monitors outcomes, the studies produced with these data face important limitations. These include the lack of a control group and (potentially) high levels of missing data and selection into monitoring which cannot be evaluated due to the lack of information for visitors who do not agree with data collection, happening post-intervention.

Extent of coverage

- @ease succeeds in removing barriers on access to mental health support, covering a group of people with high distress and suicidal ideation, and who often did not receive formal mental health care in the recent past.

Effectiveness

The routine outcome monitoring of @ease includes measures of effectiveness covering domains such as psychological distress (CORE-10), social and occupational functioning (SOFAS), previous school absenteeism and previous mental health support, suicidal ideation and planning, and quality of life (EQ-5D-5L; see Table 10.1 for details on the instruments). Evidence presented in this section comes mostly from the first outcome evaluation (Boonstra et al., 2024^[16]). Changes in these domains could only be evaluated for the subgroup of young people with more than one visit: 168 out of the 754 visitors that filled questionnaires between January 2018 and December 2022. The exact size of this subgroup, designated as returnees in the remainder of the chapter, varies considerably for each outcome due to missing data. To note, the group of returnees was significantly older than one-off visitors and had higher proportions of male and native visitors, visitors not living with their parents, visitors with parental mental health problems, and visitors not in education (Boonstra et al., 2024^[16]).

Psychological distress and functioning improve over time for @ease returnees. Of the 95 returnees who completed the psychological distress assessments at both the first and last visit (only 56.6% of all 168 returnees), 43.2% improved their self-rated psychological distress to a better clinical CORE-10 category, and 28.4% improved by decreasing 6 or more CORE-10 points, indicating *reliable change*. These improvements occurred over a short period of time, as about half (49.1%) of those who completed the CORE-10 questions had their last visit within six weeks after their first visit. Of the 91 returnees scoring above the CORE-10 cut-off of 11 points, only 8.8% had a *clinically significant* change to a score below 11 points.

Peer-rated social and occupational functioning also improved over time. Based on the data from 53 returnees completing questionnaires at the first and last visits, 39.6% improved social and occupational functioning by at least one category (10+ points in SOFAS, considered a *reliable change*) and 28.0% had a *clinically significant* change, moving from below to above the cut-off of 69.

An increase over time was also observed in the proportion of returnees receiving mental health support from a school-based adviser, mentor, therapist, community worker or other professional: from 34% before the first visit (mean number of days with support 2.30), 49.7% before second visit (mean 3.13 days) and 60.4% before third visit (mean 4.96 days). Estimates obtained from mixed models on the odds of receiving mental health support confirmed statistically significant increases over time. This was not the case for school absenteeism, for which there was no statistically significant difference over time, although the proportion of returnees with at least one absence from school in the previous three months decreased from 43.8% before first visit (with mean of absent days 3.10 days), to 35.2% before second visit (3.04 days) and 16.7% before third visit (2.07 days) (Boonstra et al., 2024^[16]).

For suicidal ideation and planning, trends over time do not depict a clear change. The proportion of returnees with suicidal ideation ranged from 29.9% after the first visit (out of 77) to 31.2% after the second visit (out of 93) and 24.4% after the third visit (out of 41). From the individuals with suicidal ideation, 43.5%, 39.3% and 20.0% had suicidal plans, respectively after each visit. Quality of life results are not available at this time, due to limited number of individuals assessed repeatedly. Overall, visitors reported high satisfaction with @ease (4.5 out of 5 on average; 59.8% very satisfied, 33.5% satisfied, 4.2% neutral and 2.5% not satisfied) (Boonstra et al., 2024^[16]).

Importantly, the interpretation of findings about the effectiveness of @ease should be done with caution, due to at least three methodological limitations. First, such pre-post comparisons without a control group cannot account for natural trends, shocks, or other factors that visitors may be exposed to during visits and which may drive changes over time rather than the intervention. It is also not possible to account for statistical artefacts such as regression to the mean. Therefore, any improvements described above might be solely a result of time passing, or other exposures to which visitors are subjected in between @ease visits. Second, the @ease effect may be underestimated, particularly in terms of psychological distress, due to the lack of a baseline measure prior to any intervention (instead, questionnaires were administered at the end of the @ease visits). Last, missing data resulting both from visitors not agreeing to the informed content and from peers' incomplete responses, are likely to introduce selection bias into the findings, whose direction and magnitude are unknown. More recent data from 2023 suggest that 78% of the visitors completed the questionnaires, but there is no indication of such a proportion for visitors between 2018 and 2022. Some evidence is available on the effectiveness of other youth mental health initiatives (Box 10.2), although the differences between these interventions and @ease should be taken into account when comparing results.

Box 10.2. Effectiveness of other youth mental health initiatives

Despite the large number of youth mental health care initiatives in place worldwide for several years, outcome analyses are scarce (Boonstra et al., 2023^[14]) and it has not been possible to definitely conclude whether these initiatives are effective (Hetrick et al., 2017^[19]). Lack of outcome evaluations has been justified by the lack of consensual measures on mental health in youth (Kwan and Rickwood, 2015^[20]) and challenges to capture the broad scope of these interventions in youth development in a holistic manner (Filia et al., 2021^[21]).

Most outcome evaluations were identified for headspace Australia and Jigsaw Ireland. Following a pre-post design, these analyses measure increasing indicators of change over time.

- headspace, Australia: The most recent evaluation included 58 233 young people accessing 108 headspace centres for the first time between 1 April 2019 to 30 March 2020 (Rickwood et al., 2023^[22]). Between the first visit and the last data collection, 35.5% had *significant* improvements in psychological distress (Kessler-10), 36.1% in social and occupational functioning (SOFAS score), 46.9% in self-reported quality of life (MyLifeTracker, a headspace co-developed measure), and 71.0% in any of the three outcomes. The respective proportions of visitors with *clinically significant change* were, 22.4%, 37.8%, 29.9% and 51.7%. These results were obtained based on less than half of the initial sample, corresponding to individuals for which at least two data points were available. The results are generally comparable to the outcomes reported in a previous study (Rickwood et al., 2015^[23]). In both 2015 and 2023 studies, 90-day follow-up data showed that distress scores further decreased with time, but the extremely low response rate at this time point (3.1% and 4%) advises for caution when interpreting follow-up results (Rickwood et al., 2023^[22]; Rickwood et al., 2015^[23]).
- Jigsaw, Ireland: The outcome analysis focusses on psychological distress, measured by CORE-10 and YP-CORE. On a study looking at 2 420 visitors between January and December 2013, 62% had a *reliable* and *clinically significant* improvement in their psychological distress measured by CORE-10, and 68% of participants had a *reliable* improve in YP-CORE (O'Keeffe et al., 2015^[24]).

Caution is required in comparing results above to @ease findings, because of different country contexts, the lack of a control group and most of all the differences in service models. headspace Australia and Jigsaw Ireland have a stronger medical focus than @ease and provide an enhanced blend of primary and specialised care. This could range from therapeutic approaches provided by trained practitioners (general counselling, cognitive behaviour therapy, acceptance and commitment therapy, among others) to support by multidisciplinary teams, while @ease support is provided by peers and follows mostly counselling-based techniques such as active listening and solution-focus techniques (O'Reilly et al., 2022^[25]; Rickwood et al., 2023^[22]).

Efficiency

@ease cost-effectiveness has not been studied.¹ From a cost perspective, the intervention mostly relying on voluntary (unpaid) work of young peers (Leijdesdorff et al., 2022^[13]) leads to a relatively small investment in workforce being needed. Based on the average @ease centre, workforce costs total about EUR 60 000 per year related to hiring a location manager for each centre, volunteer training and related activities. This corresponds to about 60% of the annual costs, which are complemented by rent and office related expenses (25%) and marketing (6%). Two particularities of the Dutch model are that each @ease centre contributes with an annual fee to the @ease central organisation (10%) for support provided at the

national level in aspects such as strategy, marketing, IT and volunteer management; and that the costs of the healthcare professional and psychiatric care backup are covered by partner organisations of the initiative or voluntarily by the healthcare professional (representing an annual budget of approximately EUR 150 000).

Being based on peer's voluntary work, the scale-up of @ease may face fewer limitations related to workforce availability or funding. From the health system perspective, it is unclear whether @ease reduces the care utilisation: it might increase appointments with general practitioner (GP) or psychologist in a first instance, by lowering the barriers to seek care and identifying its need; it might also lower consumption of specialist services at a later stage by preventing acute and severe situations.

Equity

@ease reaches young people in vulnerable circumstances, but to a limited extent. The analysis of visitor demographics shows that a relatively small share of young people who seek @ease support were in vulnerable situations (Boonstra et al., 2024^[16]):

- @ease supported a considerable proportion of young people with at least one parent having mental health problems (32.8% for one-time visitors and 41.3% for returnees). Among those having a mother with mental health problems, depressive disorder was the most reported by the visitor (53.8%), followed by anxiety disorder (9.9%). For fathers, most-reported disorders were also depressive disorders (36.7%), followed by addiction (16.3%) and trauma-related disorders (10.2%).
- About 8% of the visitors (51 out of 611) were not in education or employment.
- In terms of living situation, there were 18 visitors (2.9% out of 619) in a potentially vulnerable situation (e.g. homeless, "staying over", assisted housing) plus 8 living with a caregiver and 9 in "other" situation.
- Gender-wise, 2.4% of the visitors identified as non-binary, with the proportion being 4.6% among returnees.
- Foreign-born individuals made up a large proportion of the visitors (41.3% of one-time visitors and 36.9% returnees), but more than 85% of these come from European countries. The large group of users born in Europe results from @ease centres being primarily located in university cities and differs from the national demographics, in which most foreign-born young people have a non-western background.

Peer training materials are made available in Dutch but also in English, supporting the coverage of non-Dutch English speakers. Through the recent outreach initiative "Everybody @ease", peer counsellors have been visiting neighbourhoods to reach young people where they reside, including those harder to reach. The existence of an online chat available at the national level, initiated during COVID-19 and kept in function during @ease centres opening hours should also improve @ease impacts on equity for the most recent years of activity (Boonstra et al., 2024^[16]). From June 2020 to December 2023 peers engaged in 5 657 online chat conversations with 3 309 individual visitors (monthly average of 132 chats with 77 unique individuals).

Evidence-based

The evidence on the @ease intervention is mainly collected from the study by Boonstra et al. (Boonstra et al., 2024^[16]). The routine outcome monitoring of @ease represents a core element of the initiative, and plans to use the data collected have been published early on, in the form of a protocol paper. However, the key weaknesses of the study by Boonstra et al. (2024) are the lack of a control group and of an accurate

baseline characterisation of the visitors' clinical outcome. Following the advice by a youth panel, the data collection questionnaire and corresponding informed consent are only presented to the visitor at the end of each @ease visit. This means that there is no data collection prior to the intervention (at baseline). There is also a lack of information on the number and characteristics of visitors who did not consent to data collection, and the data collected is incomplete, including on outcomes evaluated by the peer following the visit. In fact, the number of visitors with information on functioning, which is rated by the peer, is lower than visitors with information on psychological distress, which is self-reported. The lack of data prevents the accurate assessment of selection bias, confounders and withdrawals and dropouts. Additionally, from an intervention perspective, the lack of data from past visits hinders the continuity of care. This is particularly important given that the peers who provide support often change between visits.

The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domain of "Data collection methods", moderate in "Study Design", and weak in "Selection Bias", "Confounders", "Blinding" and "Withdrawals and Dropouts" (see Table 10.2) (Effective Public Health Practice Project, 1998^[26]).

Table 10.2. Evidence Base assessment, @ease

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Not likely
	What percentage of selected individuals agreed to participate?	Can't tell
	<u>Selection bias score</u>	Weak
Study design	Indicate the study design	Cohort
	Was the study described as randomised?	No
	<u>Study design score</u>	Moderate
Confounders	Were there important differences between groups prior to the intervention?	Can't tell
	What percentage of potential confounders were controlled for?	80% or more
	<u>Confounder score</u>	Weak
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Yes
	<u>Blinding score</u>	Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
	<u>Data collection methods score</u>	Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	No
	Indicate the percentage of participants who completed the study?	Can't tell
	<u>Withdrawals and dropout score</u>	Weak

Source: Effective Public Health Practice Project (1998^[26]) "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Boonstra et al. (2024^[16]), "Evaluating changes in functioning and psychological distress in visitors of the @ease youth mental health walk-in centres", <https://doi.org/10.1192/bjo.2024.58>.

Extent of coverage

@ease succeeds in removing barriers on access to mental health support, covering a group of young people who have clinical symptoms of mental ill-health and/or suicidal ideation and have mostly not received mental health support in the past three months. Data collected after the first visit show that 90.7% of visitors and 97.1% of returnees had clinically significant psychological distress. Visitors also had

moderate impairment in social functioning. Two-thirds of visitors had not received mental health support in the past three months. This was also the case among those with clinical levels of psychological distress (71.1% of one-time visitors and 64.1% of returnees) which would possibly have continued undetected if not visiting @ease. More than a quarter of visitors (27.6% out of 481) were rated by peers as having suicidal ideations, and the majority of these did not previously seek for support or treatment (65.5% of one-time visitors and 57.1% of returnees with suicidal ideation) (Boonstra et al., 2024^[16]).

Visitors tend to freely access @ease centres without barriers. Two-thirds of the visitors between 2018 and 2020 came into the centre by walking in, without an appointment (Leijdesdorff et al., 2022^[13]). In terms of the intensity of support provided, 586 out of the 754 (77.7%) respondents visited once, 109 visited twice and 59 visited three times or more (168 returnees in total, 22.3%). The average number of visits was 1.65 for all visitors (standard error (s.e.) 0.15) and 3.90 (s.e. 0.66) for returnees; second and third visits happened on average 12 weeks and 17 weeks after the first one (Boonstra et al., 2024^[16]).

The geographic coverage of @ease has been expanded across the Netherlands, with centres in Maastricht, Amsterdam, Heerlen, Rotterdam, Groningen, Leiden, Leeuwarden, Zwolle, Haarlem, Roermond, Eindhoven and Apeldoorn. However, @ease centres are mostly located in urban environments, which might make it difficult to access for youth living in rural areas – although the country benefits from a good public transportation system. Furthermore, each @ease centre opens only a few afternoons a week, and the support is therefore not immediately available at all times for young people in need or at the moment they decide to seek for care.

However, as with the other domains of the framework assessment, the evaluation of coverage is constrained by the lack of data regarding the actual number of @ease visitors. This is because there is no count of those who did not want to complete the questionnaire.

Policy options to enhance performance

Enhancing effectiveness

Expanding the design of @ease to include better links with mental health services and promote integrated care. A stronger emphasis on integrated care could be achieved by dedicated referral pathways for non-crisis visitors or the adoption of the one-stop shop format used in other youth mental health initiatives (Hetrick et al., 2017^[19]), particularly with regards to linking youth support services provided by municipalities or work and education support services. In headspace Denmark, for example, there are “seconded” municipality employees at the headspace centres, promoting integration with municipal services (headspace, n.d.^[27]). An even simpler approach would be to create guidance for the peers on the systematic provision of information on support available in the Dutch health and social care systems. Reinforcing the links with the mental health care system is particularly relevant for two subgroups of @ease visitors: young people with severe symptoms and those at the transition to adulthood. Among @ease visitors, there is a cohort of young people with severe and complex mental conditions and potentially not accompanied anywhere else. While this is a positive result of efforts to remove barriers in access to care by @ease, it also represents a challenge to ensure that this group of young people receive appropriate support beyond peer-led appointments (McGorry et al., 2022^[28]). Evidence from other countries’ youth care initiatives suggests that those with more severe symptoms and higher functional impairment respond less to the support received, potentially requiring more intensive expert care (Hetrick et al., 2017^[19]). Furthermore, young adults around 18 years old are often caught in the transitional gap between children and adolescent mental health services (CHAMS) and adult mental health services (AMHS). In fact, one main objective of other (integrated primary) youth mental health care initiatives has been to shift the upper boundary of youth mental health care from age 18 to 25. @ease is also well-placed to play an important role in preventing young adults from falling through the system cracks.

Increasing continuity in @ease support. By design, @ease intervention is freely accessible, meaning that the visitor decides if and when to return to @ease. Such design was selected to match young people preferences and to overcome barriers that apply to traditional services (Boonstra et al., 2023^[14]). However, this approach may prevent continuous engagement, potentially leading to lost opportunities for further benefit from @ease visitors. There are options to nudge visitors into continuous support while still empowering them to own and decide about their support journeys. For instance, in cases of high visitor satisfaction and need for additional care, the peers could immediately suggest an appointment for a follow-up visit. Follow-up with the same peer should also be prioritised to ensure the build-up of a therapeutic relationship which is likely to improve outcomes.

Enforcing more consistent data collection. This would be beneficial in informing subsequent interactions with the returnees, which are often conducted by different peers, and in monitoring the intervention effectiveness. It is recommended that efforts are made to reduce the non-response rate and increase the completeness of the questionnaire responses. This should be done both with visitors and peers.² Peers could be provided with (non-)financial incentives for data collection. Visitors could be presented with information justifying the need for data collection and explained the relevance of this information. The timing of data collection could also be revisited to allow a proper characterisation of the baseline, at least for the first visit (see Enhancing the evidence-base).

Enhancing efficiency

Ensuring that peers deliver maximum value in their ways of working is key to increase @ease cost-effectiveness, for example in terms of better data collection. Peer incentives can be either financial or non-financial (such as guidelines or standards).

Enhancing equity

Increasing the proportion of traditionally underserved populations reaching to @ease. These population groups include, for example, youth not in employment, education or training (NEET) or in instable housing situations, from the LGBTQI+ community or from low socio-economic groups or minoritised ethnicities. These groups are traditionally harder to reach by traditional services, but youth mental health initiatives in other countries have been successful in doing so (Hetrick et al., 2017^[19]). To increase the representation of these groups, @ease should invest in dissemination among the respective social circles and active recruitment of peers that can act as ambassadors, as well as peers with cultural and linguistically diverse backgrounds. In further expansions of @ease, priority should be given to opening new centres in socially disadvantaged neighbourhoods and/or rural areas and investing in alternative channels such as promoting the online chat to reach out to underrepresented groups that may face barriers such as stigma, costs and time of transportation. For instance, telephone and online appointments are used in other youth mental health care initiatives (McGorry et al., 2022^[28]).

Enhancing the evidence-base

Enhance data collection. The evaluation of @ease is limited due to missing data on visitors, which raises concerns about the internal and external validity of the results, and prevents the generalizability of the findings. A minimum set of variables should be collected for all individuals (e.g. gender, age, country of birth), allowing a better characterisation of non-respondents. For young people who consent to have their data collected, there should be a focus on increasing the proportion of questions responded, namely the peer-rated information which does not depend on the visitor. Data collection should be reinforced as part of peers training and strongly enforced by the local manager and on-site healthcare practitioner. Incentivising peers might also be a solution to improve the completeness of the data reported.

Revisiting the timing of data collection. Visitors are currently only requested to complete a questionnaire at the end of the @ease visit. Unfortunately, this restricts the ability to conduct baseline characterisation (which measures the situation before the intervention) and introduces inaccuracies into routine outcome monitoring, in particular for psychological distress. For instance, data on psychological distress could be collected at the beginning of the conversation and presented as relevant to inform the advice. For visitors who decline to provide data at the beginning of the visit, the peer should provide detailed information on data privacy and the relevance of the data collection after the visit. This should be followed by an opportunity for visitors to re-consider their decision. For those providing information prior to the visit, the peer would enquire about their availability to complete additional information after the conversation (e.g. satisfaction with @ease).

Conducting a randomised experiment with a control group. It might be worth revisiting the moral concerns surrounding the randomisation of young people in need of care in the context of resource scarcity. This is particularly relevant when considering the equally important ethical implications of investing in interventions without a strong evidence basis (Kisely and Looi, 2022^[29]). The experiment could make use of an active control group that would either receive standard-of-care or an alternative option (e.g. digital self-help tools). Alternatively, statistical methods and econometric tools exist to allow for causal inference in observational settings (e.g. matching method). The use of quasi-experimental designs could be considered in further expansion of @ease, by following a staggered implementation and/or taking advantage of secondary data, for example the microdata infrastructure of Statistics Netherlands. Linking current research to administrative data would allow measuring long-term outcomes in health, education and labour market participation. These outcomes are highly relevant for the estimation of @ease benefits and cost-effectiveness, particularly given the large proportion of university students using the programme.

Enhancing extent of coverage

Investing in sustained mental health support through @ease. While @ease is designed with a high degree of flexibility, the high proportion of visitors who are both satisfied and in clinical need after the first visit indicate the need for active efforts to increase the return rate. To achieve this, peers could present the benefits of continued support during the conversation and immediately schedule a follow-up appointment after the visit. There is potential for an expansion in the number of opening days, opening hours and channels available for remote follow-up (online, telephone, video) (Hetrick et al., 2017^[19]; O'Reilly et al., 2022^[25]).

Transferability

This section explores the transferability of @ease and includes three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring @ease.

Previous transfers

Several youth mental health care initiatives have been implemented worldwide in the last 20 years. Among these, some initiatives feature youth participation as a key aspect in their service models. Several care networks (Foundry, ACCESS Open Minds and ICCT in Canada and New Zealand Youth One Stop Shop and single centres (The Junction in the United Kingdom, CHAT in Singapore, SPOT in US, and KYDS Youth Development Service in Australia) have been described as offering peer support to visitors (Hetrick et al., 2017^[19]). Most initiatives include peers as an additional form of care provision. It is less common for these initiatives to strongly rely on peer-delivered care, as @ease. Only headspace Denmark, started in 2013, has been identified with a similar design (McGorry et al., 2022^[28]), having its centres run by peers: a small group of paid youth counsellors helped by volunteers of all ages and supported by a local manager and often a municipality worker and psychiatry practitioner as well (headspace, n.d.^[27]).

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of @ease were identified (see Table 10.3). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 10.3. Indicators to assess the transferability of @ease

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Volunteering – Share of individuals volunteering time to an organisation in the past month (%) (Gallup, 2023 ^[30])	@ease relies on voluntary youth to provide support to their peers. Therefore, the intervention will be more transferable in countries where volunteering and community engagement is high.	↑ value = more transferable
<i>Sector specific context</i>		
Psychologists per 1 000 population (OECD, 2021 ^[31])	Although based on peers, all @ease centres need to have a mental health practitioner present while open. Therefore, the intervention is more transferable in countries with a higher proportion of psychologists.	↑ value = more transferable
Mental health nurses per 1 000 population (OECD, 2021 ^[31])	Although based on peers, all @ease centres need to have a mental health practitioner present while open. Therefore, the intervention is more transferable in countries with a higher proportion of mental health nurses.	↑ value = more transferable
Talking therapy provided by primary care providers (OECD, 2021 ^[31])	@ease consists of a peer support intervention developed as an entry point (or a complement) to mental health support provided by practitioners in primary care. If no mental health support is provided in primary care, countries might likely follow other models of youth centres where mental health support is provided by practitioners (e.g. Australian headspace model). Therefore, the intervention is more transferable in countries with a similar set-up to the Dutch one, in which counselling and therapy are widely available.	Yes = more transferable
<i>Political context</i>		
Strategy or action plan that guides implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[32])	@ease is more transferable to countries that have a strategy to implement mental health policy in place, facilitating the commitments and modifications needed in terms of leadership/governance, funding, and infrastructure, among others.	Yes = more transferable
Policies and programmes to support and promote mental health of children and adolescents (OECD/WHO Regional Office for Europe, 2023 ^[33])	A country with a policy focussed on mental health of youth is more likely to support and have the proper funding and infrastructure to implement @ease. Therefore, the intervention is more transferable in countries that already have policies and programmes to promote the mental health of children and adolescents	Yes = more transferable
Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare (OECD/WHO Regional Office for Europe, 2023 ^[34])	A country with policy focussed on promotion, prevention and treatment of mental health in primary care is more likely to be at the right stage of development of mental health system to implement support in the community following the @ease model. If no mental health support is provided in primary care, countries might likely follow other models of youth centres where mental health support is provided by practitioners (e.g. Australian headspace model). Therefore, the intervention is more transferable in countries that have implemented policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare.	Yes = more transferable
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[35])	Youth mental health care centres place a stronger emphasis on prevention, therefore the intervention is more transferable to countries that allocate a higher proportion of health spending to prevention.	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below. Due to 50% or more of the indicators missing, five countries were removed from the analysis.

- a) In the Netherlands, the share of individuals volunteering time to an organisation in the past month is 32%, in the highest quartile of the distribution of OECD and EU countries studied. This suggests that the Dutch population is more used to engage in volunteering than most countries being considered for @ease transfer.
- b) The number of psychologists per 1 000 population in the Netherlands (0.94) is higher than for most of OECD and EU countries with data (median 0.43). In eight countries with lower number of psychologists, the higher number of mental health nurses can compensate for the practitioners needed to implement @ease.
- c) The Netherlands reported that talking therapy is provided by “some” primary care providers, while only Estonia and Norway responded “all”. Widespread psychological support in primary care might favour @ease implementation and co-ordination with the mental health care system.
- d) The Netherlands did not provide information on having a strategy or action plan to guide the implementation of mental health policy. However, the positive answer of the vast majority of countries (90%) suggests that implementing @ease would benefit from existing infrastructure and experience.
- e) Most countries (90%) do also have policies and programmes to support and promote the mental health of children and adolescents, including the Netherlands. The implementation of @ease can benefit from the prioritisation of this policy area in most countries.
- f) As six other countries, the Netherlands does not have policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary healthcare. For the countries with such programmes, the implementation of @ease might be facilitated but it is also important to align its objectives and adapt to other existing initiatives with similar goals.
- g) The Netherlands allocates 0.58% of its GDP to prevention, which is above the median of the countries studied (0.40%). Countries with a higher spending on prevention are more likely to have economic support for the transfer of @ease.

Table 10.4. Transferability assessment by country

A darker shade indicates ease is more suitable for transferral in that particular country

	Volunteering	Psychologists per 1 000 population	Mental health nurses per 1 000 population	Talking therapy	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies for promotion, prevention and treatment in primary care	Prevention spending (% GDP)
Netherlands	0.32	0.94	n/a	Some	n/a	Yes	No	0.58
Australia	0.34	1.03	0.91	Some	Yes	Yes	Yes	0.35
Austria	0.24	1.18	n/a	Some	Yes	Yes	No	1.25
Belgium	0.26	0.10	1.26	Some	Yes	Yes	Yes	0.35
Canada	0.34	0.49	0.69	Some	No	Yes	n/a	0.68
Chile	0.17	n/a	n/a	n/a	Yes	Yes	Yes	0.31
Colombia	0.21	n/a	n/a	n/a	Yes	Yes	Yes	0.16
Costa Rica	0.22	n/a	n/a	n/a	Yes	No	Yes	0.06
Czechia	0.24	0.03	0.31	Nobody	n/a	Yes	Yes	0.77
Denmark	0.25	1.62	n/a	Some	Yes	n/a	Yes	0.48
Estonia	0.20	0.06	0.23	All	Yes	Yes	Yes	0.62
Finland	0.24	1.09	n/a	n/a	Yes	Yes	Yes	0.48
France	0.30	0.49	0.98	n/a	Yes	Yes	Yes	0.68
Germany	0.27	0.50	n/a	n/a	No	Yes	Yes	0.83
Greece	0.20	0.09	0.13	Few	Yes	Yes	No	0.37
Hungary	0.17	0.02	0.34	n/a	Yes	Yes	No	0.56
Iceland	0.25	1.37	n/a	Some	Yes	Yes	Yes	0.28
Ireland	0.29	n/a	n/a	Some	Yes	Yes	Yes	0.36
Israel	0.28	0.88	n/a	Nobody	n/a	Yes	Yes	0.02
Italy	0.19	0.04	0.23	Nobody	Yes	Yes	Yes	0.59
Japan	0.19	0.03	0.84	Few	Yes	Yes	Yes	0.36
Korea	0.20	0.02	0.14	Few	Yes	Yes	Yes	0.77
Latvia	0.12	0.67	0.23	Nobody	Yes	Yes	Yes	0.46
Lithuania	0.11	0.16	0.50	Some	Yes	Yes	Yes	0.44
Luxembourg	0.31	0.59	n/a	Few	n/a	Yes	No	0.26
Mexico	0.20	n/a	n/a	Nobody	Yes	Yes	Yes	0.18
New Zealand	0.34	0.86	0.75	Some	Yes	Yes	Yes	n/a
Norway	0.31	1.40	0.66	All	Yes	Yes	Yes	0.27
Poland	0.07	0.16	0.31	Nobody	Yes	Yes	Yes	0.14
Portugal	0.13	n/a	n/a	n/a	Yes	Yes	Yes	0.35
Slovak Republic	0.17	n/a	n/a	n/a	No	No	No	0.13
Slovenia	0.27	0.09	0.36	Some	Yes	Yes	Yes	0.50
Spain	0.19	0.55	0.03	n/a	Yes	Yes	Yes	0.37
Sweden	0.16	0.99	0.51	n/a	Yes	Yes	Yes	0.55
Switzerland	0.27	0.26	n/a	Few	Yes	Yes	Yes	0.33
Türkiye	0.10	0.03	1.50	Nobody	Yes	Yes	Yes	n/a
United Kingdom	0.26	0.36	0.53	Some	Yes	Yes	Yes	1.55
United States	0.39	0.30	0.04	n/a	Yes	Yes	Yes	0.84

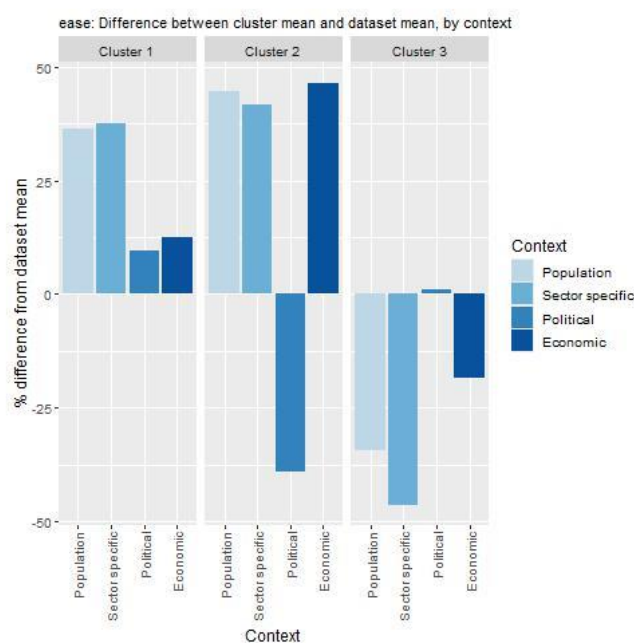
Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicator can be found in Table 10.3.

Source: Gallup (2023^[30]), Share of individuals volunteering time to an organization in the past month (%); OECD (2021^[31]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, <https://doi.org/10.1787/4ed890f6-en>; OECD/WHO Regional Office for Europe (2023^[32]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy; OECD/WHO Regional Office for Europe (2023^[33]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support and promote mental health of children and adolescents; OECD/WHO Regional Office for Europe (2023^[34]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to enable mental health promotion, prevention and treatment of mental health conditions in primary health care; OECD (2024^[35]), OECD Data Explorer - Prevention spending as a percentage of GDP, <http://data-explorer.oecd.org/s/1n/>.

To help consolidate findings from the transferability assessment above, countries have been clustered into three groups, based on indicators reported in Table 10.3. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A. Key findings from each of the clusters are below with further details in Figure 10.1 and Table 10.5:

- Countries in cluster one have population, sector, political, and economic conditions in place that would support the introduction of @ease. This cluster consists of 14 countries.
- Countries in cluster two have population, sector-specific and economic indicators favourable to the implementation of @ease, although these countries may wish to consider ensuring that the implementation aligns with political priorities. This cluster consists of four countries, including the Netherlands.
- Countries in the remaining cluster may wish to undertake further analyses to ensure the programme has populational, sector-specific and economic arrangements to support its implementation. This group includes 20 countries.

Figure 10.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 10.5. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia Belgium Denmark Finland France Germany Iceland Ireland Israel New Zealand Norway Slovenia United Kingdom United States	Austria Canada Luxembourg Netherlands	Chile Colombia Costa Rica Czechia Estonia Greece Hungary Italy Japan Korea Latvia Lithuania Mexico Poland Portugal Slovak Republic Spain Sweden Switzerland Türkiye

Note: Due to high levels of missing data, the following countries were omitted from the analysis: Bulgaria, Croatia, Cyprus, Malta, and Romania.
 Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone are not ideal to assess the transferability of public health interventions. Box 10.3 outlines several new indicators policymakers could consider before transferring @ease.

Box 10.3. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of stigma about mental health conditions in the population and amongst youth?

Sector specific context

- What is the performance of the Children and Adolescents Mental Health services (CAMHS): ratio of psychologists per capita, waiting lists, transition to Adult Mental Health services (AMHS)?
- Is access to CAMHS referred by general practitioners?
- Is youth mental health support provided in primary care and by whom (e.g. general practitioners or dedicated professionals such as mental health nurses and psychologists)?
- What is the country's reliance on charities, community groups and NGOs for youth mental health support and youth support more broadly?

Political context

- Do municipalities or other local structures have any responsibility in providing support to youth mental health?

Economic context

- Are there dedicated funds to implement initiatives to prevent mental ill-health in youth, either at the local or at national level?

Conclusion and next steps

@ease provides peer-based low-barrier support to young people walking-in or with an appointment at @ease centres, anonymously, at no cost and without referral. Support is provided in non-clinical settings by volunteer young adult peers trained in active listening, solution-focussed strategies and motivational interviewing, and supervised by an on-site health professional.

@ease may improve the psychological distress and functioning in young people returning after the first visit, but definitive conclusions about effectiveness have so far been hampered by the lack of a control group and the small number of visitors with outcome information. Existing evidence suggests that @ease returnees improve over time in terms of psychological distress, social and occupational functioning, and potentially school absenteeism in the last three months. Returnees also appear to increase their use of mental health support between the first, the second and the third visits. Given the high proportion of visitors in clinical need and satisfied with the support received, the effectiveness of @ease could be maximised by increasing the continuity of support and promoting a therapeutic relationship between the peer and the visitor. The current @ease working method could also be extended to better support integration of care, facilitating visitors' access to either social services or mental health care.

@ease covers a group of young people with considerable clinical needs, often with suicidal ideation and who have mostly not received mental health support in the recent past. Expanding the opening hours of @ease centres and channels to provide support (e.g. online, videoconference) as well as increasing the return rate would maximise the current extent of coverage. Additional efforts are needed to reach to traditionally underserved groups, such as gender and sexual minorities, minority ethnic groups or those with low socio-economic status.

Better data collection is essential to produce @ease results. This includes increasing the proportion of young people consenting to data collection and increasing questionnaire completeness, in particular peer-reported data. The provision of (non-)financial incentives might be a tool to achieve the latter objective. Conducting a controlled study to evaluate the effectiveness of @ease and complementing it with an economic evaluation will allow for a more accurate picture of the potential cost-effectiveness of @ease. The use of volunteer peers, which result in low workforce costs, will also be a key factor in the programme's evaluation.

@ease transferability analysis suggests that the initiative would mostly find positive conditions for a transfer in 18 countries. For the remaining 20 countries, additional analyses would be needed to ensure that population, sector-specific and economic arrangement are in place to support the transfer.

Box 10.4 outlines next steps for policymakers and funding agencies.

Box 10.4. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance @ease are listed below:

- Improve the return rate of users and the continuity of support through incentivising follow-up appointments, expanding @ease centres opening hours and using alternative communication channels.
- Expand the scope of @ease to promote integration of care and to support youth in further accessing mental health care and social services, particularly at the transition to adulthood (when there are coverage gaps).
- Improve the data collected through routine outcome monitoring both by increasing the number of young people who consent to data collection and by increasing the completeness of the data, such as peer-reported variables.
- Conduct a controlled study, preferably with randomisation by using an active control group, and a cost-effectiveness study.
- Implement mechanisms to minimise the risk of fidelity loss while quickly scaling @ease through the opening of centres across the Netherlands.
- Improve the ability of @ease to attract and support traditionally underserved groups, such as gender and sexual minorities, minority ethnic groups or those with low socio-economic status.

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Notes

¹ In fact, anecdotal evidence provided by the @ease research team suggests that refusal to complete the questionnaire by the visitors is low and a part of the visitors without data might be due to peers not administering the questionnaire (and respective consent).

11 This is me (“To sem jaz”)

This chapter covers the case study of This is me (#tosemjaz), a prevention programme aimed at developing social and emotional skills and self-image in adolescents in Slovenia. The case study includes an assessment of This is me against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

This is me: Case study overview

Description: *This is me* is a prevention programme aimed at strengthening social and emotional skills and building a positive self-image as key protective factors of adolescent mental health. The programme consists of two universal prevention interventions. Intervention 1 (#tosemjaz) offers anonymous, simple, rapid, and free access to online expert advice answering youth's questions, either asynchronously or synchronous via chat conversations. Intervention 2 consists of a comprehensive model of 10 preventive workshops that systematically address the development of social and emotional competencies and realistic self-evaluation. Intervention 2 targets school classes in primary/lower secondary education and is implemented mostly by teachers or school counsellors trained for that purpose.

Best practice assessment:

OECD best practice assessment of *This is me* ("To sem jaz")

Criteria	Assessment
Effectiveness	Evidence to evaluate the effectiveness of #tosemjaz online counselling (intervention 1) is not available. While most results from the study assessing the 10 preventive school workshops (intervention 2) are statistically non-significant, they suggest potential effects on student outcomes (interpersonal difficulties, coping and self-concept) that should be further evaluated. Classroom climate, as rated by the teachers, significantly improved by the end of the programme, compared with baseline ($p=0.03$).
Efficiency	<i>This is me</i> cost-effectiveness has not been evaluated. Cost-wise, both interventions require low investment in human resources. #tosemjaz online counselling mostly relies on the voluntary work of individuals that are trained to respond to queries by maximising advice and information developed over time. Volunteers are supported by a full-time (paid) editorial office. The 10-workshop programme is implemented by teachers or school counsellors, mostly during class time.
Equity	Both <i>This is me</i> interventions are universal preventive strategies freely made available to youth (intervention 1) and to students (intervention 2) in Slovenia. These interventions have the potential to reach out to most vulnerable groups: the online advice can be used at any point in time, in an anonymous way and from anywhere with internet connection. The school workshops are deployed at the classroom level and mostly during class, potentially reaching groups at higher risk that would otherwise not seek for help.
Evidence-base	Despite being implemented for long time, there is only one study evaluating <i>This is me</i> , namely the 10 school workshops programme. The study includes a control arm but ranks poorly on confounding and blinding.
Extent of coverage 	#tosemjaz online counselling has answered more than 57 000 questions over a period of 23 years, mostly from girls. The severity of the problems driving the questions seems to have increased in recent years. In 2023, <i>This is me</i> school workshops have been deployed in 15% of Slovenian schools.

Enhancement options: *To enhance the effectiveness* of the school-based programme intervention 2, it is essential to ensure that the complete set of 10 workshops is delivered as per the programme objective, to identify and maximise programme features that promote connectedness between students, and to select workshop providers that already have a positive relationship with students. *To enhance equity*, it is recommended to increase the uptake of #tosemjaz, particularly the synchronous chat sessions, by the population groups at higher risk of poor mental health, including those identified during the school workshops, bridging interventions 1 and 2. *To enhance the evidence base*, it is essential to conduct an outcome evaluation of the online services and improve the study design and outcome measures of the evaluation of the school-based programme. *To enhance the extend of coverage*, greater availability and dissemination of synchronous chat sessions would be beneficial, as well as boosting the number of schools receiving the programme.

Transferability: 22 out of 43 OECD and EU countries have the population, political and economic contexts that would facilitate the transfer of *This is me*, while another six countries require further political support. For the remaining 15 countries, the potential for transfer of *This is me* is more limited.

Conclusion: *This is me* promotes universal prevention efforts for youth mental health in Slovenia through a comprehensive approach that includes two separate interventions. Enhancements in terms of effectiveness, coverage and the evidence base could excel the value delivered by the programme.

Intervention description

This is me ("To sem jaz" in Slovenian) is a youth mental health prevention programme with the objective of supporting young people in coping with the everyday challenges of growing up. It focusses on developing social and emotional skills and self-image, in youth from 13 years old onwards.

The programme includes two complementary universal prevention interventions. Intervention 1 consists of online information and counselling services available via a dedicated website (www.tosemjaz.net), providing anonymous, publicly available and free access to expert advice on a voluntary basis. Intervention 2 consists of a comprehensive model of 10 preventive workshops implemented in schools. It follows an evidence-based model for preventive work to develop social and emotional skills in the classroom.

This is me was founded in April 2001 in Celje, Slovenia. The online advice service was first implemented and has been ongoing for 23 years. Its creation was informed by a study on the needs of the target group (adolescents aged 14-18), which highlighted the challenges of adolescence, especially about low self-image, unpleasant feelings and ways of coping with the everyday challenges of growing up. The two interventions are described below in more detail based mostly on information provided by the Celje Regional Unit of the National Institute of Public Health from Slovenia.

Intervention 1

The **online service for young people**, branded as #tosemjaz, provides a space for support, advice and counselling. #tosemjaz gives young people facing the challenges of growing up, access to verified, evidence-based information and guidance from experts.

Young people can access the website and consult with experts in two different ways. Asynchronous online advice has been the model followed since the #tosemjaz implementation. Adolescents choose a nickname, describe their problem, and submit their question. An editorial team reviews each question, publishes it and assigns it to a member of the team, who will then publish the answer publicly. Synchronous online guidance and counselling has become available since March 2022. Through this format, young people have the option to anonymously chat with an expert who is online at the same time. The synchronous online sessions are regularly advertised on #tosemjaz website. For instance, in 2023, synchronous online sessions occurred three times a month with a psychologist and once a month with a gynaecologist. Although user registration asks young people to submit personal information, registration is not a mandatory condition for adolescents to receive an expert advice through the online service. Registered and unregistered users are equally likely to have access to expert advice.

#tosemjaz relies on a unique multidisciplinary network of volunteer professionals working online. In 2023, this network consisted of 61 psychologists, 17 medical doctors from various specialties (such as gynecologist) and 22 counsellors from other fields such as social work, social pedagogy and sport, for a total of 100 volunteers contributing without financial remuneration. A secondary objective of *This is me* is to ensure the growth and diversity of this volunteer network and ensure the development of online counselling as a discipline, for example through the development of guidelines and standards to support further advice provided online.

The key requirement to become a counsellor is to have a bachelor's or a master's degree from an accredited higher education institution. Since 2019, all new counsellors are supervised by experts working in the editorial office. The possibility of consulting a supervisor remains available throughout their activity in case of doubts when preparing an answer. An editorial office plays a central role in the online advice service, by daily managing the communication between adolescents and experts and ensuring safe and respectful communication. The editorial office classifies and codes the online questions based on their content category, topic and subtopic, and if available, gender and age of the users. The periodic analysis

of this information helps monitoring user needs and planning further preventive work. An e-platform for content analysis known as #TSJDashboard is used by the editorial office to prepare regular monthly and annual reports on the activity provided.

The provision of online information and advice by experts is based on literature developed within the *This is me* programme, namely a monograph that contains almost 6 000 online questions answered till 2014 (also available for consultation by the general public and used as guidelines for the induction of new counsellors since 2023).

Online crisis interventions and editorial protocols are set up to manage cases of extreme distress and crisis situations. In these situations, online counsellors provide emotional relief to adolescents and relevant information and guidance to obtain face-to-face professional help (per editorial protocol). In cases of extreme distress, the editorial staff might consult external experts from social services, police and justice.

Besides expert advice, #tosemjaz website is also a repository of professionally verified sources of information, including about 300 articles supported by pictures, graphics and infographics that cover a range of different topics (from the body to sexuality, love, relationships with family and friends, among others). Numerous articles and columns are supported by audio and video material and worksheets, particularly those dealing with mental health. Since 2022, this content is also proactively sent to subscribers in a e-magazine called #tosemjaz. *A friend when growing up*.

Intervention 2

The second intervention that is part of *This is me* is a **universal prevention programme in the school environment. It consists of 10 preventive workshops** that help adolescents to build social and emotional skills and a better self-image.

This intervention has its origins in an information content produced for the #tosemjaz in 2007: “10 steps for a better self-image”. It was then further developed in a handbook for preventive work in schools, available from 2011 onwards. The current 10-workshop programme is implemented based on the supplemented handbook *Maturing through the This is Me programme: Development of social and emotional skills and self-image*, available since 2019 and informed by an evaluation study conducted in 2017/18.

Each workshop is evidence-based and addresses one or more of the fundamental areas of adolescent experience and behaviour, developing particular social and emotional competencies (Table 11.1). The activities of the workshop aim at strengthening skills that enable adolescents to cope more effectively with the challenges of growing up and help them building better quality relationships and greater mental resilience. This process can be put in the context of social and emotional learning, through which children and adolescents acquire fundamental social and emotional competencies in five interconnected fields: self-awareness, self-management, social awareness, relationship skills and responsible decision making (CASEL, 2012^[1]). Social and emotional competencies are aimed at reducing risk factors and strengthening protective factors for successful psychosocial adaptation. The workshops aim at encouraging adolescents to have an active attitude towards setting goals, taking responsibility, solving problems, co-operating with others, developing self-respect, coping with stress and improving other life skills.

Table 11.1. 10-workshop programme of *This is me* (intervention 2)

Number	Topic of the Workshop
1st	I respect and accept myself
2nd	I set goals for myself and work on attaining them
3rd	I co-operate with others and accept them – I have friends
4th	I solve problems
5th	I cope with stress
6th	I think positive
7th	I accept responsibility for my behaviour
8th	I know I am a special and unique individual
9th	I stand my ground
10th	I recognise, accept and express my emotions

Source: Information provided by the Celje Regional Unit of the National Institute of Public Health from Slovenia.

Workshops providers are both class and subject teachers and school counsellors. The workshops are typically scheduled during class time or tutor group periods. They are adapted to the adolescent phase of development (age 13 to 17), coinciding with the final years of primary and lower secondary education and the first year of upper secondary education. Primary and secondary schools are invited to plan and implement *This is me*, with the assistance of training on the programme's concept and the provision of programme literature. The training of the implementation of the programme is provided to all the education professionals in the school, including teachers, school counsellors and principals. In addition, health and social care professionals, youth and NGOs workers who are part of the school environment may also receive the training. The model has been tested in practice and has obtained the expert recommendation of Slovenia's National Education Institute for implementation in Slovenia's schools.

The programme includes literature and materials made publicly available such as the handbook "*Maturing through the This is Me programme: Development of social and emotional skills and self-image*", which consists of practical guidelines and instructions for workshop implementation, including worksheets for each workshop. The self-help manual *What can I do to make it easier?* has been published in 2022, aiming at adolescents aged 15 and over. It is based on the behavioural cognitive paradigm, helping young readers to understand the circular connection of thoughts, emotions and behaviour, providing guided self-help exercises, and making the link with the #tosemjaz website. Promotional materials and e-work packs providing information about #tosemjaz online service are made available to schools as supplementary materials.

OECD Best Practices Framework assessment

This section analyses *This is me* against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 11.1 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Evidence available to evaluate the performance of *This is me* differs by intervention. Information about the online advice service (intervention 1) mostly consists of process and user experience indicators with no formal evaluation of outcomes. The 10-workshop programme (intervention 2) was initially evaluated in 2007 and underwent a more comprehensive evaluation in 2017/18. The objective was to provide schools with a verified model for conducting preventive work in the classroom (Sedlar et al., 2019^[2]).

Box 11.1. Assessment of *This is me*

Effectiveness

- Evidence to evaluate the effectiveness of #tosemjaz online counselling (intervention 1) is not available.
- While most results from the study assessing the 10 preventive school workshops (intervention 2) are statistically non-significant, they suggest potential effects on student outcomes (interpersonal difficulties, coping and self-concept) that should be further evaluated.
- Classroom climate, as rated by the teachers, significantly improved by the end of the programme, compared with baseline ($p=0.03$). Similar improvement is not identified in the classroom climate as rated by the students.

Efficiency

- Cost-effectiveness of both interventions has not been evaluated. Both interventions require low investment in human resources. #tosemjaz online counselling mostly relies on the voluntary work of individuals that are trained to respond to queries by maximising advice and information developed over time. Volunteers are supported by a full-time (paid) editorial office. The 10-workshop programme is implemented by teachers or school counsellors, mostly during class time.

Equity

- Both interventions are universal preventive strategies freely made available to youth (intervention 1) and to students (intervention 2) in Slovenia. Both interventions have the potential to reach out to most vulnerable groups: #tosemjaz online counselling can be used at any point in time, in an anonymous way and from anywhere with internet connection. The school workshops are deployed at the classroom level and mostly during class, potentially reaching groups at higher risk that would otherwise not seek for help.

Evidence-base

- Most of the existing evidence on *This is me* effectiveness comes from one study that evaluated the 10 school workshops programme in 2017/18. The study includes a control arm but ranks poorly on confounding and blinding.

Extent of coverage

- #tosemjaz online counselling has answered more than 57 000 questions over a period of 23 years, mostly from girls. The severity of the problems driving the questions seems to have increased in recent years. In 2023, *This is me* school workshops have been deployed in 15% of Slovenian schools.

Effectiveness

Intervention 1

Despite the extensive information produced about the #tosemjaz online counselling, there is no evaluation of the effectiveness of #tosemjaz on young people. Existing evidence describes the type of questions and responses posted on the #tosemjaz website, as well as some characteristics of online service users (see section Extent of coverage for more details). Additionally, a user survey and user interviews were

conducted in 2013 but these focussed mostly on user experience and expectations. Results suggest that most users of the online counselling found the answers useful and helpful, and valued the possibility of writing about their problems anonymously and receiving verified expert advice. Similarly, the literature provides limited evidence on the effectiveness of online counselling. A meta-analysis showed that online universal and selective (focussing on groups at risk) prevention interventions effectively reduce depressive symptoms, but have limited effects on anxiety and stress scores. But, these findings are based on interventions that include more intense and continued support than that is typically provided within #tosemjaz (e.g. some degree of cognitive or bias modification training) (Noh and Kim, 2023^[3]). It is worth noting that while most literature on technology-delivered prevention for youth mental health is positive about the effectiveness of this mode of delivery, the studied interventions usually provide some degree of psychotherapy to groups at risk or with symptoms (selective or indicated prevention, respectively). As a result, it is not possible to extrapolate the results to #tosemjaz (Noh and Kim, 2023^[3]; van Doorn et al., 2021^[4]). The literature on help-seeking for mental health difficulties indicates that several attributes common to #tosemjaz are beneficial to the users. These include anonymity and privacy, ease of access and immediacy and the ability to connect with others and share experiences. Despite the lack of preference for formal mental health or government websites, young people value services with human contact and run by (mental health) professionals, online communities and discussion forums (Pretorius, Chambers and Coyle, 2019^[5]).

Intervention 2

An evaluation study conducted in 2017/18 is the basis of *This is me* effectiveness assessment. It included 10 primary schools in which 224 students (mean age at baseline 12.9 years, corresponding to grade 8) participated in the workshop programme, provided by 13 education professionals at the class level. The study also collected data from 201 students from control classes (not subjected to the workshops) and from 64 teachers teaching the classes receiving workshops, but that were not involved in their implementation. Evaluations were conducted after five workshops (intermediate) and 10 workshops (final). Results from the final evaluation, described below, are obtained from 170 to 185 students per group, depending on the outcome (Sedlar et al., 2019^[2]).

The impact of *This is me* workshops on students was measured in three domains:

- interpersonal difficulties, measured with the Questionnaire on Interpersonal Difficulties in Adolescence in six domains: family relationships, friendships, relationships with the opposite sex, assertiveness, and public speaking (Inglés et al., 2008^[6]);
- coping, measured with the Adolescent Coping Questionnaire (Frydenberg et al., 2001^[7]) and distinguishing between effective coping style (e.g. a focus on solving problems, maintaining friendships, focus on work, seeking professional help, accepting the support of others, seeking relaxing diversions, physical exercise) and ineffective coping style (e.g. ignoring problems, worrying, not overcoming, self-blame, keeping to yourself, wishful thinking);
- self-concept, which captures the image that one has about herself, is measured with the Self-Concept Questionnaire (Musitu et al., 2016^[8]), portraying characteristics, views and beliefs that individuals usually attribute to themselves overall and in specific dimensions (family/domestic environment, academic performance, social relationships, physical appearance, and emotional states).

Students attending the *This is me* workshops showed no change in their outcomes over time (from the baseline to intermediate and final measurements) in the three domains above, compared to the control group who experienced deterioration in these three areas. While interpersonal difficulties increased in the control group, mostly in the domains of friendships, opposite sex and assertiveness, students participating in *This is me* workshops had a (statistically non-significant) reduction in these problems by the end of the 10 workshops, both overall (mean $\pm$ standard deviation: 44.58 $\pm$ 25.73 to 43.15 $\pm$ 25.94, $p=0.39$) and in each

of the six domains (Sedlar et al., 2019^[2]; Boben, 2018^[9]). Coping strategies did not change significantly in the intervention group, while both effective and ineffective strategies tend to decrease in the control group (Sedlar et al., 2019^[2]; Boben, 2018^[9]). Last, the self-concept of students in the control group decreases over time, mostly within the family environment, while for those participating in the 10-workshop it remains mostly similar to baseline, displaying small positive increases in some specific dimensions.

Changes over time and between the intervention and control groups reported above are mostly small in magnitude and statistically non-significant. The non-significance of results might be associated with the small number of students participating in the study, and the heterogeneous composition of the students (e.g. the geographical location of the schools or the size and performance of the classes). While some schools selected more problematic classes to participate, other schools took the opposite approach.

In addition to student outcomes, the Classroom Environment Questionnaire (Zabukovec, 1998^[10]) was used to measure the current and desired classroom climates as perceived by students and teachers. The control group reported some deterioration in the classroom environment, while the intervention group showed no change over time (Sedlar et al., 2019^[2]; Boben, 2018^[9]). Interestingly, classroom climate scores given by students were lower than the average scores given by their teachers (47.54 ± 6.50 vs. 52.46 ± 5.00 , respectively) and students did also report a larger gap between existing and desired classroom climate than teachers (6.36 ± 7.43 vs. 3.31 ± 5.48 , respectively). Teachers considered that the classroom climate had improved by the end of the programme, with improvement in the perception of the existing classroom climate ($p=0.03$) and existing interpersonal relationships ($p=0.07$). Last, measurement of satisfaction shows that students rated the workshops as satisfactory overall. They particularly appreciated the collaborative and supportive atmosphere in the classroom and the opportunity to express and exchange opinions with their classmates and the teacher (Sedlar et al., 2019^[2]; Boben, 2018^[9]).

Efficiency

Intervention 1

This is me online advice mostly relies on the voluntary work of individuals that are trained to respond to queries by maximising advice and information developed over time and are supported by a full-time (paid) editorial office. The voluntary contribution reduced the costs of the intervention, while the possibility to be based anywhere and participating remotely increases the pool of potential volunteers. The efficiency of the intervention is enhanced by using past interactions to develop material which supports the experts, such as a bank of answers. Using past advice as a basis for future responses, help maximise the time dedicated to each request.

Intervention 2

Workshop providers are key actors for the deployment of the 10-workshop programme to students. Between 2011/12 and 2022/23, the number of workshops held, and the number of providers included have varied upwards and downwards, without a clear trend. The average number of workshops per provider per year has also varied over time, from a minimum of 4.4 workshops per provider in 2012/13 to a maximum of 8.9 in 2022/23. Average numbers below 10 might be explained by two reasons, either most providers miss one or two workshops to complete the programme, or a small number of providers only deliver one of the 10 workshops.

Equity

Both interventions constituting *This is me* are universal preventive strategies freely made available to young people (intervention 1) and students (intervention 2) in Slovenia.

Intervention 1

#tosemjaz can be used at any point in time (asynchronous intervention) and from anywhere with internet connection, making it widely available by people at risk of mental ill-health. On the other hand, because it is digital, #tosemjaz might not be accessible to those without the technological resources and literacy needed, potentially being the most vulnerable and hard-to-reach population groups.

From about 5 400 online questions coded during 2020, 2021 and 2022, 81% were submitted by girls, and 19% by boys. A much larger proportion of girls using the service reveals gender difference in needs and expectations. It is likely that girls are either more aware of, or attribute more value to, the support provided by #tosemjaz.

Intervention 2

Because it is deployed at the classroom level, without requiring any proactive decision by students, the workshop programme might also potentially reach out to groups at risk that would otherwise not seek help. Additionally, the (multimedia) handbook *What can I do to make it easier* includes guided self-help exercises in the form of sound recordings, accessible to everyone, everywhere and at any time.

Results of the 2017/18 evaluation study show significant differences in the impact of the school workshops on boys and girls. Boys displayed better results than girls in terms of interpersonal difficulties, particularly those linked to public speaking. The workshops had the greatest impact on the girls in terms of their ability to employ effective coping strategies (Sedlar et al., 2019^[2]; Boben, 2018^[9]).

Evidence-based

The evidence on *This is Me* is mainly collected from a study conducted in 2017/18 to evaluate intervention 2 (workshop programme conducted in schools) (Sedlar et al., 2019^[2]). Other evidence on *This is me* consists of process indicators showing the volume and extent of the support provided.

The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domains of “Data collection methods” and moderate in “Selection Bias”, “Study Design” and “Withdrawals and dropouts” (Table 11.2) (Effective Public Health Practice Project, 1998^[11]).

Table 11.2. Evidence Base assessment, *This is Me*

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Somewhat likely
	What percentage of selected individuals agreed to participate?	Can't tell
	<u>Selection bias score</u>	Moderate
Study design	Indicate the study design	Cohort analytic
	Was the study described as randomised?	No
	<u>Study design score</u>	Moderate
Confounders	Were there important differences between groups prior to the intervention?	Yes
	What percentage of potential confounders were controlled for?	Less than 60%
	<u>Confounder score</u>	Weak
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes
	Were the study participants aware of the research question?	Can't tell
	<u>Blinding score</u>	Weak
Data collection methods	Were data collection tools shown to be valid?	Yes

Assessment category	Question	Rating
	Were data collection tools shown to be reliable?	Yes
	<u>Data collection methods score</u>	Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	Less than 60%
	<u>Withdrawals and dropout score</u>	Moderate

Source: Effective Public Health Practice Project (1998^[11]), "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Sedlar et al. (2019^[2]), "Evalvacija šolskega preventivnega programa To sem jaz".

Extent of coverage

Intervention 1

During the 23 years that #tosemjaz online counselling has been available (2001 to 2023), experts have answered more than 57 000 questions, corresponding to an annual average of 2 500 questions. On an annual basis, the website receives about 180 000 unique visitors, more than 260 000 visits and 1 000 000 page views. About 75% of the questions are answered in less than three days. Age and gender distribution of questions has remained mostly stable over time. From the 5 429 questions coded by the editorial staff from 2020 to 2022, 81% were from girls and 19% from boys; 46% were submitted by young people aged 14-17, 32% by 18-21 and 19% by 10-13. About half of questions were classified either as "Mental health" (20%), "Physical health" (17%) and "Relationships" (16%) categories. Two main changes have been noted in the inflow of questions for the past years. First, a growth in overall number of questions received after March 2022, when the website went through a redesign. Second, an increase in the proportion of questions classified as "most severe" from 15% to 20% from 2021 to 2022 (questions that relate to the topics of suicide, anxiety, depression, eating disorders, self-harm, family and peer violence, and sexual abuse). Since 2017, and with the exception of 2023, there has been an increase in the number of questions related to suicide (from 52 to 100 questions between 2017 and 2022).

Intervention 2

In the school year 2022/23, around 15% of schools in Slovenia were included in the 10-workshop programme, for a total of 132 primary and secondary schools in which 209 workshop providers ran 1 855 workshops involving more than 19 000 adolescents. This has been the highest number of providers, schools and workshops achieved in the last 12 years of the programme although the volume has been varying over the years rather than following a stable increasing trend.

Interventions 1 and 2

More recently, the scope and coverage of *This is me* is partially extended beyond the boundaries of both interventions through the materials and information being disseminated. Copies of the handbook *What can I do to make it easier?* were made available to 637 primary and secondary schools, reaching all school counselling services in Slovenia, and to 706 services in the fields of healthcare and social care that work with young people. In total, 52 000 copies of the handbook were printed over the period 2022-2024. In 2023, in the context of the Slovenian Year of Mental Health national campaign, every student in Slovenia making the transition from primary or lower secondary school to upper secondary school (grade 9) had received a printed copy of the handbook, which in turn refers to the content of #tosemjaz website.

Another dimension of *This is me* coverage refers to the training of educators and other professionals dealing with youth. In 2019, copies of the newly developed version of the handbook providing workshop implementation guidance (*Maturing through the This is Me programme*) were offered to all libraries, primary

and secondary schools in Slovenia (100% coverage). Information about the programme reached more than 6 000 professionals from the fields of education, healthcare and social care through events held in 2020 and 2022; and 433 school counsellors received the training in 2022. Dissemination materials promoting intervention 1 have also been widely distributed in schools (e.g. traditional and PDF posters, animated online content for school websites and digital displays).

Policy options to enhance performance

Enhancing effectiveness

Intervention 1

Increasing the number of synchronous guidance and counselling sessions and their dissemination offers opportunities to improve the continuity of support provided to young people that need more than a one-off interaction through the asynchronous format. During the online chat sessions, young people can follow-up on the advice received immediately, ask follow-up questions, and provide additional details on their situation that allows counsellors to target their support. Existing evidence on online universal prevention interventions should be considered in ensuring a common and evidence-grounded approach to this web-based chat support, within the context of #tosemjaz. Evidence suggests that most online help-seeking happens after 11 pm and that online services available 24 hours a day are valued (Pretorius, Chambers and Coyle, 2019^[5]). Expanding sessions to these terms might require remuneration of experts providing the sessions and might also represent a shift from universal to selective prevention.

With regards to the asynchronous #tosemjaz services, the lack of effectiveness evaluations prevents detailed recommendations about enhancing this domain of the intervention.

Intervention 2

Ensuring that the full set of the 10 school workshops is completed. Results of both quantitative and qualitative analyses indicate that the effectiveness of the programme increases with the number of workshops provided. This may be due to the opportunity for students to consolidate new ways of thinking and behaving. Putting more emphasis in completing the 10 workshops is particularly relevant given the (reported) challenges to find the time within the classic curricula to implement the full programme. In addition, it would be relevant to assess the impact of longer periods of implementation, in line with the recommendation based on the 2017/18 study, to space the 10-workshops over the course of two school years. Having an audit and fidelity-of-implementation model to assess the content of the workshops provided would be an important step towards ensuring the programme consistently delivers its maximum value across the different schools.

Identifying and maximising programme features that promote connectedness between students and with teachers. Qualitative insight from students, teachers and workshop providers collected during the 2017/18 evaluation suggests that changes in co-operation, trust and openness in communication had occurred among students during the programme. Workshop providers reported increasing integration and co-operation among students, as well as willingness to integrate classmates that had previously been excluded from the class dynamics. Student highlighted having mostly valued co-operation, and expression and exchanging opinions (Sedlar et al., 2019^[2]; Boben, 2018^[9]). A higher level of school connectedness is associated with lower levels of depressive and anxiety symptoms (Raniti et al., 2022^[12]). Understanding if there are specific workshops or mechanisms in the delivery that promote this aspect might present opportunities to increase the effectiveness of this prevention strategy.

Selecting workshop providers that already have a (positive) relationship with the students.

Differences in results across schools seem to be linked to the relationship established between students and the workshop provider, with better results appearing when this relationship was already established before the programme. Although 70% of students had already received the workshop from one of their teachers (alone or in partnership with other counselling staff) (Sedlar et al., 2019^[2]), this proportion could still be increased by making it a key recommendation that workshop providers have an existing relationship with the class.

Further recommendations on enhancing effectiveness require evidence on a different set of outcomes. Universal prevention in schools is established in the literature as effective on a large range of outcomes including emotional distress, behavioural problems and academic achievement (Harrison et al., 2022^[13]; Nice, 2022^[14]), which should be studied for *This is me*. Literature also suggests that multicomponent and multilevel interventions increase in effectiveness (Harrison et al., 2022^[13]). In the context of *This is me* there are potential opportunities to maximise the links between the school-based intervention (intervention 2) and the online advice (intervention 1). #toemjaz could be used beyond its universal approach to provide selective or indicated (for individuals identified through screening or with symptoms) prevention to students identified during the workshops. Students in critical periods of the life course (e.g. family break-ups, bereavement, developmental transitions during puberty, among others) and students identified as requiring extra support to develop their social and emotional skills could be referenced to synchronous support through the online chatting sessions. On the other direction, all the existing opportunities to disseminate #toemjaz support during the 10-workshop programme should be maximised, given that several universal preventive online activities have schools as points of departure (Noh and Kim, 2023^[3]).

Enhancing efficiency

Ensuring the completeness of the 10 workshops per class would improve efficiency. Efforts that boost effectiveness and coverage without significant increases in costs will have a positive impact on efficiency. Between 2012/13 and 2022/23, the average number of workshops per provider varied between 4.4 and 8.9, potentially suggesting that a considerable proportion of 10-workshop programmes is not fully implemented. A low level of completeness not only threatens effectiveness of the intervention but also fails to maximise the training received and the experience acquired. Active efforts should be done to promote programme completion and the implementation of several workshop programmes/year by provider.

Enhancing equity

Intervention 1 and 2

Increasing the uptake of interventions 1 and 2 by groups at higher risk of poor mental health due to their socio-economic status, migration background, identifying as LGBTQI+, among others. Being designed as universal prevention *This is me* interventions do not focus on specific (groups of) young people. Given that youth in most vulnerable circumstances is usually harder to reach, measuring and strengthening their uptake could be made a priority.

Complementing *This is me* with new specific components aiming to address the needs of youth in most vulnerable circumstances. Existing evidence supports the effectiveness of multicomponent and/or multilevel preventive interventions (Harrison et al., 2022^[13]). Determining the exact nature of these interventions/components requires additional data collection and evidence generation to shed the light on the distributional effects of *This is me* interventions, to identify what groups might benefit the least/have larger unmet need.

Intervention 1

Increasing the uptake of #tosemjaz online advice services in boys. The large proportion of #tosemjaz questions that is submitted by girls (81% between 2020 and 2022) hints a potential to increase on information about the online advice, or a result of known gender-patterns in help-seeking attitudes around this age. Part of this difference might also be a consequence of higher need from girls, and type of support each group prefers. While the former reason for the differences could be addressed by improvements in the dissemination content and channels aimed at boys, the later reasons are more challenging to address and might require designing intervention dedicated to boys.

Enhancing the evidence-base

Intervention 1

Carrying out an evaluation of the #tosemjaz online counselling effectiveness. Future evaluations of #tosemjaz should go beyond process indicators and user experience and study the impact on outcomes. Despite the one-off nature of #tosemjaz online advice, the evaluation of its effectiveness could be achieved through the implementation of pre-post measurement tools or through a randomised evaluation (comparing the active provision of information through the expert answer with the access to an information portfolio without interaction, for example) (Shen et al., 2023^[15]; Hoffberg, Stearns-Yoder and Brenner, 2020^[16]). For better evidence on youth needs and on the coverage of the intervention more characteristics should (tentatively) be collected from users, while maintaining the option of full anonymity. A relevant variable to measure, at least for the synchronous component of #tosemjaz, would be the repeated use of the intervention, to identify the frequent users of the online chat (Efe et al., 2023^[17]).

Intervention 2

Enhancing the study design and outcome measures of the evaluation of the school-based programme. Given the limitations of the 2017/18 evaluation and the modifications to the intervention since then an additional study would represent important improvement to the current evidence base. The study should include sample size calculations to avoid the potential problem of small numbers, a more extended follow-up assessment beyond the end of the 10 workshop programme, the randomisation of classes allocated to the intervention and the control group, and a larger range of outcomes, informed by the existing evaluations of other universal school-based preventive programmes: emotional distress (e.g. anxiety, depressive and stressful symptoms), behavioural problems (e.g. positive social behaviour and conduct problems) and academic achievement (Nice, 2022^[14]). Robust evidence about the benefits of universal interventions is particularly relevant in the context of potential for iatrogenic harm, as well as the crowded school curriculums and resulting opportunity costs (Nice, 2022^[14]).

Intervention 1 and 2

Evidence of cost-effectiveness is needed for both interventions, aiming at establishing the potential value-for-money these might return given the low investment in workforce needed.

Enhancing extent of coverage

Intervention 1

Increasing synchronous chat sessions availability and dissemination. These sessions could be reframed as selective and/or indicative prevention activity to be targeted at students identified during the school workshops as being at higher risk distress or in need of improving their social and emotional skills.

In addition to providing general information about the chat sessions for all those attending the workshops, targeted recommendations could be made for those in greater needs. Importantly, increasing demand for the online chat format of advice might require reinforcements in the recruitment and training of volunteer experts, as well as some adaptation of this training to the synchronous format of communication. Experience with and literature on traditional helplines may provide useful insight to inform these modifications.

Intervention 2

Boosting the number of schools receiving the programme. While materials and training about *This is me* have been made available country-wide, the proportion of Slovenian schools currently implementing the 10-workshop programme (15%) should be increased to bring the programme to a larger number of students. Evidence about the implementation of universal mental health prevention programmes in schools suggests that some strategies are more effective in improving adoption: informing and engaging principals as local opinion leaders, improving teachers' buy-in and organising regular school personnel implementation meetings. Training does also seem to be positively associated with adoption, mostly when used in combination with other strategies. These different options together with insight from school auscultation should be considered when scaling up *This is me* in the Slovenian context (Baffsky et al., 2023^[18]).

Transferability

This section explores the transferability of *This is me* and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring *This is me*.

Previous transfers

This is Me has not been transferred to other OECD countries, although several countries have analogous programmes of workshops/sessions strengthening students social and emotional learning.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of *This is me* were identified (Table 11.3). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 11.3. Indicators to assess the transferability of *This is me*

Indicator	Reasoning	Interpretation
<i>Population context</i>		
Volunteering – share of individuals using the internet for seeking health information in the last 3 months (Eurostat, 2023 ^[19])	#tosemjaz website of the <i>This is me</i> intervention depends on the willingness of young people to seek information and get advice online. Therefore, the intervention is more transferable to a population comfortable seeking health information online.	↑ = more transferable
Share of individuals volunteering time to an organisation in the past month (Gallup, 2023 ^[20])	#tosemjaz website relies on advice that is provided by experts on a voluntary basis. Therefore, the intervention will be more transferable in countries where volunteering and community engagement is high.	↑ value = more transferable
<i>Sector specific context</i>		
Psychologists per 1 000 population (OECD, 2021 ^[21])	Psychologists are the most commonly represented profession within the network of volunteer experts providing online advice through #tosemjaz. Therefore, the intervention is more transferable in countries with a higher proportion of psychologists.	↑ value = more transferable
Teacher motivation (OECD, 2021 ^[22])	<i>This is me</i> 10-workshop programme is mostly provided by teachers in schools. Therefore, the intervention is more transferable in countries where teacher motivation is high.	↑ value = more transferable
Ratio of students to teaching staff (OECD, 2021 ^[23])	<i>This is me</i> 10-workshop programme is provided in the classroom. A smaller ratio of students to teaching staff will allow the workshop provider to dedicate more attention to each student and promote better connectedness between students and with the provider.	↑ value = less transferable
<i>Political context</i>		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[24])	<i>This is me</i> is more transferable to countries that have a strategy to implement mental health policy in place, facilitating the commitments and modifications needed in terms of leadership/governance, funding, infrastructure, among others.	Yes = more transferable
Policies and programmes to support and promote mental health of children and adolescents (OECD/WHO Regional Office for Europe, 2023 ^[25])	Countries with a policy focus on youth mental health are more likely to fund and endorse the implementation of <i>This is me</i> . Therefore, the intervention is more transferable in countries that already have policies and programmes to promote the mental health of children and adolescents	Yes = more transferable
Policies and programmes to support mental health in educational settings (OECD/WHO Regional Office for Europe, 2023 ^[26])	<i>This is me</i> is a school-based programme and is more transferable to countries that already have policies and programmes in place to support mental health in educational settings	Yes = more transferable
Policies and programmes for integrating digital technologies and tools into mental health service delivery (OECD/WHO Regional Office for Europe, 2023 ^[27])	The implementation of #tosemjaz should benefit in several ways from a system in which digital technologies are well integrated, for example through support from leadership and governance, more willingness and knowledge of experts to volunteer in such an internet-based intervention, and more experience of users with receiving support digitally. Therefore, the intervention is more transferable in countries that are used to integrate digital tools for mental health care delivery.	Yes = more transferable
<i>Economic context</i>		
Prevention spending as a percentage of GDP (OECD, 2024 ^[28])	<i>This is me</i> is a prevention programme and is more transferable to countries that allocate a higher proportion of health spending to prevention.	↑ value = more transferable
Spending on early childhood education and primary and secondary schools as a percentage of GDP (OECD, 2024 ^[29])	<i>This is me</i> is a school-based programme and will be more successful in countries that spend more on early childhood education and primary and secondary schools	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below:

- a) In Slovenia, 48% of individuals have used the internet for seeking health information in the last three months, slightly below the median of OECD and EU countries of (53%). Therefore, the majority of countries have favourable conditions for the transfer of *This is me* (intervention 1).
- b) In terms of the share of individuals volunteering time to an organisation in the past month (27%), Slovenia is positioned on the highest quartile of the distribution for OECD and EU countries, suggesting that Slovenian population is more used to engage in volunteering than most countries being considered for *This is me* (intervention 1) transferability.
- c) The number of psychologists per 1 000 population in Slovenia (0.09) is lower than for most of OECD and EU countries with available data (median 0.43), suggesting that the availability of psychologists in most countries may facilitate the implementation of *This is me* (intervention 1).
- d) In Slovenia, teacher's motivation is in the lowest quartile of the OECD and EU countries (0.89). high teacher's motivation is likely to facilitate the transfer of *This is me* (intervention 2) in countries.
- e) Slovenia's ratio of students to teaching staff is 19.05, which is among the highest of OECD and EU countries. As most countries have a lower ratio of students to teaching staff, they should have favourable conditions for the transfer of *This is me* (intervention 2).
- f) As in Slovenia, the vast majority of countries (90%) have a strategy or action plan to guide the implementation of mental health policy. This suggests that *This is me* is likely to benefit from existing infrastructure and experience to be implemented.
- g) Most countries (90%) do also have policies and programmes to support and promote the mental health of children and adolescents, including Slovenia. Implementing *This is me* can benefit from the prioritisation of this policy domain in most countries.
- h) Similarly, 90% of the countries have policies and programmes in place to support mental health in educational settings, suggesting an appropriate policy landscape across the health and education domains to implement *This is me* (intervention 2).
- i) Policies and programmes for integrating digital technologies and tools into mental health service delivery are slightly less common, only in place in 74% of the countries, including Slovenia.
- j) Slovenia allocates 0.5% of its GDP to prevention, which is above the OECD and EU median of 0.45%. Countries with a higher spending on prevention are more likely to have economic support for the transfer of *This is me*.
- k) Data on spending on early childhood education and primary and secondary schools as a percentage of GDP is missing for Slovenia. However, a higher share of spending should be favourable to the transfer of *This is me* (intervention 2) as a school prevention activity. OECD and EU countries median is 3.77%.

Table 11.4. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates *This is me* is more suitable for transferral in that particular country

	Internet use for health information	Volunteering	Psychologists per 1 000 population	Teacher motivation	Ratio of students to teaching staff	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies supporting mental health in educational settings	Policies for integrating digital technologies	Prevention spending (% GDP)	Education spending (% GDP)
Slovenia	0.48	0.27	0.09	0.89	19.05	Yes	Yes	Yes	Yes	0.50	n/a
Australia	0.42	0.34	1.03	0.96	n/a	Yes	Yes	Yes	Yes	0.35	4.50
Austria	0.53	0.24	1.18	0.96	13.72	Yes	Yes	Yes	Yes	1.25	3.62
Belgium	0.49	0.26	0.10	0.95	13.39	Yes	Yes	Yes	Yes	0.35	4.13
Bulgaria	0.34	0.06	n/a	0.95	11.86	Yes	No	No	No	n/a	n/a
Canada	0.59	0.34	0.49	0.99	n/a	No	Yes	Yes	n/a	0.68	3.54
Chile	0.27	0.17	n/a	0.97	20.88	Yes	Yes	Yes	Yes	0.31	5.51
Colombia	0.41	0.21	n/a	0.98	45.73	Yes	Yes	Yes	Yes	0.16	4.44
Costa Rica	0.44	0.22	n/a	n/a	11.17	Yes	No	No	Yes	0.06	n/a
Croatia	0.53	0.11	n/a	0.95	10.12	Yes	Yes	Yes	No	n/a	n/a
Cyprus	0.58	0.23	n/a	n/a	n/a	Yes	Yes	Yes	Yes	n/a	n/a
Czechia	0.56	0.24	0.03	0.93	11.74	n/a	Yes	Yes	No	0.77	3.47
Denmark	0.67	0.25	1.62	0.94	10.17	Yes	n/a	Yes	No	0.48	4.76
Estonia	0.60	0.20	0.06	0.88	8.11	Yes	Yes	Yes	Yes	0.62	4.25
Finland	0.76	0.24	1.09	0.83	8.42	Yes	Yes	Yes	Yes	0.48	4.78
France	0.50	0.30	0.49	0.92	22.29	Yes	Yes	Yes	No	0.68	4.43
Germany	0.66	0.27	0.50	n/a	9.01	No	Yes	Yes	Yes	0.83	3.77
Greece	0.50	0.20	0.09	n/a	9.63	Yes	Yes	Yes	No	0.37	2.86
Hungary	0.60	0.17	0.02	0.93	12.67	Yes	Yes	Yes	Yes	0.56	3.30
Iceland	0.65	0.25	1.37	0.79	4.53	Yes	Yes	Yes	Yes	0.28	6.29
Ireland	0.57	0.29	n/a	n/a	3.99	Yes	Yes	Yes	Yes	0.36	2.43
Israel	0.50	0.28	0.88	0.97	n/a	n/a	Yes	Yes	Yes	0.02	6.09
Italy	0.35	0.19	0.04	0.79	11.18	Yes	Yes	No	No	0.59	3.77
Japan	n/a	0.19	0.03	0.89	12.71	Yes	Yes	Yes	n/a	0.36	2.77
Korea	0.50	0.20	0.02	n/a	12.94	Yes	Yes	Yes	Yes	0.77	3.53

	Internet use for health information	Volunteering	Psychologists per 1 000 population	Teacher motivation	Ratio of students to teaching staff	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies supporting mental health in educational settings	Policies for integrating digital technologies	Prevention spending (% GDP)	Education spending (% GDP)
Latvia	0.48	0.12	0.67	0.93	11.35	Yes	Yes	Yes	Yes	0.46	3.60
Lithuania	0.61	0.11	0.16	0.91	10.16	Yes	Yes	Yes	Yes	0.44	3.21
Luxembourg	0.58	0.31	0.59	n/a	9.18	n/a	Yes	Yes	Yes	0.26	3.42
Malta	0.59	0.31	n/a	0.96	n/a	No	n/a	Yes	Yes	n/a	n/a
Mexico	0.50	0.20	n/a	0.99	19.01	Yes	Yes	Yes	n/a	0.18	3.75
Netherlands	0.74	0.32	0.94	0.86	15.95	n/a	Yes	Yes	No	0.58	3.86
New Zealand	n/a	0.34	0.86	0.96	6.09	Yes	Yes	Yes	Yes	n/a	5.13
Norway	0.69	0.31	1.40	0.89	11.40	Yes	Yes	Yes	Yes	0.27	6.57
Poland	0.47	0.07	0.16	n/a	12.81	Yes	Yes	n/a	Yes	0.14	4.01
Portugal	0.49	0.13	n/a	0.94	15.65	Yes	Yes	n/a	n/a	0.35	3.82
Romania	0.33	0.06	n/a	0.98	14.40	Yes	No	No	No	n/a	n/a
Slovak Republic	0.53	0.17	n/a	0.93	11.38	No	No	n/a	No	0.13	3.37
Spain	0.60	0.19	0.55	0.89	12.75	Yes	Yes	Yes	Yes	0.37	3.76
Sweden	0.62	0.16	0.99	0.94	13.81	Yes	Yes	Yes	Yes	0.55	5.78
Switzerland	0.67	0.27	0.26	n/a	17.88	Yes	Yes	Yes	Yes	0.33	1.56
Türkiye	0.51	0.10	0.03	0.98	12.90	Yes	Yes	Yes	Yes	n/a	3.37
United Kingdom	0.67	0.26	0.36	n/a	36.30	Yes	Yes	Yes	Yes	1.55	4.53
United States	0.38	0.39	0.30	0.99	12.92	Yes	Yes	Yes	Yes	0.84	3.47

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 11.3.

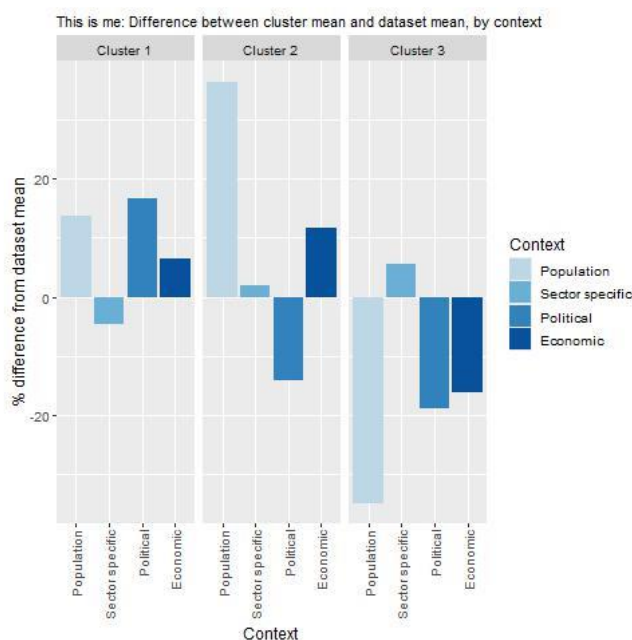
Source: Eurostat (2023^[19]), *Individuals using the internet for seeking health-related information*, <https://ec.europa.eu/eurostat/databrowser/view/tin00101/default/table?lang=en> (accessed on 24 February 2025); Gallup (2023^[20]), *Share of individuals volunteering time to an organization in the past month (%)*, OECD (2021^[21]), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, Paris, <https://doi.org/10.1787/4ed890f6-en>; OECD (2021^[22]), *OECD Data Explorer - Teacher motivation*, <https://doi.org/10.1787/health-data-en> (accessed on 16 April 2024); OECD (2021^[23]), *OECD Data Explorer - Ratio of students to teaching staff*, <http://data-explorer.oecd.org/s/1nm> (accessed on 16 April 2024); OECD/WHO Regional Office for Europe (2023^[24]), *Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy*; OECD/WHO Regional Office for Europe (2023^[25]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support and promote mental health of children and adolescents*; OECD/WHO Regional Office for Europe (2023^[26]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support mental health in educational settings*; OECD/WHO Regional Office for Europe (2023^[27]), *Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes for integrating digital technologies and tools into mental health service delivery*; OECD (2024^[28]), *OECD Data Explorer - Prevention spending as a percentage of GDP*, <http://data-explorer.oecd.org/s/1nl> (accessed on 7 April 2024); OECD (2024^[29]), *OECD Data Explorer - Spending on early childhood education and primary and secondary schools as a percentage of GDP*, <http://data-explorer.oecd.org/s/1nl> (accessed on 5 September 2025).

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 11.3. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 11.1 and Table 11.5:

- Based on high-level indicators, countries in cluster one have population, political, and economic conditions in place to support the introduction of *This is me*. This cluster comprises 22 countries, including Slovenia.
- Countries in cluster two have population, sector-specific and economic arrangements to support the implementation of *This is me*. However, these countries may wish to consider ensuring that the implementation aligns with political priorities. This cluster consists of six countries.
- Countries in cluster three have sector-specific conditions to support the transferability of *This is me*, although they may wish to undertake further analysis to ensure that the programme is affordable, aligns with political priorities, and has population arrangements in place to facilitate the transfer. This cluster consists of 15 countries.

Figure 11.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.
Source: OECD analysis.

Table 11.5. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia	Canada	Bulgaria
Austria	Czechia	Chile
Belgium	Germany	Costa Rica
Colombia	Malta	Croatia
Cyprus	Netherlands	Denmark
Estonia	United States	France
Finland		Greece
Hungary		Italy
Iceland		Latvia
Ireland		Lithuania
Israel		Poland
Japan		Portugal
Korea		Romania
Luxembourg		Slovak Republic
Mexico		Türkiye
New Zealand		
Norway		
Slovenia		
Spain		
Sweden		
Switzerland		
United Kingdom		

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 11.2 outlines several new indicators policymakers could consider before transferring This is me.

Box 11.2. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of interest among young people in seeking information online? And is this interest equally distributed across different sociodemographic groups? (intervention 1)
- What is the proportion of young people without access to internet (in own devices)? (intervention 1)
- What is the level the mental health literacy and knowledge of social and emotional competences in children and parents? (intervention 2)

Sector specific context

- What is the level of digital literacy among psychologists and other mental health practitioners? What are their beliefs about provision of digital mental health support? (intervention 1)

- What is the proportion of schools with universal prevention activities implemented in the domains of mental health? (intervention 1)
- What is the level of mental health literacy among teachers and school staff? (intervention 2)
- What is the time available within class timetable to implement new activities? (intervention 2)

Political context

- What is the level of cross-sectoral co-operation between policymakers and institutions working in the domains of education and health?

Economic context

- Are there dedicated funds to implement promotion of good mental and prevention of mental ill-health objectives?

Conclusion and next steps

***This is me* consists of two different interventions aimed at protecting adolescent mental health: online expert counselling** answering youth's questions either asynchronously or synchronous via chat conversations (intervention 1) and a school-based programme of **10 preventive school workshops** in primary and lower secondary education (intervention 2).

Better evidence is needed to adequately judge the effectiveness of *This is me* interventions. Existing results from an evaluation of the 10-workshop programme show that the workshops have improved classroom climate. They also suggest potential effects on student outcomes (interpersonal difficulties, coping and self-concept) (non-significant) that should be further evaluated. While cost-effectiveness has not been evaluated, *This is me* interventions mostly rely on volunteering or within-class teacher work, without requiring large workforce investments. Evidence about cost-effectiveness is also needed to corroborate value returned by the potential low-cost of the interventions.

As a universal prevention strategy, *This is me* has the potential to easily reach all young people, including those in most vulnerable circumstances. Still, dedicated efforts could be done to ensure that harder to reach people are aware of #tosemjaz and benefiting from the school workshops, including through better bridging interventions 1 and 2.

An expansion of *This is me* can be achieved through an increase of the availability and dissemination of online chat sessions and the extension of the coverage of the 10-workshop programme to more Slovenian schools (currently only 15%).

Based on high-level indicators, *This is Me* interventions are highly transferable in 22 out of 43 OECD and EU countries, and intermediately transferable to six countries. All countries have the opportunity to tailor mental health prevention strategies according to their specific needs, resources and contexts. This also applies to certain countries that may encounter challenges related to population arrangements, political priorities and the affordability of implementing the programme.

Box 11.3 outlines next steps for policymakers and funding agencies.

Box 11.3. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance *This is me* are listed below:

- Design and implement evaluations of *This is me* interventions 1 and 2, including its cost-effectiveness.
- Implement an auditing and monitoring and fidelity-of-implementation model to assess the content of the workshops when scaling up the school-based programme in all Slovenian schools (intervention 2).
- Expand the availability and dissemination of synchronous support provided in #tosemjaz through only chat sessions (intervention 1). If needed, consider the remuneration of experts providing these sessions.
- Build additional links between interventions 1 and 2 of *This is me*, namely by providing students identified to be in need during the class workshops with support from the #tosemjaz online chat sessions.
- Examine the barriers facing by schools to implement *This is me* intervention 2, to increase the share of schools receiving the programme.

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12 Icehearts

This chapter covers the case study of Icehearts, a prevention programme that uses team sports to provide long-term mentoring support to socially vulnerable children and adolescents in Finland. The case study includes an assessment of Icehearts against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to other OECD and EU27 countries.

Icehearts: Case study overview

Description: Icehearts is a Finnish prevention programme that uses team sports to provide long-term mentoring support to socially vulnerable children and adolescents. Each Icehearts team consists of about 10-25 children and is led by a mentor who supports the children at home, at school, after school and through team sports. The programme aims to prevent social exclusion, to promote social-emotional skills and to improve mental well-being. The Icehearts mentors are full-time, paid professionals with a 12-year commitment to the child.

Best practice assessment:

OECD best practice assessment of Icehearts

Criteria	Assessment
Effectiveness	At the group level, improved prosocial behaviour was found among programme participants at the 4-year follow-up but no changes in emotional problems, conduct problems, hyperactivity or peer problems were observed.
Efficiency 	Icehearts is estimated to save approximately EUR 857 000 in social and healthcare costs over a 12-year period while also reducing by half the number of people who are not in employment, education, or training (NEET). The decrease in NEET rates would correspond to an estimated EUR 1.9 million gain for the government through increased income tax revenues and lower unemployment benefits. Economic benefits are estimated to be more than four times higher than the investment in each Icehearts team.
Equity 	The target group for Icehearts consists of socially vulnerable children and adolescents, often affected by factors such as single-parent family, problem behaviour, or changes in family structure.
Evidence-base	Icehearts was evaluated using data collection methods that are valid and reliable with low dropout rates, however, limitations of the study included the lack of a control group and a small sample size.
Extent of coverage	In Finland, there are currently 70 Icehearts team including over 1 000 children and adolescents.

Enhancement options: To *enhance efficiency*, further cost-benefit analysis is needed to underline the economic viability of the programme. To *enhance equity*, Icehearts could consider expanding its options for sports-based activities to offer a wider range of opportunities. Currently, the programme is predominantly made up of boys, but actively facilitating the participation of girls could improve the equity of the programme. To *enhance the evidence-base*, there is a need to secure long-term and sustainable research funding to enable comprehensive tracking of Icehearts teams throughout the duration of the programme. To *enhance the extent of coverage*, there is a need for increased administrative capacity to expand the programme further, either through increased funding or through partnerships with other organisations.

Transferability: The Icehearts Europe Project aims to upscale the Finnish Icehearts model across Europe and will pilot the model in Denmark, Estonia, Slovenia, Spain and Italy. The outcomes from the implementation will inform the refinements of the model, preparing for a wider adoption by stakeholders and organisations interested in the model.

Conclusion: Icehearts has demonstrated to some extent its potential in promoting social-emotional skills and mental well-being among socially vulnerable children in Finland, showing promising results in improving participants physical activity, social skills, and self-esteem.

Intervention description

Icehearts is a positive youth development programme that targets socially vulnerable children and adolescents by providing long-term support by a mentor through team sports (Appelqvist-Schmidlechner,

Haavanlammi and Kekkonen, 2021^[1]). Icehearts was established in 1996 as a non-governmental organisation in the city of Vantaa, Finland. The Icehearts programme aims to prevent social exclusion, to promote social-emotional skills and to improve mental well-being among children and youth. This is done through consistent long-term professional support in a trustworthy relationship between an Icehearts mentor and the children (Appelqvist-Schmidlechner, Haavanlammi and Kekkonen, 2021^[1]).

Icehearts targets socially vulnerable children and adolescents, usually identified at the age of six, who are at risk of social marginalisation. The initiative, funded by the municipalities, aims to select children as a collaborative effort involving the municipality's social services, preschool and first grade teachers, and Icehearts mentors. The selection process starts in preschool years where mentors attend preschool activities before starting the Icehearts team. Once the first grade has started, teachers and headmasters may also recommend children for the programme. The child's carer ultimately decides whether the child will participate in the programme and the team activities.

Icehearts has broad selection criteria, allowing for the inclusion of children with a variety of social problems, regardless of whether or not they have a formal diagnosis. The programme is adaptable and suitable for children with behavioural, economic, developmental and mental health challenges. Common causes of social vulnerability among the children in Icehearts include difficulties in interacting with others, problem behaviour, changes in family structure or having a single-parent family background (Appelqvist-Schmidlechner et al., 2017^[2]). Children with symptoms that are so severe that prevent them from participating in a group setting may not benefit from the programme.

Each Icehearts team is led by a mentor who is a paid, full-time professional with a 12-year commitment to the child. The Icehearts mentor works closely with schools and other support networks. The work of Icehearts mentors is roughly divided into four areas:

1. Team sports: The mentor organises and leads team sports activities. During the afternoon, the children of the team spend time together, play and participate in excursions with their mentor. Different sports are tested based on local opportunities.
2. After school activities: The mentor provides structured after-school programmes, including help with homework and organised afternoon activities.
3. Support with schoolwork: The mentor acts as an extra adult resource in the classroom, assisting children with their studies and contributing to a stable and supportive school environment.
4. Providing individual support to the child: When needed, the mentor works one-to-one with a child, providing a safe space for conversation and emotional support when problems arise in everyday life.

After primary school, from 7th grade until the age of 18, the emphasis is placed not only on the participation of organised sport but also on providing customised psychosocial support (Appelqvist-Schmidlechner, Haavanlammi and Kekkonen, 2021^[1]).

Icehearts uses team sports as a tool to ensure the inclusion of marginalised children. Team sports provide an environment where children can experience a sense of belonging, learn social skills and make friends, while being physically active (Appelqvist-Schmidlechner, Haavanlammi and Kekkonen, 2021^[1]). The Finnish Icehearts programme involves more than 1 000 children and adolescents participating in both girls' and boys' teams, with the majority of the participants being boys. Each team is led by a mentor of the corresponding gender, with girls' teams being led by a female mentor and boys' teams being led by a male mentor. Each mentor will have approximately 10-25 children in their team. A team consists of a core group of around eight to ten children with more severe emotional and behavioural problems. An additional 10-15 children with less severe challenges are also invited to join the team, these may include challenges such as coming from a single parent family, an immigrant background, or a low-income family (Appelqvist-Schmidlechner et al., 2024^[3]).

OECD Best Practices Framework assessment

This section analyses Icehearts against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 12.1 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 12.1. Assessment of Icehearts

Effectiveness

- At 4-year follow-up, 49% of the Icehearts participants showed improved prosocial behaviour, whereas 34% showed a worsening situation, according to parent's evaluations as measured by the Strengths and Difficulties Questionnaire (SDQ).
- After one year, nearly four out of ten Icehearts children had improved social-emotional well-being, whereas nearly half showed a worsening, indicating mixed impacts.
- According to mentors, over three-quarters of children showed improvements in the areas of physical activity, social skills, friendships, self-esteem and mood.

Efficiency

- Icehearts is estimated to save approximately EUR 857 000 in social and healthcare costs over a 12-year period while also reducing by half the number of young people who are not in employment, education, or training (NEET). This decrease in NEET rates would correspond to an estimated EUR 1.9 million gain for the government through increased income tax revenues and lower unemployment benefits.

Equity

- Icehearts focusses on socially vulnerable children and adolescents, offering inclusion regardless of socio-economic status, gender, ethnicity or diagnosis.
- Icehearts effectively reaches its target group, with participants being more likely to come from a single parent family or experiencing changes in family structures compared to the control group.

Evidence-base

- Icehearts was evaluated based on the results from the Icehearts longitudinal study and had "good" data collection method with valid and reliable measures, and scored "good" in terms of withdrawals and dropouts with a high percentage of participants who completed the study (80%).
- The limitations of the study included the lack of a control group and a small sample size.

Extent of coverage

- There are currently 70 Icehearts teams across Finland with over 1000 children and adolescents included in the programme.

Effectiveness

Prosocial behaviour was improved in half of Icehearts children, but there was no decrease in behavioural difficulties at 4-year follow-up

A longitudinal study by Appelqvist et al. (2024^[3]) showed improvement in prosocial behaviour at the 4-year follow-up. The study sample comprised 65 boys who participated in the Icehearts programme and a community reference sample (control group) of 75 boys recruited from the same school and another school in the same municipality. The Strengths and Difficulties Questionnaire (SDQ) was used to assess the children's outcomes (Box 12.2). The study found that **nearly half of the Icehearts participants (49%) showed an improvement in prosocial behaviour after four years, while approximately one-third (34%) showed a deterioration in their situation**, based on parents' evaluation. The authors suggested that participation in team sports allows Icehearts children to interact with peers and improve their social skills in a positive environment, which may contribute to an improvement in prosocial behaviour. No statistically significant changes were found for the other SDQ subscales (e.g. peer problems, hyperactivity, conduct problems, etc.).

Box 12.2. Strength and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire that is widely used to assess emotional and behavioural problems in children and adolescents aged 2-17 years. It is available in several languages and in different versions, such as for parents, teachers or self-completion.

The SDQ consists of 25 items on a three-point scale: not true, somewhat true, certainly true. The scoring procedure for the SDQ links each of the 25 items to one of the five distinct subscales:

1. Conduct problems
2. Emotional symptoms
3. Hyperactivity
4. Peer relationship problems
5. Prosocial behaviour

The sum score for each of these subscales ranges from zero to ten.

The first four subscales can be added together to give a total difficulties score, which score ranges from 0 to 40.

In addition, the SDQ can be used to assess three primary indicators often examined in studies:

- Internalising problems: a combination of emotional symptoms and peer relationship problems;
- Externalising problems: a combination of conduct problems and hyperactivity;
- Prosocial behaviour: corresponding to the prosocial behaviour subscale.

Source: Goodman (1997^[4]), "The strengths and difficulties questionnaire: A research note", <https://doi.org/10.1111/j.1469-7610.1997.tb01545.x>; Goodman, Lamping and Ploubidis (2010^[5]), "When to use broader internalising and externalising subscales instead of the hypothesised five subscales on the strengths and difficulties questionnaire (SDQ): Data from British parents, teachers and children", <https://doi.org/10.1007/s10802-010-9434-x>.

While the study did **not find a reduction in behavioural difficulties among the participants of the Icehearts programme**, the absence of further deterioration after facing severe challenges and vulnerabilities can be considered a positive outcome in itself. The programme may have prevented further negative developments that could have occurred without it, through the provision of support and long-term mentorship (Appelqvist-Schmidlechner et al., 2024^[3]).

Social-emotional well-being improved in nearly four out of ten Icehearts children at one year follow-up, although it worsened in nearly half of children

A study by Appelqvist & Kekkonen (2020^[6]) looked at changes in the behaviour and emotional life of Icehearts children, as reported by parents. The study is part of the Icehearts longitudinal study, which runs from 2015 to 2028, and was conducted with children from five Icehearts teams. A total of 46 children participated in the study, all boys aged 6 to 8 years old and in their first year of primary school at the start of the study in 2015. The study found that **after one year, 39% of the participating children had an improvement in their SDQ total difficulties score, 47% had a worsening, and the remaining 22% had an unchanged situation**. In addition, positive changes were observed in children who had not yet developed serious behavioural and emotional problems, as well as in children who were using psychiatric services (Appelqvist-Schmidlechner and Kekkonen, 2020^[6]).

Physical activity, social skills, friendships, self-esteem and mood improved in more than three-quarters of children

Another study by Appelqvist and Kekkonen (2020) looked at mentor's evaluations of Icehearts children. Results showed that after four years, almost all children were still involved in team activities and two out of three children were still involved in after-school activities. In addition, mentors estimated that the Icehearts activity had at least somewhat improved the children's physical activity, social skills, friendships, self-esteem and mood for the majority of children (76%-84%). The long-term support and presence of the mentor in the child's daily life was seen as an important factor in supporting the child (Appelqvist-Schmidlechner and Kekkonen, 2020^[7]).

Efficiency

A cost-benefit analysis was conducted in 2017 based on the outcomes of one Icehearts team that participated in the programme for 12 years (Hilli, 2017^[8]). Register data from the 1987 national cohort study was used as a comparison group. The analysis focussed on the use of social and health services and being not in employment, education, or training (NEET) as outcome variables.

The findings showed that participation in the programme reduced the need for heavy social and healthcare interventions, resulting in saving of approximately EUR 857 000 in social and healthcare costs over 12 years. In addition, the programme halved the number of NEET cases. Among 32 boys who participated in an Icehearts team at different times, the predicted number of NEETs was 10, but only 5 were observed, corresponding to a 50% reduction. The reduction in NEET rates is estimated to generate EUR 1.9 million in government revenues through increased tax revenues and lower unemployment benefits, due to higher education attainment (Hilli, 2017^[8]).

When combined, the total estimated economic benefit of the programme amounts EUR 2.8 million per Icehearts team over 12 years. With an estimated annual budget per team of approximately EUR 50 000, or EUR 600 000 for the 12-year period, the benefits exceed the costs by more than four times. Programme costs are covered by the municipality in which the Icehearts team operates and include the costs associated with the mentor, such as salaries, insurance, travel costs, administration and occupational health services. Icehearts also receives donations covering expenses such as rental of sports facilities, camps, excursions and snacks, which brings the budget to around EUR 60 000-65 000. Icehearts has a

flexible cost structure, with mentors responsible for organising activities within the available budget. Some municipalities allow Icehearts to use sports facilities and classrooms free of charge.

Equity

Icehearts targets socially vulnerable children and adolescents who are at risk for social exclusion and marginalisation. The programme includes children regardless of their socio-economic background, gender, ethnicity or diagnosis. The selection criteria for Icehearts children are broad and flexible and are designed to accommodate children with or without a diagnosis. This includes children with behavioural problems, mental health problems, poor economic background and developmental disorders.

Icehearts has been successful in identifying, reaching and supporting children who need early intervention due to their family or adverse life situation. A study by Appelqvist and colleagues (2017^[2]) investigated the psychosocial well-being of children aged 6-to-8-year-old participating in the initial phase of the Icehearts programme. The study included 46 children who participated in the Icehearts programme, compared with a control group of 180 children of the same age. Results showed that Icehearts successfully identifies and reaches the target groups. Icehearts participants were more likely to come from single-parent families and to have experienced changes in their family structure, compared to the control group. For instance, 60% of the Icehearts children had experienced a parental separation, compared to 18% in the control group, and 40% had experienced a mother or father moving away or a new partner joining the family, compared to 13% in the control group. Participants and their families were more prone to face a number of challenges, including those related to health, mental health, and financial issues. Two-thirds of the Icehearts participants experienced social-emotional and behavioural problems, and around 40% experienced frequent conflicts with other children and often felt worried or cried (Appelqvist-Schmidlechner et al., 2017^[2]).

Evidence-base

The results on the effectiveness of Icehearts are based on the longitudinal study by Appelqvist-Schmidlechner & Kekkonen (2020^[6]), which is part of the Icehearts longitudinal study from 2015 to 2028. The Icehearts longitudinal study and other on-going and future studies of Icehearts are presented in Box 12.3. The *Quality Assessment Tool for Quantitative Studies* assesses the quality of evidence as strong in the domains of “Data collection methods” and “Withdrawals and Dropouts”, moderate in “Study Design”, and weak in “Selection Bias”, “Confounders” and “Blinding” (Table 12.1).

Table 12.1. Evidence Base assessment, Icehearts

Assessment category	Question	Rating
Target population		
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Not likely
	What percentage of selected individuals agreed to participate?	80%-100%
Selection bias score		Weak
Study design	Indicate the study design	Cohort
	Was the study described as randomised?	No
Study design score		Moderate
Confounders	Were there important differences between groups prior to the intervention?	Can't tell
	What percentage of potential confounders were controlled for?	Can't tell
Confounder score		Weak
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes

Assessment category	Question	Rating
	Were the study participants aware of the research question?	Yes
	<u>Blinding score</u>	Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
	<u>Data collection methods score</u>	Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	80-100%
	<u>Withdrawals and dropout score</u>	Strong

Source: Effective Public Health Practice Project (1998^[9]) "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Appelqvist-Schmidlechner & Kekkonen (2020^[6]), "Muutokset Icehearts-lasten käyttäytymisessä ja tunneelämässä. Tuloksia Icehearts-pitkittäistutkimuksesta".

Box 12.3. On-going and future studies of Icehearts

The Finnish Institute for Health and Welfare is currently conducting two longitudinal studies involving the Icehearts programme: the Icehearts longitudinal study and the Children and Youth Social Impact Bond (SIB) Study. The Icehearts longitudinal study runs from 2015 to 2028 and aims to investigate the psychosocial well-being of children participating in the Icehearts programme and the perceived benefits and effects of the programme. The study follows five Icehearts teams (n=65) for 13 years, until the participating children reach the age of 20. A mixed methods approach will be used, combining quantitative (questionnaires and register data) and qualitative (interviews and observations) research methods.

The Children and Youth SIB Study aims to assess the cost-effectiveness of various preventive initiatives targeting disadvantaged children and adolescents, including Icehearts. The study runs from 2019 to 2031 and uses the SIB (Social Impact Bond), which is a form of impact investing model that is particularly suited to the financing and effective implementation of promotional and preventive activities. Specifically, SIB have been used to finance the implementation of the Icehearts programme in cities, such as Hämeenlinna, with private investment funds financing the programme for six children for 12 years. The programme is expected to generate cost savings for local authorities and governments, for instance related to the use of social and health services. Part of these savings will be used to pay in return the investment funds. The re-payments depend on pre-defined outcomes (e.g. whether the service users are in education or employment, having avoided "afterwards services" and exclusion from normal life). The Children and Youth SIB Study aims to provide information on the cost-effectiveness of the approaches financed by the Children SIB, to study the impact of the activities on the psychosocial well-being of children and young people, and to examine the feasibility of using the Children SIB to fund preventive work in municipalities and regions.

Icehearts Finland also has its own follow-up tool that systematically collects data. This data includes mentors' assessment of each child's progress twice a year, parents' assessment of their child's progress once a year, and children's assessment of their own progress once a year.

Source: Terveystien ja hyvinvoinnin laitos (n.d.^[10]), "Pitkittäistutkimus ehkäisevän toiminnan kustannus-vaikuttavuudesta (Lapset SIB)", <https://thl.fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/pitkittaistutkimus-ehkaisevan-toiminnan-kustannus-vaikuttavuudesta-lapset-sib->; Finnish Institute for Health and Welfare (THL) (n.d.^[11]), "Icehearts longitudinal study", <https://thl.fi/en/research-and-development/research-and-projects/icehearts-longitudinal-study>; Government Outcomes LAB, 2021 "Children's Welfare Social Impact Bond, Finland", <https://golab.bsq.ox.ac.uk/knowledge-bank/case-studies/childrens-welfare-social-impact-bond-finland/>.

Extent of coverage

Icehearts currently has 70 teams in operation and over 1000 children are involved in the programme across Finland. Each team consists of a permanent mentor and sometimes additional support staff. In total, there are approximately 95 people working with Icehearts children. Each Icehearts team consists of 10-25 children aged 6-18. The programme operates in 14 municipalities across Finland, including Helsinki, Vantaa, Espoo, Tampere, Turku, Pori, Seinäjoki, Riihimäki, Hämeenlinna, Lahti, Lappeenranta, Joensuu, Kerava and Ulvila. Despite the high demand for the model, Icehearts has a small central team, consisting of four people in the administration and four people in the support department, which limits the ability to expand the model.

Policy options to enhance performance

Enhancing effectiveness

Reducing the workload of mentors could help mitigate the risk of overload. Icehearts owners reported that Icehearts mentors are managing a substantial workload, being responsible for large teams of 10-25 children with a 12-year commitment. The Icehearts team is often made up of children with severe needs and these situations demand a considerable amount of time, energy and commitment from the mentors. Mentors are involved in many areas, including team sports, schoolwork, family support and individual support, and this requires a high level of commitment. Based on the information collected from interviews, the workload of mentors may pose a potential risk of burnout, stress, and/or exhaustion among the mentors, and may impact on their ability to provide effective and empathetic support. However, despite these challenges, turnover among Icehearts mentors is reportedly very low.

Enhancing efficiency

Enhancing the efficiency of the Icehearts programme is important to optimise the allocation of resources and maximise the positive outcomes for the participants. Further information on the cost-effectiveness of the Icehearts programme will be available in the following years through the Children and Youth SIB study, where Icehearts is one of the studied interventions. The cost-effectiveness will be analysed based on service use of the programme participants.

Enhancing equity

The equity and inclusivity of the Icehearts programme can be improved by making it more accessible to participants, by making a greater effort to find ways for every child to be physically active. After a few years in the programme, the team has to choose a sport (ice hockey, football, floorball, etc.). However, children's motivation can vary depending on the sport that is chosen for the team. To address this, Icehearts could consider offering a wider range of sport-based activities to ensure that all participants are enthusiastic about the programme. By expanding the range of sports-based activities and opportunities for physical activity, participants can explore and engage in areas that match their interests.

Expanding the Icehearts programme to include more girls could enhance the equity of the programme. Currently, Icehearts is predominantly made up of boys and boys' teams and, there are opportunities to create a more balanced and diverse participant base. By actively facilitating the participation of girls and creating more girls' teams, Icehearts can ensure a more balanced access to the benefits of the programme for all genders. Many girls face unique challenges during childhood and adolescence and the presence of a trusted mentor could benefit their personal growth and well-being.

Icehearts has the potential to be adapted to better serve minority communities in Finland, ensuring that the programme is inclusive for children from diverse backgrounds. In 2014, the initiative broadened its scope by launching a Swedish-speaking organisation – the Active Explorers Club – in Espoo, Finland. Today, five Swedish-speaking Icehearts teams operate in the Helsinki and Espoo areas, providing support and intervention services to at-risk children and adolescents in both Finnish- and Swedish-speaking communities (Icehearts, n.d.^[12]). To enhance inclusivity, the programme could continue to expand its multilingual offerings and incorporate culturally relevant activities tailored to the needs of various minority groups.

Enhancing the evidence-base

The Icehearts programme has accumulated a substantial body of evidence through a variety of studies and ongoing longitudinal research. However, given the long duration of the programme, it is costly to conduct comprehensive long-term studies. The specific selection process for Icehearts participants makes it difficult to establish appropriate control groups and to randomise research. The scarcity of ongoing funding and research resources represents a significant challenge to improving the evidence base for Icehearts.

To strengthen the evidence base, it is essential to secure long-term and sustainable research funding to conduct comprehensive longitudinal research following Icehearts teams over the duration of the programme. In addition, increasing the number of participants in both the control group and the intervention group would contribute to a more robust research base.

Enhancing extent of coverage

Expanding the extent of coverage for Icehearts is an important consideration in reaching a larger number of participants in need of support. However, due to limited administrative capacity of the programme, this presents a significant challenge. To overcome this, it is essential to explore ways to increase the funding of the programme and to build close partnerships and collaborations with schools, communities, municipalities, other organisations or support services to gain further support and mutualise resources. These strategies would assist in broadening the programme's reach and extending its support to a larger audience.

Transferability

This section explores the transferability of Icehearts and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring Icehearts.

Previous transfers

The Icehearts Europe project is currently being implemented to scale up the Finnish Icehearts model to a European level. The International Sport and Culture Association (ISCA) and Icehearts Finland are working together to launch a Europe-wide expansion of the programme, collaborating with 10 partners across Europe. The aim of the project is to promote the well-being and mental health of disadvantage and at-risk children and adolescents in Europe, based on the Finnish Icehearts model. The project runs for three years (2023-2025), and the model is piloted in five countries: Denmark, Estonia, Slovenia, Spain and Italy. The selected programme implementers are considered as first adopters and will test the Icehearts Europe model during the project. The results of these pilots will be used to refine the model and train facilitators so that second adopters (e.g. stakeholders and organisations interested in the Icehearts model) can

potentially implement the programme in the future. The project is funded by a EUR 4 million EU4Health Action Grant (ISCA, 2023^[13]; Icehearts, n.d.^[14]). The feasibility of transferring Icehearts to other EU countries is further reinforced by the existence of a Swedish-speaking version of the model.

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

Several indicators to assess the transferability of Icehearts were identified (see Table 12.2). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 12.2. Indicators to assess the transferability of Icehearts

Indicator	Reasoning	Interpretation
<i>Sector specific context</i>		
Ratio of students to teaching staff (OECD, 2021 ^[15])	Much of the work of Icehearts mentors takes place in the classroom. A smaller class size is an enabler for a student-centred intervention like Icehearts. A smaller student/teacher ratio will facilitate for better co-operation.	↑ value = less transferable
<i>Political context</i>		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[16])	Icehearts is more transferable in countries that have a strategy or action plan in place to guide the implementation of mental health policy	Yes = more transferable
Policies and programmes to support and promote mental health of children and adolescents (OECD/WHO Regional Office for Europe, 2023 ^[17])	The programme aims to prevent social exclusion and promote the well-being of vulnerable children and adolescents. Therefore, the intervention is more transferable in countries that support the mental health of children and adolescents.	Yes = more transferable
Policies and programmes to support mental health in educational settings (OECD/WHO Regional Office for Europe, 2023 ^[18])	Many of the Icehearts activities take place in schools, as the mentors follow the children in educational settings. Icehearts is therefore more transferable in countries with policies and programmes to support mental health in educational settings.	Yes = more transferable
Policies and programmes to address stigma and discrimination (OECD/WHO Regional Office for Europe, 2023 ^[19])	Icehearts targets vulnerable children and adolescents at risk of social exclusion, which is related to stigma and discrimination. Icehearts is therefore more transferable to countries with policies and programmes that address stigma and discrimination.	Yes = more transferable
<i>Economic context</i>		
Prevention spending as a share of current health expenditure (OECD, 2022 ^[20])	Icehearts is a preventive programme, therefore it is more transferable to countries that allocate a higher proportion of health spending to prevention.	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below:

- In Finland, the ratio of students to teaching staff is 8.42, which is below the median of 12.7 in OECD and EU countries. Countries with a lower ratio of students to teaching staff have better conditions for the transfer of Icehearts.
- As in Finland, the vast majority of countries (90%) have a strategy or action plan to guide the implementation of mental health policy. This suggests that Icehearts is likely to receive political support in most potential transfer countries.

- c) The vast majority of countries (90%) have policies and programmes to support and promote the mental health of children and adolescents, including Finland. Countries with policies that support this have better potential for transferability.
- d) As in Finland, a large proportion (90%) of countries have policies and programmes in place to support mental health in educational settings. As many of the Icehearts activities take place in schools, this finding suggests that Icehearts would be likely to receive political support in most potential transfer countries.
- e) Finland does not have policies and programmes in place to address stigma and discrimination, while 93% of countries do have this in place. Countries with policies that support this have a greater potential for the transfer of Icehearts.
- f) Finland allocates 4.70% of its current health expenditure to preventive care, which is above the OECD and EU median of 4.42%. Countries with a higher spending on prevention are more likely to have economic context for the transfer of Icehearts.

Table 12.3. Transferability assessment by country, Icehearts (OECD and non-OECD European countries)

A darker shade indicates Icehearts is more suitable for transferral in that particular country

Country	Ratio of students to teaching staff	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies supporting mental health in educational settings	Policies addressing stigma and discrimination	Prevention spending (% health expenditure)
Finland	8.42	Yes	Yes	Yes	No	4.70
Australia	n/a	Yes	Yes	Yes	Yes	3.24
Austria	13.72	Yes	Yes	Yes	No	10.33
Belgium	13.39	Yes	Yes	Yes	Yes	3.13
Bulgaria	11.86	Yes	No	No	No	3.25
Canada	n/a	No	Yes	Yes	Yes	6.11
Chile	20.88	Yes	Yes	Yes	Yes	3.35
Colombia	45.73	Yes	Yes	Yes	Yes	2.05
Costa Rica	11.17	Yes	No	No	Yes	0.78
Croatia	10.12	Yes	Yes	Yes	Yes	4.43
Cyprus	n/a	Yes	Yes	Yes	Yes	2.19
Czechia	11.74	n/a	Yes	Yes	Yes	8.12
Denmark	10.17	Yes	n/a	Yes	Yes	5.08
Estonia	8.11	Yes	Yes	Yes	No	8.30
France	22.29	Yes	Yes	Yes	Yes	5.49
Germany	9.01	No	Yes	Yes	Yes	6.45
Greece	9.63	Yes	Yes	Yes	Yes	4.04
Hungary	12.67	Yes	Yes	Yes	Yes	7.58
Iceland	4.53	Yes	Yes	Yes	Yes	3.31
Ireland	3.99	Yes	Yes	Yes	Yes	5.89
Israel	n/a	n/a	Yes	Yes	Yes	0.27
Italy	11.18	Yes	Yes	No	No	6.52
Japan	12.71	Yes	Yes	Yes	Yes	3.24
Korea	12.94	Yes	Yes	Yes	Yes	7.95
Latvia	11.35	Yes	Yes	Yes	Yes	5.13
Lithuania	10.16	Yes	Yes	Yes	Yes	5.56
Luxembourg	9.18	n/a	Yes	Yes	Yes	4.70
Malta	n/a	No	n/a	Yes	Yes	1.45
Mexico	19.01	Yes	Yes	Yes	Yes	2.95
Netherlands	15.95	n/a	Yes	Yes	Yes	9.59

Country	Ratio of students to teaching staff	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies supporting mental health in educational settings	Policies addressing stigma and discrimination	Prevention spending (% health expenditure)
New Zealand	6.09	Yes	Yes	Yes	Yes	n/a
Norway	11.40	Yes	Yes	Yes	Yes	2.70
Poland	12.81	Yes	Yes	n/a	Yes	2.10
Portugal	15.65	Yes	Yes	n/a	Yes	3.17
Romania	14.40	Yes	No	No	No	3.73
Slovak Republic	11.38	No	No	n/a	No	1.61
Slovenia	19.05	Yes	Yes	Yes	Yes	5.26
Spain	12.75	Yes	Yes	Yes	Yes	3.45
Sweden	13.81	Yes	Yes	Yes	Yes	4.93
Switzerland	17.88	Yes	Yes	Yes	Yes	2.82
Türkiye	12.90	Yes	Yes	Yes	Yes	n/a
United Kingdom	36.30	Yes	Yes	Yes	Yes	12.49
United States	12.92	Yes	Yes	Yes	Yes	4.83

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 12.2.

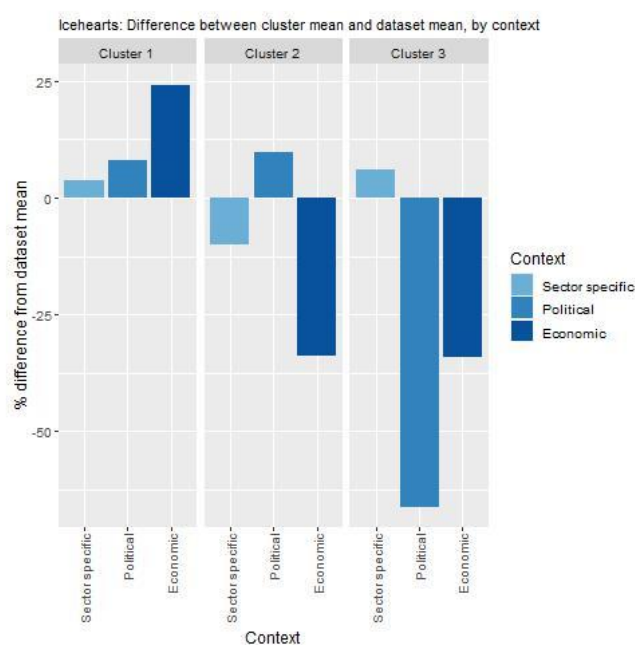
Source: OECD (2021^[15]), OECD Data Explorer - Ratio of students to teaching staff, <http://data-explorer.oecd.org/s/1nm> (accessed on 16 April 2024); OECD/WHO Regional Office for Europe (2023^[16]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy; OECD/WHO Regional Office for Europe (2023^[17]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support and promote mental health of children and adolescents; OECD/WHO Regional Office for Europe (2023^[18]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support mental health in educational settings; OECD/WHO Regional Office for Europe (2023^[19]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to address stigma and discrimination; OECD (2022^[20]), OECD Data Explorer - Prevention spending as a percentage of current health expenditure, <http://data-explorer.oecd.org/s/1nl> (accessed on 11 April 2025).

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 12.2. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 12.1 and Table 12.4:

- Countries in cluster one has sector-specific, political and economic arrangements in place to readily transfer Icehearts to their local context. This cluster includes 25 countries.
- Countries in cluster two have the political support to implement Icehearts, but they may wish to consider that the programme is affordable and can be implemented within the municipality's environment. This cluster includes 13 countries.
- Countries in cluster three have sector-specific arrangements in place to transfer Icehearts, but they may wish to consider ensuring that the programme is affordable and that it aligns with political priorities. This cluster includes a small number of countries (five).

Figure 12.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 12.4. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Austria Canada Croatia Cyprus Czechia Denmark Estonia Finland Germany Hungary Ireland Israel Korea Latvia Lithuania Luxembourg Netherlands Norway Poland Slovenia Spain Sweden Türkiye United Kingdom United States	Australia Belgium Chile Colombia France Greece Iceland Japan Malta Mexico New Zealand Portugal Switzerland	Bulgaria Costa Rica Italy Romania Slovak Republic

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 12.4 outlines several new indicators policymakers could consider before transferring Icehearts.

Box 12.4. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the ethnicity and cultural diversity of the target population?
- What is the level of knowledge about social and emotional skills in children/parents?
- What is the level of health literacy in the population?

Sector specific context

- What is the level of acceptability of the Icehearts approach in the school (teachers, pupil's parents)?
- What infrastructure is available in the community to encourage team sport and activities?

Political context

- Has the intervention received political support from key decision makers?
- Has the intervention received commitment from key decision makers?

Economic context

- What is the cost of the intervention (e.g. annual salary of an Icehearts mentor)?

Conclusion and next steps

Icehearts is a Finnish prevention programme for socially vulnerable children and adolescents. Through long-term professional support from an Icehearts mentor, the programme aims to prevent social exclusion, to promote social-emotional skills and to improve mental well-being. Each Icehearts team is led by a mentor and consists of 10-25 children, with a sports team formed to ensure the inclusion of marginalised children.

Icehearts has been effective in reaching its target groups and the majority of Icehearts children have shown improvements in physical activity, social skills, friendship, self-esteem and mood, according to Icehearts mentors. The effectiveness of Icehearts is mixed, with some children showing improvements in social-emotional well-being and prosocial behaviour, and others worsening in these areas.

Icehearts is highly transferable to 25 OECD and EU countries and intermediately transferable to other 13 countries. The transferability analysis using clustering suggests that Icehearts can be readily transferred to 58% of countries, which were included in the cluster of highest transferability. Besides, 30% of countries were included in the cluster of intermediate transferability.

The transfer of the Finnish Icehearts model to other European countries is currently underway through the Icehearts Europe project, funded by the European Union. The pilot implementation countries are Denmark, Estonia, Spain, Slovenia and Italy. This project will help to gather information on the contextual differences

between the implementation sites and the next step will focus on adapting and refining the model based on diverse contexts to ensure broader, successful implementation.

Box 12.5 outlines next steps for policymakers and funding agencies.

Box 12.5. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance Icehearts are listed below:

- Ensure funding to continue the implementation of the programme as well as for future scale-up and transfer efforts.
- To facilitate the implementation of the Icehearts model in new countries, ensuring strategic support from key stakeholders (e.g. schools, communities, municipalities) for successful adaptation and integration of the programme.

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13 Zippy's Friends

This chapter covers the case study of Zippy's Friends, a school-based social and emotional learning programme for children aged 5-7 years. The case study includes an assessment of Zippy's Friends against the five best practice criteria, policy options to enhance performance and an assessment of its transferability to OECD and EU27 countries.

Zippy's Friends: Case study overview

Description: Zippy's Friends is a school-based social and emotional learning programme for children aged 5-7 years. The programme is structured around engaging stories and illustrations featuring the stick insect "Zippy" and his friends, which serves to teach children how to cope with everyday difficulties, expressing their feelings, and supporting others. The programme is spread across 24 sessions of 45-60 minutes and aims to improve emotional literacy, resilience, social and coping skills to equip children with the tools needed to navigate challenges through adolescence and into adulthood.

Best practice assessment:

OECD best practice assessment of Zippy's Friends

Criteria	Assessment
Effectiveness	Zippy's Friends has been shown to improve coping strategies and social-emotional skills in children, particularly increasing active coping strategies and reducing oppositional coping strategies (e.g. opposition and withdrawal behaviours reduced by 9% and 15% respectively).
Efficiency	The cost of implementing the programme may include expenses for training and material, teacher time, supply teacher, additional activity materials, and transport and supervision for optional activities, however, a comprehensive cost evaluation is lacking.
Equity 	Zippy's Friends can be delivered to pupils with Special Educational Needs and Disabilities and there is evidence of improvements in social and emotional skills for children from low socio-economic status backgrounds.
Evidence-base 	A randomised controlled trial was used to assess the impact of Zippy's Friends and the evidence was rated as strong in several areas.
Extent of coverage	Zippy's Friends operates in more than 30 countries and has reached more than 2.5 million children since its inception.

Enhancement options: To *enhance the effectiveness* of Zippy's Friends, emphasis should be placed on addressing time constraints and the engagement of school leadership, assessing the long-term impact of the programme, and creating a supportive environment for implementation while involving parents and communities. To *enhance equity*, emphasis should be placed on increasing inclusivity and ensuring that the programme is culturally sensitive and relevant to children from diverse backgrounds. To *enhance the evidence-base*, there is a need for a longer-term monitoring and evaluation follow-up period, with additional outcomes.

Transferability: Zippy's Friends is a global programme that has been transferred to over 30 countries around the world (including 17 OECD and EU countries). Partnership for Children is responsible for setting up the programme with new partner organisations and there are several steps involved in transferring the programme to a new country.

Conclusion: Zippy's Friends has been implemented in more than 30 countries and has been shown to be effective in improving coping strategies and social-emotional skills in children, which underpin children's mental health. It has also demonstrated improved social skills, emotional literacy and emotional recognition among children with special education needs and disabilities.

Intervention description

The Zippy's Friends programme is a recognised mental health promotion programme for children aged between 5 to 7, established by Partnership for Children in several countries around the world. It was launched in London in 1996 as one of the Skills for Life programmes (see Box 13.1). Zippy's Friends aims to develop social and coping skills for all children so that they can cope with everyday challenges and negative life events (Mishara and Ystgaard, 2006^[1]). Zippy's Friends is usually delivered in kindergartens,

elementary schools or equivalent institutions as part of routine classroom teaching by a trained classroom teacher or education professional. It is typically carried out with whole classrooms of children. The training for teachers and education professionals is delivered through an online platform.

Box 13.1. Skills for Life Programmes

Zippy's Friends is run by Partnership for Children, a UK registered charity that helps children to be mentally and emotionally healthy by providing a range of school-based programmes that help young children around the world cope with difficulties, communicate effectively and develop skills for life. Zippy's Friends is made for 5-7 years old children and is part of a series of evidence-based programmes called Skills for Life. Other programmes in the Skills for Life series include:

- Apple's Friends (for ages 7-9): Reinforces the skills learned in Zippy's Friends for 5-7 year-olds children. However, Apple's Friends is an independent programme and children do not need to have participated in Zippy's Friends to take part. Apple's Friends has been revised and updated in 2022 to reflect teacher feedback, to run the programme over two years with new activities.
- Passport (for ages 9-11): Based on the same theory as Zippy's Friends and Apple's Friends, but for older children. The programme teaches children positive strategies for dealing with problems through activities such as discussion role play, games and reading comic strips.
- SPARK Resilience (for ages 10-12): A universal school-based resilience-promoting programme that focus on cognitive behavioural therapy, mindfulness and positive psychology. It aims to help children strengthen their skills in managing strong emotions and to reframe habitual ways of thinking.
- Zippy's Friends for Pupils with Special Educational Needs and Disabilities (SEND): An adapted version of the mainstream Zippy's Friend programme where teachers use a Special Needs Supplement alongside the mainstream programme. The supplement has been adapted with alternative and additional activities to include a range of children with SEND, to enhance their coping and social skills. The SEND version is designed for a wider age range, including primary and secondary school children, and has been successfully implemented with 6-17 year-olds.

Source: Partnership for Children (n.d.^[2]), "Our Skills for Life programmes", <https://www.partnershipforchildren.org.uk/what-we-do/programmes-for-schools/>.

Zippy's Friends aims to improve children's social skills, coping skills, emotional literacy, class climate, and reduce bullying. Zippy's Friends is composed of story-based illustrations which builds on a series of stories involving the character "Zippy", a stick insect, and his group of friends. The curriculum is divided into six modules: Feelings, Communication, Friendship, Conflict, Change and Loss, and Moving forward. Each module has four sessions and each session is designed to last for 45-60 minutes. Each session takes place once a week and 24 sessions are usually delivered over the course of an academic year (Clarke, Bunting and Barry, 2014^[3]).

Zippy's Friends uses engaging stories and illustrations to encourage children to think independently and manage everyday challenges, including expressing feelings and helping others with their problems. The programme aims to equip children with the skills to effectively handle problems and crises as they move into adolescence and adulthood. Each session builds upon the previous one, reinforcing the lessons learned. As a manualised structured programme, children interact and engage in dialogue through tasks and discussions. Children work with the materials and curriculum through drawing, performing, role playing, dialogue and play (Holen et al., 2012^[4]). Zippy's Friends is a flexible programme, that can be adjusted to suit different contexts, including the target age group, pace, and frequency of sessions.

OECD Best Practices Framework assessment

This section analyses Zippy's Friends against the five criteria within OECD's Best Practice Identification Framework – Effectiveness, Efficiency, Equity, Evidence-base and Extent of coverage (see Box 13.2 for a high-level assessment). Further details on the OECD Framework can be found in Annex A.

Box 13.2. Assessment of Zippy's Friends

Effectiveness

- Zippy's Friends was effective in reducing oppositional coping strategies (e.g. opposition and withdrawal behaviours reduced by 9% and 15% respectively) (effect size measured by Cohen's $d = -0.380$) and in increasing active coping strategies (Cohen's $d = 0.186$), but no significant effects were found on the mental health subscales of Strength and Difficulty Questionnaire.
- Compared to the control group, children who participated in Zippy's Friends were significantly better at self-management, for instance managing school stress, postponing their needs, adapting to the school environment and maintaining order.
- Children with Special Educational Needs and Disabilities (SEND) receiving Zippy's Friends showed significant improvements in teacher's rating of social skills, emotional literacy and emotional recognition.

Efficiency

- The cost of implementing the programme may include expenses for training and material, teacher time, supply teacher, additional activity materials, and transport and supervision for optional activities, however, a comprehensive cost evaluation is lacking.
- The cost for teacher training and materials is around GBP 512 (EUR 325) per class.

Equity

- Zippy's Friends has a version for Pupils with SEND which includes visual aids and special widget symbols, which has been effective in improving numerous subscales of emotional and social skills.
- Studies of Zippy's Friends with children from low socio-economic status backgrounds have suggested improvements in social and emotional skills, specifically on emotional literacy, social-emotional competencies, and behavioural problems.

Evidence-base

- A randomised controlled trial was used to assess the impact of Zippy's Friends and the evidence was rated as strong in the areas of study design, data collection methods, and withdrawals and dropouts.

Extent of coverage

- The delivery of intervention is not part of compulsory education, however, some cases of implementation are funded by government authority.
- Zippy's Friends operates in more than 30 countries and has reached more than 2.5 million children since its inception.

Effectiveness

Several studies have examined the effectiveness of Zippy's Friends across various outcomes. While the results have been mixed, the programme has had a positive impact on multiple aspects of children's coping mechanisms and social and emotional skills (Box 13.3).

Box 13.3. Social and emotional skills in children

Social and emotional skills are a subset of an individual's abilities, attributes and characteristics that are essential for social functioning. These skills encompass how individuals manage emotions, interact with others, and approach challenges. Key components of social and emotional skills include:

- Emotional regulation
- Co-operation
- Resilience
- Self-efficacy
- Empathy

Social and emotional skills are fundamental to the development of children and adolescents. When combined with cognitive abilities and academic achievement, they form a comprehensive set of competencies that are essential for success in school, work and later in life. Beyond enabling academic and cognitive growth, these skills are valuable developmental outcomes in their own right.

Source: OECD (2021^[5]), "Beyond Academic Learning: First Results from the Survey of Social and Emotional Skills", <https://doi.org/10.1787/92a11084-en>; OECD (2024^[6]), "PISA 2022 Results (Volume V): Learning Strategies and Attitudes for Life", <https://doi.org/10.1787/c2e44201-en>.

Coping strategies

One of the main objectives of Zippy's Friends is to improve children's coping skills for handling difficult emotions and reducing stress, and to prevent mental health problems by increasing their repertoire of coping strategies. A randomised controlled trial (RCT) by Holen and colleagues (2012^[4]) in Norway investigated the effectiveness of Zippy's Friends in improving coping strategies and mental health outcomes in children. Different coping strategies were assessed using the Kidcope checklist (Box 13.4). Results showed that children who received Zippy's Friends intervention had a more pronounced effect in reducing oppositional and withdrawal strategies beyond the natural changes observed in the control group. A difference-in-difference analysis, which adjusts for changes in the control group and over time, showed that the intervention led to an additional 0.036 unit decrease in oppositional strategies (corresponding to a 9% reduction) and a 0.028 unit decrease in withdrawal strategies (a 15% reduction) compared to the control group. Furthermore, the study showed significant reductions in oppositional strategies reported by the children (with an effect size of Cohen's $d = -0.380$) and increases in active strategies reported by parents (Cohen's $d = 0.186$). The study found no significant effects on the mental health subscales as measured by the Strengths and Difficulties Questionnaire (SDQ) (Holen et al., 2012^[4]).

Box 13.4. The Kidcope Checklist: Assessing coping strategies in children

The Kidcope Checklist was developed by Spirito, Stark and Williams (1988^[7]) to assess coping strategies in children and adolescents. Based on the stress-coping theory of Lazarus and Folkman (1984^[8]), the checklist evaluates how children respond to stressful situations.

In Holen et al. (2012^[4]), which examined the effectiveness of Zippy's Friends, a Norwegian version of the Kidcope was used. The checklist was modified so that children responded to a specific peer-related problem: "What are you likely to do if your best friend does not want to play with you during recess or lunch break, and you are socially excluded in the playground?".

Two versions of the checklist were used:

- Children's version: responses were dichotomous (yes/no) to indicate whether they would use each coping strategy.
- Parents' version: parents rated their child's use of each strategy on scale, ranging from "Not at all" to "Almost all the time".

Three main types of coping strategies are identified and studied by Holen et al. (2012^[4]):

- Active strategies – e.g. trying to see the good side, calming oneself down, talking to others, or solving the problem.
- Withdrawal strategies – e.g. stay on your own or keeping quiet about the problem.
- Oppositional strategies – e.g. for example blaming others, shouting, screaming or getting angry.

Similar results are also reported in other studies. A 2015 study from the Netherlands by The Trimbos Institute found a significant programme effect on improved "adaptive coping" (problem-solving coping skills) among participants in the intervention group (The Trimbos Institute, 2016^[9]). In a study conducted in Denmark and Lithuania, the participants receiving Zippy's Friends used significantly more positive coping strategies and showed significant improvements in social skills, compared to the control groups (Mishara and Ystgaard, 2006^[11]).

Social and emotional skills

A 2016 RCT study conducted in Czechia found that pupils receiving Zippy's Friends had **better self-management skills** compared to the control group. After participating in Zippy's Friends, children were better at managing school stress, delay immediate desires or impulses, adapting to the school environment and maintaining order (e.g. stay organised), compared to controls. They also scored higher in areas such as peer co-operation, conflict resolution, accepting criticism and describing their feelings (Žufníček et al., 2016^[10]). Similarly, in the Netherlands, children who participated in Zippy's Friends scored **significantly higher on emotional recognition** – the ability to identify and understand emotions in oneself and others – than those in the control group. In addition, results from parent's measures showed a significant improvement in social and emotional skills in the intervention group, particularly in emotional literacy (The Trimbos Institute, 2016^[9]).

A study by the Education Endowment Foundation (EEF) from the United Kingdom found no evidence for an increase in emotional self-regulation or social skills (Sloan et al., 2018^[11]). However, this finding may be subject to two limitations. Firstly, the control group received a range of social and emotional learning programmes and strategies at the same time as the intervention group, and secondly, the timing of the outcome measure (immediately after the end of the programme) may have affected the ability to detect any impact (Sloan et al., 2018^[11]).

A UK study evaluated Zippy's Friends in Special Educational Needs and Disabilities (SEND) schools, focussing on children with disabilities. **Significant progress was observed in social skills** across subscales measuring co-operation, communication, responsibility and assertion. However, no significant changes were noted in the subscales measuring empathy, self-control and engagement (Unwin, Stenfert Kroese and Blumson, 2018^[12]). Similarly, a study of Zippy's Friends with children in disadvantaged schools in Ireland reported **significant positive increases in emotional literacy skills (including self-regulation, motivation, self-awareness and social skills)**, with evidence for sustained effect at the 12-month follow-up (Clarke, Bunting and Barry, 2014^[3]).

Efficiency

The cost of implementing Zippy's Friends includes several expenses and may vary over time. Expenses include training and material, teacher time (approximately 45-60 minutes for delivery and 10-25 minutes for preparation), supply teacher, additional activity materials, and transport and supervision for optional activities, such as class trip. Expenses related to training and material amount approximately GBP 512 (EUR 325) in the first year based on one class of 27 pupils. This includes an initial one-day teacher training session and the purchase of programme materials for both teachers and students. The per-pupil cost decreases over time: GBP 19 (EUR 12) in the first year, GBP 13 (EUR 8.25) in the second year, and GBP 10 (EUR 6.35) in the third year (Sloan et al., 2018^[11]).

Equity

Zippy's Friends for Pupils with SEND was launched in 2013. This specific edition of the Zippy's Friends programme includes visual aids and special widget symbols adapted for the pupils with SEND. While the programme aims to deliver 24 sessions in approximately one year, the schedule, target beneficiary profiles and activities have been adapted to the circumstances. The programme can be delivered at a slower pace with shorter sessions and more repetitions, and has been successfully implemented with 6-to-17-year-old SEND children. The effectiveness of this programme has been proven, with improvements across various subscales of emotional and social skills of SEND children as a results of the Zippy's Friends intervention (Unwin, Stenfert Kroese and Blumson, 2018^[12]).

A review of the Zippy's Friends programme for children from low socio-economic status (SES) backgrounds indicated positive outcomes in social and emotional skills development. A UK study focussing on children from disadvantaged schools, found a significant positive impact on children's emotional literacy comparing data from pre- and post-intervention (Clarke, Bunting and Barry, 2014^[3]). Evidence also shows that children from low socio-economic backgrounds who participated in Zippy's Friends were less likely to use oppositional strategies, such as blaming others or reacting aggressively, compared to those in the control group (Cohen's $d = -0.443$) (Holen et al., 2012^[4]), and improved social-emotional competencies and reduced behavioural problems (The Trimbos Institute, 2016^[9]).

There is currently limited evidence available on the impact of Zippy's Friends by sex. The Zippy's Friends intervention was associated with a reduction in oppositional strategies among girls (Cohen's $d = -0.551$) as well as an increase in active and support-seeking coping strategies (Cohen's $d = -0.443$). This was not observed in boys. Teachers also reported that boys who participated in Zippy's Friends experienced a smaller negative impact from mental health difficulties in daily life compared to boys in the control group (Cohen's $d = -0.224$) (Holen et al., 2012^[4]).

Evidence-based

There are several studies that have evaluated Zippy's Friends and many of these have used RCTs to assess impact. For the purposes of this case study, the study undertaken by Holen and colleagues (2012^[4]) was used to assess the evidence-base. This study was selected because it is a peer-reviewed journal

article with an RCT design. It evaluates Zippy's Friends in an OECD country (Norway) and is not limited to specific settings. Results suggest a significant positive impact of Zippy's Friends on children's mental health.

Using the *Quality Assessment Tool for Quantitative Studies* (Table 13.1), the design of the study evaluating Zippy's Friends was rated as "strong" in several areas: study design, data collection methods, and withdrawals and dropouts. However, as with other evaluation studies of Zippy's Friends or other social and emotional learning programmes, blinding of assessors or participants was difficult in practice because the informants for the study included parents, teachers, and even children.

Table 13.1. Evidence base assessment, Zippy's Friends

Assessment category	Question	Rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population?	Very likely
	What percentage of selected individuals agreed to participate?	Can't tell
Selection bias score		Moderate
Study design	Indicate the study design	Randomised controlled trial
	Was the study described as randomised?	Yes
Study design score		Strong
Confounders	Were there important differences between groups prior to the intervention?	No
	What percentage of potential confounders were controlled for?	Can't tell
Confounder score		Weak
Blinding	Was the outcome assessor aware of the intervention or exposure status of participants?	Yes (for teachers and parents): No (for children)
	Were the study participants aware of the research question?	Yes (for teachers and parents): No (for children)
Blinding score		Weak
Data collection methods	Were data collection tools shown to be valid?	Yes
	Were data collection tools shown to be reliable?	Yes
Data collection methods score		Strong
Withdrawals and dropouts	Were withdrawals and dropouts reported in terms of numbers and/or reasons per group?	Yes
	Indicate the percentage of participants who completed the study?	86-96%
Withdrawals and dropout score		Strong

Source: Effective Public Health Practice Project (1998^[13]) "Quality assessment tool for quantitative studies", <https://www.nccmt.ca/knowledge-repositories/search/14>; Holen et al. (2012^[4]), "The effectiveness of a universal school-based programme on coping and mental health: a randomised, controlled study of Zippy's Friends", <https://doi.org/10.1080/01443410.2012.686152>.

Extent of coverage

Zippy's Friends is not a compulsory part of the educational curriculum, and its implementation and roll-out rely on non-governmental organisations (NGOs) and individual educational institutions. However, there are examples of government funding for the implementation of the programme, such as in Ireland and Norway, suggesting the potential for scaling up the intervention at a national level (Holen et al., 2012^[4]; Clarke, Bunting and Barry, 2014^[3]).

Information on coverage of Zippy's Friends is not publicly available at national or regional level. However, Partnership for Children, a UK-based NGO, collects information on coverage of the Skills for Life programmes from partner organisation in each country using the programme. In total, the programme is implemented in more than 30 countries (including 17 OECD and EU countries) and more than 2.5 million children have been enrolled in Zippy's Friends since the launch of the programme. In the year of 2023, around 140 000 children were enrolled in the programme worldwide (Partnership for Children, 2025^[14]).

Policy options to enhance performance

Enhancing effectiveness

A review of evaluation studies of school-based mental health interventions has identified several factors associated with positive outcomes (see Box 13.5). By comparing these factors with the design and implementation of Zippy's Friends, several policy options to enhance the effectiveness of the programme are outlined below.

Box 13.5. Examples of factors related to school-based mental health interventions

This box lists pillars and factors related to the success of school-based preventive mental health interventions. This list is based on the joint work of WHO, UNESCO and UNICEF on the promotion and protection of mental health in schools and learning environments, however, it is not exhaustive (WHO/UNESCO/UNICEF, 2022^[15]). It provides policy guidance for strengthening education systems to protect and promote the mental health and psychosocial well-being of children and adolescents.

- **Consideration of context:** School environment varies depending on the factors such as student's profile (e.g. age, gender, disabilities, language skills), teacher's profile, nurturing environment, and cultural characteristics. To avoid differences in learnings between children, it is essential to implement an inclusive intervention, while taking into account various contextual factors.
- **Comprehensive and collaborative approach:** Multilayered and multisectoral approach between the school, family, and the community is an essential component.
- **Sufficient support from schools and government:** Both tangible and intangible support from learning institutions and government and their capacity is important. Support on educational workforce including the teacher's well-being should be addressed.

Addressing time constraints and engaging school leadership

Time constraints were identified as a key barrier to the delivery of Zippy's Friends, with teachers reporting difficulties in ensuring that sessions fit appropriately into the school timetable and that there is enough time to deliver the programme within the school day (Sloan et al., 2018^[11]). To enhance the effectiveness of Zippy's Friends, consideration should be given to ensuring that teachers have sufficient time to prepare and deliver sessions.

Senior management support was also identified as a barrier to delivery, with some teachers reporting a lack of awareness from school leadership (Sloan et al., 2018^[11]). To address this, it is important to ensure that school leadership is well informed about the programme and the time commitment required from classroom teachers. Such awareness raising can ensure that teachers receive the support they need to deliver the programme effectively. Adopting a whole-school approach, where there is awareness and support for the programme at all levels, can be an important step in this direction.

Assessing long-term impacts of social and emotional learning programmes

Sloan and colleagues (2018^[11]) point out that measuring outcomes immediately after programme delivery may be too early to detect changes in outcomes. The impact of social and emotional learning programmes may take time to be reflected in academic outcomes. To better understand the delayed effects of social and emotional learning programmes, such as Zippy's Friends, it is necessary with longitudinal follow-up

assessment. As it is difficult to assess behavioural change in the target group for Zippy's Friends, aged 5-7 years, a longer-term evaluation can help to capture lasting benefits of the programme.

Supportive environment for implementation

Effective implementation is crucial to achieving the desired outcomes of school-based mental health programmes such as Zippy's Friends. This depends heavily on the commitment of teachers and their adherence to the training guidelines. Challenges such as insufficient school leadership and lack of awareness can hinder the programme's successful implementation. Institutional support is particularly important as Zippy's Friends is not part of the mandatory curriculum, and this support can also improve the outcomes of other school-based interventions for children. Integrating mental health interventions for children into the compulsory academic curriculum has shown significant improvements in school-based interventions, compared to curriculum-driven or separately operated interventions. This is consistent with the policy recommendation from the joint UN work emphasising school and government support (Box 13.5) (WHO/UNESCO/UNICEF, 2022^[15]).

Involving parents and communities in which children live

Beyond school, the environment in which children live is important. The involvement of different parties, including children, parents, teachers, caregivers, and the community contributes to the continuum of care and education for children's mental health. Engaging parents is important for reinforcing the lessons learned in school in the home environment. Interventions and programmes that foster collaboration among children, parents, and teachers tend to be the most effective (Unwin, Stenfert Kroese and Blumson, 2018^[12]). Research indicates that when parents are actively involved, the effectiveness is increased for mental health promotion and emotional literacy interventions (Adi et al., 2007^[16]).

Enhancing efficiency

Given the lack of cost-effectiveness evaluations of Zippy's Friends, it is important for policymakers and administrators to focus on evaluating the programmes efficiency over time. A key challenge is to quantify the long-term impact of the programme, given that benefits in terms of students' academic achievement and mental well-being may only become apparent after an extended period.

Enhancing equity

To avoid gaps in children's learning, it is important that the intervention is inclusive and adapted to children's characteristics. Characteristics such as age, gender and language skills can lead to different adaptations and effects. For example, a UK-based intervention focussing on children with SEND found that only younger children showed significant improvements in empathy, while older children did not show any improvement over time (Unwin, Stenfert Kroese and Blumson, 2018^[12]). Evidence from an evaluation of the Zippy's Friends programme in Norway suggests differences in coping strategies between boys and girls (Holen et al., 2012^[4]). To enhance the equity of Zippy's Friends and to ensure that all the children benefit equally, a multi-faceted approach is necessary. This includes cultural adaptation to make the programme culturally sensitive and relevant to children from diverse backgrounds and strengthening parental and community involvement to support children's learning at home.

Enhancing the evidence-base

Although most of existing evaluation studies are designed as RCTs, they still have limitations in terms of time and outcomes. Building evidence with a longer monitoring and evaluation follow-up period and additional outcomes would help to improve the quality of the evidence. First, longer follow-up studies would

help to analyse the trajectory of the effectiveness of mental health prevention interventions, which could also contribute to find the right timing for delivering the interventions. Second, the outcomes of the existing evidence are mainly limited to coping, social and emotional skills. Additional measures such as clinical outcomes and academic attainment outcomes could help to size the intervention impact on the long term and could help policymakers link Zippy's Friends intervention with other mental health prevention policies later in life, ensuring a continuous approach to care.

Enhancing extent of coverage

Information on participation rates in existing evaluation studies of Zippy's Friends shows that they are mostly limited to specific administrative municipalities or school types. The extent of coverage for Zippy's Friends can be enhanced at both school level and individual level. Although a high dropout rate for Zippy's Friends has not been specifically identified, the reasons for withdrawal and dropout of individuals are mainly driven by parental consent. To reduce the risk of dropout, it is important to have a focus on raising awareness and improving communication strategies. Language, cultural challenges, or disabilities at the parental level may be reasons for withdrawal (e.g. in families with cultural and linguistic diverse backgrounds, parental consent may be more difficult to be obtained). At the school level, studies have not identified the reasons for withdrawal and dropout, but promoting the intervention to the public and school management institutions would reduce the risk of dropping out. To increase participation at both individual and school level, diversifying the tools used for recruitment, communication and monitoring could enhance the engagement. In addition, by expanding digital access through online platforms and mobile apps, which provide better opportunities for remote learning, could increase the reach of Zippy's Friends.

Transferability

This section explores the transferability of Zippy's Friends and is broken into three components: 1) an examination of previous transfers; 2) a transferability assessment using publicly available data; and 3) additional considerations for policymakers interested in transferring Zippy's Friends.

Previous transfers

Zippy's Friends was originally developed by Partnership for Children (PfC), which was funded as a UK registered charity in 2001. Zippy's Friends was launched internationally in 2002. Zippy's Friends is part of the "Skills for Life" programmes which includes the other programmes Apple's Friends, Passport, SPARK Resilience and Zippy's Friends for SEND (Box 13.1). These programmes have been transferred to over 30 countries around the world and has reached more than 2.5 million children (Partnership for Children, n.d.^[17]). PfC is in charge of setting up and implementing Zippy's Friends in new countries (See Box 13.6). As of 2023, 17 OECD countries (Belgium, Bulgaria, Canada, Czechia, Denmark, France, Iceland, Ireland, Korea, Lithuania, the Netherlands, Norway, Poland, Portugal, the Slovak Republic, the United Kingdom, and the United States) are running the Zippy's Friends.

Box 13.6. Setting up Zippy's Friends in a new country

The UK-based organisation “Partnership for Children” (PfC) is responsible for setting up the programme with new partner organisations, and there are several steps involved in launching the programme in a new country. Zippy's Friends and the other Skills for Life programmes are not provided to individual schools, but a licence agreement is signed with a partner agency to manage the programme in a region or country. Partner organisations vary in size and nature, from government departments to NGOs, voluntary organisations and academic institutions. Organisations willing to adopt the programme can apply to become a Partnership for Children International Licensed Partner.

After expressing interest, organisations contact PfC and provide the necessary documentation for review. PfC conducts due diligence by reviewing the organisation's financial statements, senior staff curriculum vitae, and references. Once vetted, the partner appoints a co-ordinator for school recruitment, training, and teacher communication. Both parties then discuss and sign a license agreement, which grants the partner the right to deliver the programmes for a specified period and in a specified area, with associated fees and royalties. PfC provides programme materials in English; the partner translates and prints them, or obtains English materials directly from PfC. PfC also delivers the initial training for trainers, after which the partner takes over responsibility for running future training sessions in their local language and context. As the programme is implemented, partners join PfC's global network, participate in international meetings and contributes to the development of PfC initiatives.

Source: Partnership for Children (n.d.^[18]), “Become an International Partner, <https://www.partnershipforchildren.org.uk/get-involved/become-an-international-partner/>

Transferability assessment

This section outlines the methodological framework to assess transferability followed by analysis results.

Methodological framework

A few indicators to assess the transferability of Zippy's Friends were identified (see Table 13.2). Indicators were drawn from international databases and surveys to maximise coverage across OECD and non-OECD European countries. Please note, the assessment is intentionally high level given the availability of public data covering OECD and non-OECD European countries.

Table 13.2. Indicators to assess the transferability of Zippy's Friends

Indicator	Reasoning	Interpretation
<i>Sector specific context</i>		
Ratio of students to teaching staff (OECD, 2021 ^[19])	A smaller class size is an enabler for a student-centred intervention like Zippy's Friends. A smaller ratio of students to teaching staff will facilitate for a better co-operation.	↑ value = less transferable
Teacher motivation (OECD, 2021 ^[20])	The perception that teachers hold on their ability to influence the development of children reflects on their motivation to engage enthusiastically with kids and school-based interventions.	↑ value = more transferable
<i>Political context</i>		
Strategy or action plan that guide implementation of the mental health policy (OECD/WHO Regional Office for Europe, 2023 ^[21])	Zippy's Friends is more transferable in countries that have a strategy or action plan in place to guide the implementation of mental health policy	Yes = more transferable

Indicator	Reasoning	Interpretation
Policies and programmes to support and promote mental health of children and adolescents (OECD/WHO Regional Office for Europe, 2023 ^[22])	The programme aims to develop children's coping skills and enhance social and emotional skills. Therefore, the intervention is more transferable in countries that support the mental health of children and adolescents.	Yes = more transferable
Policies and programmes to support mental health in educational settings (OECD/WHO Regional Office for Europe, 2023 ^[23])	Zippy's Friends is a school-based programme and is more transferable to countries that already have policies and programmes in place to support mental health in educational settings.	Yes = more transferable
<i>Economic context</i>		
Spending on early childhood education and primary and secondary schools (% GDP) (OECD, 2025 ^[24])	Zippy's Friends is a school-based programme and will be more successful in countries who spend more on early childhood education and primary and secondary schools.	↑ value = more transferable
Prevention spending as a percentage of GDP (OECD, 2024 ^[25])	Zippy's Friends is a prevention programme and is more transferable to countries that allocate a higher proportion of health spending to prevention	↑ value = more transferable

Results

The main findings of the transferability assessment are summarised below:

- In Norway, the ratio of students to teaching staff is 11.40, which is below the median of 12.7 in OECD and EU countries. Countries with a lower ratio of students to teaching staff have better conditions for the transfer of Zippy's Friends.
- The teacher motivation in Norway is 0.89, which is below the OECD and EU median of 0.94. As most countries have higher levels of teacher's motivation to engage enthusiastically with kids, they should have favourable conditions for the transfer of Zippy's Friends.
- As in Norway, the vast majority of countries (90%) have a strategy or action plan to guide the implementation of mental health policy. This suggests that Zippy's Friends would be likely to receive political support in most potential transfer countries.
- The vast majority of countries (90%) have policies and programmes to support and promote the mental health of children and adolescents, including Norway. Countries with established mental health policies for young people are better positioned to facilitate the transfer and implementation of Zippy's Friends.
- As in Norway, a large proportion (90%) of countries have policies and programmes in place to support mental health in educational settings. This indicates that a majority of countries have political support for the implementation of Zippy's Friends.
- Norway spends 6.57% of GDP on early childhood education and primary and secondary schools, which is above the OECD and EU median of 3.77%. Countries that invest a greater proportion of their GDP in education are more likely to have the economic resources to support the transfer of Zippy's Friends.
- Norway has a lower level of prevention spending as a percentage of GDP, compared to other countries (0.27% vs. 0.40% for the median in OECD and EU countries). Countries with higher spending on prevention would be more likely to have economic support for the transfer of Zippy's Friends.

Table 13.3. Transferability assessment by country (OECD and non-OECD European countries)

A darker shade indicates Zippy's Friends is more suitable for transferral in that particular country

Country	Ratio of students to teaching staff	Teacher motivation	Strategy or action plan that guide policy implementation	Policies supporting mental health of children and adolescents	Policies supporting mental health in educational settings	Education spending (% GDP)	Prevention spending (% GDP)
Norway	11.40	0.89	Yes	Yes	Yes	6.57	0.27
Australia	n/a	0.96	Yes	Yes	Yes	4.50	0.35
Austria	13.72	0.96	Yes	Yes	Yes	3.62	1.25
Belgium	13.39	0.95	Yes	Yes	Yes	4.13	0.35
Bulgaria	11.86	0.95	Yes	No	No	n/a	n/a
Canada	n/a	0.99	No	Yes	Yes	3.54	0.68
Chile	20.88	0.97	Yes	Yes	Yes	5.51	0.31
Colombia	45.73	0.98	Yes	Yes	Yes	4.44	0.16
Costa Rica	11.17	n/a	Yes	No	No	n/a	0.06
Croatia	10.12	0.95	Yes	Yes	Yes	n/a	n/a
Cyprus	n/a	n/a	Yes	Yes	Yes	n/a	n/a
Czechia	11.74	0.93	n/a	Yes	Yes	3.47	0.77
Denmark	10.17	0.94	Yes	n/a	Yes	4.76	0.48
Estonia	8.11	0.88	Yes	Yes	Yes	4.25	0.62
Finland	8.42	0.83	Yes	Yes	Yes	4.78	0.48
France	22.29	0.92	Yes	Yes	Yes	4.43	0.68
Germany	9.01	n/a	No	Yes	Yes	3.77	0.83
Greece	9.63	n/a	Yes	Yes	Yes	2.86	0.37
Hungary	12.67	0.93	Yes	Yes	Yes	3.30	0.56
Iceland	4.53	0.79	Yes	Yes	Yes	6.29	0.28
Ireland	3.99	n/a	Yes	Yes	Yes	2.43	0.36
Israel	n/a	0.97	n/a	Yes	Yes	6.09	0.02
Italy	11.18	0.79	Yes	Yes	No	3.77	0.59
Japan	12.71	0.89	Yes	Yes	Yes	2.77	0.36
Korea	12.94	n/a	Yes	Yes	Yes	3.53	0.77
Latvia	11.35	0.93	Yes	Yes	Yes	3.60	0.46
Lithuania	10.16	0.91	Yes	Yes	Yes	3.21	0.44
Luxembourg	9.18	n/a	n/a	Yes	Yes	3.42	0.26
Malta	n/a	0.96	No	n/a	Yes	n/a	n/a
Mexico	19.01	0.99	Yes	Yes	Yes	3.75	0.18
Netherlands	15.95	0.86	n/a	Yes	Yes	3.86	0.58
New Zealand	6.09	0.96	Yes	Yes	Yes	5.13	n/a
Poland	12.81	n/a	Yes	Yes	n/a	4.01	0.14
Portugal	15.65	0.94	Yes	Yes	n/a	3.82	0.35
Romania	14.40	0.98	Yes	No	No	n/a	n/a
Slovak Republic	11.38	0.93	No	No	n/a	3.37	0.13
Slovenia	19.05	0.89	Yes	Yes	Yes	n/a	0.50
Spain	12.75	0.89	Yes	Yes	Yes	3.76	0.37
Sweden	13.81	0.94	Yes	Yes	Yes	5.78	0.55
Switzerland	17.88	n/a	Yes	Yes	Yes	1.56	0.33
Türkiye	12.90	0.98	Yes	Yes	Yes	3.37	n/a
United Kingdom	36.30	n/a	Yes	Yes	Yes	4.53	1.55
United States	12.92	0.99	Yes	Yes	Yes	3.47	0.84

Note: n/a = no available data. The shades of blue represent the distance each country is from the country in which the intervention currently operates, with a darker shade indicating greater transfer potential based on that particular indicator (see Annex A for further methodological details). The full names and details of the indicators can be found in Table 13.2.

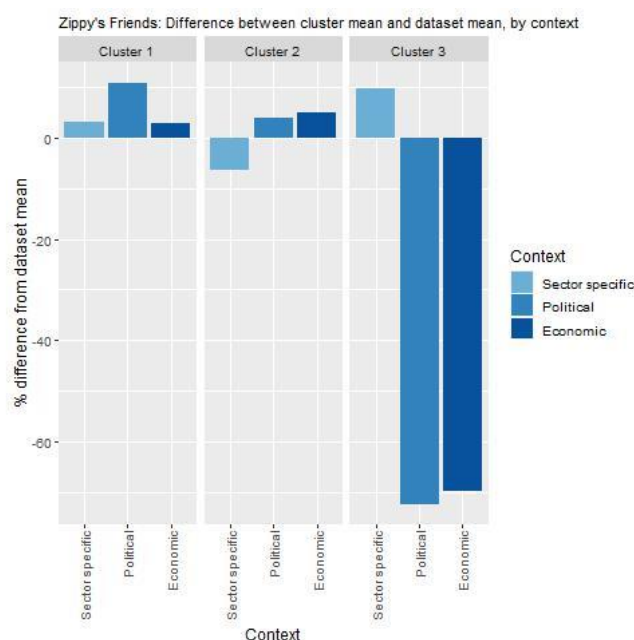
Source: OECD (2021^[19]), Ratio of students to teaching staff, <https://data-explorer.oecd.org/s/2xq>; OECD (2021^[20]), Teacher motivation, <https://doi.org/10.1787/health-data-en> (accessed on 16 April 2024); OECD (2025^[24]), Education spending (indicator), <https://doi.org/10.1787/ca274bac-en> (accessed on 24 February 2025); OECD/WHO Regional Office for Europe (2023^[21]), Mental Health Systems Capacity Questionnaire 2023 - Strategy or action plan that guide implementation of the mental health policy; OECD/WHO Regional Office for Europe (2023^[22]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support and promote mental health of children and adolescents; OECD/WHO Regional Office for Europe (2023^[23]), Mental Health Systems Capacity Questionnaire 2023 - Policies and programmes to support mental health in educational settings; OECD (2024^[25]), OECD Data Explorer - Prevention spending as a percentage of GDP, <http://data-explorer.oecd.org/s/1nl> (accessed on 7 April 2024).

To help consolidate findings from the transferability assessment above, countries have been clustered into one of three groups, based on indicators reported in Table 13.2. Countries in clusters with more positive values have the greatest transfer potential. While this analysis provides a high-level overview assuming some simplifications, it is important to note that countries in lower-scoring clusters may also have the capacity to adopt the intervention successfully. For further details on the methodological approach used, please refer to Annex A.

Key findings from each of the clusters are below with further details in Figure 13.1 and Table 13.4:

- Countries in cluster one has sector-specific, political and economic arrangements in place to transfer Zippy's Friends and therefore have the conditions to readily transfer the programme to their local context. Countries in this cluster are considered to be less likely to experience issues in implementing and operating Zippy's Friends in their local context. This group includes 21 countries.
- Countries in cluster two have the political and economic arrangements in place to transfer Zippy's Friends. Before transferring the programme, these countries may wish to consider whether the conditions in schools are in place to facilitate its implementation. This group includes 16 countries.
- Countries in cluster three have sector-specific arrangements that support the transfer of Zippy's Friends. Countries in this cluster may wish to assess the feasibility of the programme within their political and economic context, to ensure that the programme is affordable and aligns with the political priorities. This group includes 4 countries.

Figure 13.1. Transferability assessment using clustering



Note: Bar charts show percentage difference between cluster mean and dataset mean, for each indicator.

Source: OECD analysis.

Table 13.4. Countries by cluster

Cluster 1	Cluster 2	Cluster 3
Australia	Canada	Bulgaria
Austria	Czechia	Costa Rica
Belgium	Estonia	Romania
Chile	Finland	Slovak Republic
Colombia	France	
Croatia	Germany	
Denmark	Hungary	
Greece	Iceland	
Ireland	Italy	
Israel	Japan	
Latvia	Korea	
Lithuania	Netherlands	
Luxembourg	Slovenia	
Mexico	Spain	
New Zealand	Türkiye	
Norway	United States	
Poland		
Portugal		
Sweden		
Switzerland		
United Kingdom		

Note: Due to high levels of missing data, the following countries were omitted from the analysis: Cyprus and Malta.

Source: OECD analysis.

New indicators to assess transferability

Data from publicly available datasets alone is not ideal to assess the transferability of public health interventions. Box 13.7 outlines several new indicators policymakers could consider before transferring Zippy's Friends.

Box 13.7. New indicators to assess transferability

In addition to the indicators within the transferability assessment, policymakers are encouraged to collect information for the following indicators:

Population context

- What is the level of health literacy in the population?
- What is the level of knowledge about social and emotional skills in children/parents?
- What is the ethnicity and cultural diversity of the target population?
- What is the level of parental engagement with schools and teachers?

Sector specific context (early childhood education)

- What is the level of acceptability of Zippy's Friends amongst teachers and school administration?
- What is the level of (mental) health literacy amongst teachers? (e.g. how comfortable do teachers feel about delivering Zippy's Friends?)

Political context

- Has the intervention received political support from key decision makers?
- Has the intervention received commitment from key decision makers?

Conclusion and next steps

Zippy's Friends is a school-based social and emotional learning programme for children aged 5-7 years. The programme aims to improve emotional literacy, resilience, social and coping skills so that children can cope with everyday challenges and negative life events. Zippy's Friends is delivered in kindergartens, elementary schools or equivalent institutions and the programme is spread across 24 sessions of 45-60 minutes.

Zippy's Friends have been effective in reducing oppositional strategies and increasing active coping strategies. Children who participated in the programme were significantly better than controls at self-management skills social skills. The programme has also been adapted to students with special educational needs and disabilities showing significant improvements in social skills, emotional literacy and emotional recognition.

Zippy's Friends is highly transferable to 21 OECD and EU countries and intermediately transferable to other 16 countries. Zippy's Friends is widely used in over 30 countries around the world and the Skills for Life programmes have been given to more than 2.5 million children. Partnership for Children is responsible for setting up the programme with new partner organisations and help with transferring the programme to new countries and settings.

Box 13.8 outlines next steps for policymakers and funding agencies.

Box 13.8. Next steps for policymakers and funding agencies

Next steps for policymakers and funding agencies to enhance Zippy's Friends are listed below:

- Support policy efforts to provide teachers with appropriate training on children's mental health, for example, by including these topics in the curriculum to become a teacher.
- Support policy efforts to boost population mental health literacy in order to motivate parental and community involvement to support children's learning at home.
- Ensure funding for future scale-up and transfer efforts and consider government funding support for implementation.
- Promote "lessons learnt" from countries and regions that have transferred Zippy's Friends to their local setting.

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Annex A. Methodology

Selecting case studies

OECD assessed several case study interventions targeting mental health promotion and/or prevention (Table A A.1). Together, the case studies cover several OECD and non-OECD European countries.

Selected case studies represent strategic, high-priority interventions among policymakers in the OECD and EU27. A full description of the selection process is in Box A A.1.

Table A A.1. Overview of selected interventions

Name	Policy areas	Description	Country
@Ease	Facilitate access	Peer-to-peer programme for mental health support for adolescents with mild-to-moderate symptoms	Netherlands
Belgian reform	Facilitate access	Improved access to mental health support via a network of psychologists	Belgium
iFightDepression® (iFD Tool)	Facilitate access	Web-based, guided self-help programme	Germany
Icehearts	School	Programme to accompany children and adolescents with mental health issues	Finland
Mental Health First Aid (MHFA)	Front-line actors; Mental health literacy	Training individuals to listen to people with mental distress and provide first aid	Multiple
Next Stop Mum	Front-line actors; Facilitate access	Early diagnosis of post-partum depression	Poland
Prompt Mental Health Care (PMHC)	Facilitate access	Improved access to mental health support via PMHC centres for individuals with mild-to-moderate symptoms	Norway
Suicide Prevention Austria (SUPRA)	Prevent suicide; Front-line actors	Suicide prevention with multiple components	Austria
This is Me	Facilitate access; School	Online platform for adolescent and school-based programme	Slovenia
VigilanS	Prevent suicide	Prevention of reiteration of suicide attempts	France
Zippy's Friends	School	Enhancing social and coping skills in children	Multiple

Box A A.1. Process for selecting case study interventions

Case studies were selected using the following hierarchical process:

- Case studies were submitted by delegates to OECD's Expert Group on the Economics of Public Health, which includes representatives from all 38 member countries
- Case studies involved in European Joint Actions, in particular the Joint Action ImPEMENTAL that has implemented mental health interventions across Member States
- Case studies previously defined as “Best Practice” by member countries, such as those listed on the EU Best Practice Portal (European Commission, 2021^[1])

Assessing the performance and transferability of case studies

This section outlines two complementary frameworks used to assess case studies, both of which were developed by the OECD – the Best Practice Framework and the Transferability Framework. Limitations associated with the analysis are also discussed.

Best Practice Framework

The Best Practice Framework outlines five criteria to assess whether an intervention is “best practice” – namely **E**ffectiveness, **E**fficiency, **E**quity, **E**vidence-base, and **E**xtent of coverage (Table A A.2). A review of the academic and grey literature, existing best practice frameworks and feedback from delegates to OECD's expert Group on the Economics of Public Health informed the selection of criteria.

Table A A.2. OECD's Best Practice Framework – the 5 E's

Criteria	Definition
1. Effectiveness	Extent to which intervention objectives were achieved
2. Efficiency	Extent to which inputs were used to achieve desired outcomes
3. Equity	Extent to which the intervention reduced inequalities in society
4. Evidence-base	The strength and validity of evidence used to develop or evaluate the intervention
5. Extent of coverage	Extent to which the intervention reached the target population

An intervention can be awarded a “stamp of approval” against one or multiple criteria if it performs particularly well relative to similar interventions. 

Up and coming interventions (i.e. those that show promise but have not yet collected any of their own data) can be awarded a “promising best practice” stamp of approval for relevant criteria. 

For a selection of case studies, effectiveness and efficiency were measured using OECD's Strategic Public Planning for NCDs (SPHeP-NCD) microsimulation model. To analyse the health and economic impact of mental ill-health, the OECD has adapted the SPHeP-NCD microsimulation model to allow for the simulation of mental ill-health trends across OECD and EU27 countries from 2025 to 2050. An overview of the model is provided in Box A A.2.

Box A A.2. The OECD model for Strategic Public Health Planning for Non-Communicable Diseases (SPHeP-NCDs)

The OECD SPHeP-NCDs model is an advanced systems modelling tool for public health policy and strategic planning. The model is used to predict the health and economic outcomes of the population of a country or a region up to 2050. The model reproduces a comprehensive set of key behavioural and physiological risk factors and their associated non-communicable diseases, including mental ill-health. For these analyses, the model covers 30 EU/EFTA countries, including all the EU27 Member States as well as Iceland, Norway and Switzerland.

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

The model produces yearly cross-sectional representations of the population that can be used to calculate health status indicators such as life expectancy, premature deaths (including as a result of suicide), disease prevalence and disability-adjusted life years using disability weights. Healthcare costs of disease treatment are estimated based on a per-case annual cost, which is extrapolated from national health-related expenditure data. Treatment cost for anxiety and depressive disorders vary by severity level. For instance, cost of depressive disorders of moderate severity are 5 times greater than that of mild severity, while cost of severe severity are 20 times higher than that of mild severity, based on König et al. (2023^[2]). The additional cost of multi-morbidity, which is an important factor in the case of mental disorders, and the extra cost of end-of-life care are also considered. The labour market module uses relative risks relating disease status with absenteeism, presenteeism (where sick individuals, even if physically present at work, are not fully productive), early retirement and employment. These changes in employment and productivity are estimated in number of full-time equivalent workers and with other parameters contribute to calculate the impact on gross domestic product, by applying a Cobb-Douglas production function.

The model includes three leading mental health diseases: major depressive disorders (MDD) (including three different levels of severity: mild, moderate and severe); generalised anxiety disorders (GAD) and alcohol use disorders. Although these mental disorders represent over 72% of the total prevalence of mental health conditions across the EU27 and EEA countries, the model's results should be viewed as conservative since 28% of conditions remain excluded. In addition, the model does not capture the burden suffered by the persons exposed to individuals with mental disorders, such as family and friends.

Mental health disorders are modelled via specific modules created for each disease. For Major Depressive Disorder (MDD) and Generalised Anxiety Disorder (GAD), each individual in the model is assigned a score on two international scales used for diagnosing the disease (i.e. PHQ-8 and GAD-7 scales, respectively). Distribution of both scores are modelled using micro-level data with a zero-inflated beta regression using parameters age, sex, and country to model PHQ, and age, sex and PHQ to model GAD. The regression is performed in two steps where a logistic regression is used to predict the probability of zero and a beta regression is used to model the final score, taking into account the zero probability and scaling the score to between 0 and 1 to fit the distribution. Various models were tested to reproduce as closely as possible the observed PHQ (patient health questionnaire) and GAD score distributions, with the zero-inflated beta producing the best results. To compute individual scores distributions are inverted using the partially fixed quantile approach (one part is fixed throughout the individual's life while the remaining part is recalculated every two years). The approach has the dual

advantage of maintaining continuity in trajectory over time and creating individuals more likely to experience recurrent relapses throughout their lifetime. Based on the score, each individual has a probability of developing MDD and GAD, with higher scores indicating a greater risk of mental disorder. The ninth question of the PHQ-9 score is modelled separately. The probability of having suicidal thoughts – any yes response to question nine on suicidal thoughts (from occasionally to almost every day) – was estimated based on microlevel data and modelled as a function of PHQ-8 score. When question 9 is present, individuals are at higher risk of self-harm. Alcohol use disorders, on the other hand, depend on the pattern and volume of alcohol consumption, with higher consumption corresponding to a higher risk of developing the condition. All modules are calibrated to match prevalence data for the simulated diseases.

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

Transferability Framework

Public health interventions are complex given they involve multiple stakeholders, often target heterogeneous groups, and have outcomes affected by various direct and indirect factors. Therefore, positive outcomes achieved in one setting aren't necessarily transferable to a different setting.

OECD has developed a Transferability Framework to assist policymakers assess whether a best practice intervention can be transferred from where it has been implemented (i.e. best practice “owner setting”) to a different country/region (i.e. the “target setting”). Specifically, whether the desired outcomes achieved in the owner setting are achievable in the target setting (Trompette et al., 2014^[3]; Burchett, Umoquit and Dobrow, 2011^[4]).

The Transferability Framework includes four contextual factors that affect transferability:

- **Population context:** covers population characteristics such as sociodemographic factors as well as broader cultural considerations
- **Sector-specific context:** covers governance/regulation, financing, workforce, capital and access arrangements in the sector the intervention operates
- **Political context:** political will from key decision makers to implement the intervention
- **Economic context:** the affordability of the intervention in the target setting.

In each case study, indicators to assess transferability are grouped under one of these four contextual factors. For the case studies presented in this document, countries are allocated into a group based on how far the indicator's value is from the best practice owner setting. This method is referred to as the “distance from reference country” and is explained in Box A.A.3. In addition, OECD developed a clustering methodology to group countries according to their potential to transfer a best practice intervention (Box A.A.4).

Indicators were sourced from international databases to maximise coverage across OECD and non-OECD European countries (e.g. OECD Health Statistics, Eurostat, World Bank Indicators, and the WHO). Policy indicators were largely retrieved from the OECD/WHO Regional Office for Europe (2023), *Mental Health Systems Capacity Questionnaire 2023* (OECD/WHO Regional Office for Europe, 2023^[5]). Relevant indicators were excluded if data was missing for the best practice owner setting and could not be identified through desktop research, or, if more than 50% of data was missing across countries.

By using international data, the scope of the analysis was inevitably limited – i.e. indicators from international sources are high-level and don't cover all relevant information for assessing transferability.

Therefore, each case study also includes a set of “new indicators” (i.e. those with no publicly available information) policymakers should consider before transferring the intervention.

Finally, indicators to measure the risk factor level in each country (e.g. obesity rates) were not included given it is presumed all OECD and non-OECD European countries face challenges caused by growing rates of non-communicable diseases.

Box A A.3. Transferability methodology using distance from reference country

Quantitative indicators

Quantitative indicator values have been normalised using distance to a reference country, that is, the country in which the best practice intervention is currently implemented (also referred to as the best practice “owner” setting) (OECD and European Commission, 2008^[6]).

The normalisation equation is below:

$$NV_{ci} = \frac{(X_{ci} - X_{oi})}{X_{oi}} \quad \text{Equation 1.}$$

Where:

- NV_{ci} = normalised value for target setting (country c) for indicator i
- X_{ci} = original value for target setting (country c) for indicator i
- X_{oi} = original value in the owner setting for indicator i.

Normalised values for equation (1) can be interpreted as percentage distance each country is from the best practice owner setting, whose value is centred on 0. Normalised values were used to allocate countries into one of five groups for each indicator, with a darker shade indicating greater transferability potential:

- Value equal or greater than 0 = 
- Value less than 0 but greater than -25% =  (+25% when a lower value indicates better transferability)
- Value less than -25% but greater than -50% =  (>+25% but less than <+50%)
- Value less than -50% but greater than -75% =  (>+50% but less than <+75%)
- Value less than -75% =  (>75%)

Binary indicators

For binary indicators, countries that respond “Yes” to the indicator are allocated the darkest shade () while countries that respond “No” are allocated the lightest shade (.

Categorical indicators

For categorical indicators, any country that responds at least as well as the best practice owner are allocated the darkest shade (), while the remaining countries are allocated a lighter shade based on the number of remaining categories.

Box A.A.4. Transferability methodology using clustering

OECD has developed a methodology to cluster countries and to make personalised recommendations on which member states and member countries are more likely to successfully transfer a recognised best practice intervention. A high level summary of the clustering methodology is below.

Cluster analysis helps to identify countries which could successfully be transferred a best practice intervention

Cluster analysis partitions data into homogenous groups, based on similarities in the data. In this case it was used to separate countries into groups with similar characteristics, based on how well adapted or suited they are for transfer of a best practice intervention from a host country. For each cluster, specific recommendations can then be made to address potential obstacles for implementation. This can help guide decision makers and potentially lead to the smoother implementation and increased success of interventions.

K-medoids clustering was found to be the optimal methodology

To select the best methodology, 4 different cluster methods were compared: k-means, k-medoids, hierarchical and DBSCAN (Density-Based Spatial Clustering of Applications with Noise). K-medoids using Gower distance was found to be the most effective method for clustering countries taking into account validation statistics, data characteristics, interpretability of the results and flexibility to use with other datasets. This is because it works with small, imbalanced datasets with missing data, and can accommodate categorical data as well as continuous data.

The K-Medoids Clustering Algorithm

The k-medoids algorithm is based on the medoid: this is the most central observation (country in this case) in the cluster, where the total distance between it and all the other countries in the cluster is smallest. Distance is a quantitative measure of dissimilarity, where the larger the distance between two observations, the more different they are from each other. The number of clusters (k) must be chosen prior to running the algorithm.

The k-medoids algorithm has the following steps:

- Randomly assign k countries as medoids.
- Repeat until there is no change in assignment of medoid:

Assign each country to a cluster, based on distance to the closest medoid.

For each cluster, test whether selecting another country as the medoid decreases the total distance from the medoid to all other points in the cluster. If it does, reassign this country as the new medoid.

Gower Distance is used to measure similarity between countries

Gower distance was chosen because it is able to compute the difference between both categorical and continuous variables. Gower distance is calculated from the mean of the partial pairwise distances between observations (countries). The partial pairwise distance is the difference between two observations at a single variable and is calculated differently depending on whether the variable is continuous or categorical.

Continuous Variables: The partial pairwise distance, $d_{ii'}^{(j)}$, between two observations i and i' , for variable j is the difference between the two values x_{ij} and $x_{i'j}$, divided by the maximal range (R_j) of all the values for variable j , as follows:

$$d_{ii'}^{(j)} = \frac{|x_{ij} - x_{i'j}|}{R_j}$$

Categorical Variables: If two countries have the same value for a categorical variable then the partial pairwise distance is 0 (identical). Otherwise, it is 1.

The Gower distance between two observations is then calculated as the mean of the partial pairwise distances. The partial pairwise distances can be weighted differently. Here, the variables were weighted so that each contextual factor had equal weighting and therefore equal influence on the Gower distance. The resulting value lies between 0 and 1, with values closer to 0 indicating greater similarity between countries and values closer to 1 indicating greater dissimilarity. If one or both values are missing for a given variable in a pair of countries, the partial distance for that variable will not be included in the Gower distance, meaning there is no need for data imputation. However, if a country had over 50% variables missing it led to inaccurate Gower distances and so these countries were removed.

Interpreting and comparing clusters by indicator and by contextual factor

The clusters were compared by calculating the difference between the mean of each cluster and the mean of the dataset, for each indicator. A positive difference meant a higher likelihood of successful transfer for that indicator, allowing the characteristics of each cluster to be identified. To more broadly compare clusters, identifying the contextual factors (or domains) where clusters were stronger or weaker, domain scores were created and used to compare cluster means. Domain scores were created using the following steps:

- Assign categorical variables dummy values (0 = no, 1 = yes).
- Normalise using min-max scaling.
- Aggregate by the mean of the variables in each contextual factor.

Summary of steps in Clustering process

In summary, the following steps are required:

- Remove countries where >50% variables are missing.
- Compute a Gower Distance Matrix, with each contextual factor having equal weighting.
- Determine optimal value of clusters (k) between 3 and 5.
- Run k-medoids clustering using the optimal number of clusters from step 3.

Create domain scores in order to compare cluster means with the dataset means, and identify strength and weakness of each cluster.

Further details is available at Wiper et al. (2022^[7]).

Limitations

Limitations associated with the analysis of case study interventions are summarised in Table A A.3.

Table A A.3. Assessment limitations

Limitation theme	Description
Selecting case studies	Case studies were assessed against the Best Practice Framework after they were selected. For this reason, case studies do not necessarily perform well against the criteria. Case studies analysed using OECD's SPHeP-NCD model were further restricted to those that recorded data on parameters included in the model
Diversity of case studies	Due to the selection criteria, most case studies interventions are based in European countries.
Benchmarking performance	The performance of case studies is not benchmarked for two key reasons: 1) heterogeneity in terms of target populations and implementation setting (e.g. schools versus primary care) and 2) lack of comparable data
Classifying case studies	This report does not classify case studies as "best practice" or not given this is ultimately up to policymakers in each country who may have different priorities. Further, it was not possible to benchmark performance. Case study analyses instead summarise evidence considered relevant for choosing which interventions to fund, scale-up and/or transfer.
Transferability data	The assessment of transferability using the Transferability Framework relied on publicly available data at the national level. This poses several limitations – for example, it does not take into account differences within countries, in addition, it limits the extent of the analysis given availability of comparable data. For these reasons, findings should be considered as high-level only.

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Mental Health Promotion and Prevention

Best Practices in Public Health

Mental health conditions such as depression and anxiety impose a significant burden on individuals and societies. Mild-to-moderate depressive symptoms affect one in five adults across OECD and EU27 countries, and they often go unrecognised and untreated, increasing the risk of progression to more severe conditions and raising overall societal costs. As part of the OECD's work on best practices in public health, this report identifies eleven promising best practice interventions implemented across OECD and EU27 countries. These include school-based resilience programmes, mental health literacy training with a focus on front-line professionals, suicide prevention initiatives, and improved access to mental healthcare services. OECD analyses show these interventions improve mental well-being, prevent symptom deterioration, enhance educational and occupational outcomes, and deliver measurable health and economic benefits. With adequate policy support - especially investment in workforce planning and the use of established implementation strategies - these interventions can be successfully scaled and transferred across countries.



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