Child, Adolescent and Youth Mental Health in the 21st Century

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Foreword

Across OECD countries, the mental health of children, adolescents and young people has emerged as a pressing and complex policy challenge. This report provides comprehensive cross-country assessments to date of the trends, drivers and policy responses related to the mental health of young people under 25 in OECD countries, and presents clear evidence that youth mental health has been declining over the past decade. The COVID-19 pandemic accelerating the youth mental health crisis, but the underlying declining trends already visible in many countries much earlier. While the scale and nature of this decline vary across OECD Members, the pattern is consistent: more young people now report that they are experiencing symptoms of anxiety, depression and psychological distress than previous generations.

This report adds to a growing body of OECD analysis showing that mental health is a foundation for individual well-being, social participation and economic prosperity. The report follows and complements earlier reports including *A New Benchmark for Mental Health Systems* (2021) and *Fitter Minds, Fitter Jobs* (2021), which highlighted the substantial personal, social and economic costs of poor mental health, as well as the critical need to redesign mental health systems to be more preventive, more accessible and better integrated across services and sectors. This report also supports the implementation of the OECD Recommendation of the Council on Integrated Mental Health, Skills, and Work Policy, adopted by all OECD Members in 2015. The Recommendation calls on governments to promote mental health from early childhood onwards, detect and address problems early, and ensure strong links between health, social, education and employment systems. The findings in this report underline the urgency of those objectives; when young people are in poorer mental health they struggle more at school, find it harder to transition from school to the labour market, and are more likely to claim social benefits. The findings of this report clearly confirm the importance of cross-sectoral approaches to support young people's mental resilience.

This report is also a reminder that young people today are navigating an increasingly complex environment characterised by intersecting and mutually reinforcing pressures, including the impacts of digitalisation and social media, which have transformed how young people communicate, learn and access information. As shown in *How's Life for Children in the Digital Age?* (2025), digital technologies offer important opportunities for connection and learning, but can also expose young people to risks related to excessive use, harmful content, online bullying and sleep disruption. The evidence shown in this report echoes those findings; while digital environments can support well-being, their design and use patterns matter, and some young people are more vulnerable than others. Beyond the digital sphere, broader socio-economic and societal challenges, including economic insecurity, academic pressure, climate anxiety and global turbulence and conflicts, are weighing on the well-being of young people. These stressors do not operate in isolation, rather they accumulate and interact in ways that contribute to a sustained and widespread decline in youth mental health across most OECD countries.

Addressing the youth mental health crisis requires a multi-sectoral and preventive approach that goes well beyond specialist mental health services. This report, as well as in earlier OECD work such as *Mental Health Promotion and Prevention* (2025), highlights the importance of strengthening social and emotional learning in schools, promoting mental health literacy, supporting families, ensuring safe and inclusive digital environments, and expanding access to low-threshold, holistic and peer-supported services.

Countries will also need to take seriously the upstream drivers of youth mental distress including economic insecurity and widening inequalities and respond in ways that give young people confidence and hope for the future. While increasing access to mental health services cannot be the only policy response to the crisis, it is nonetheless an important aspect with experts stating near-unanimously that the level of mental health support in their countries is too low. Services that are low-threshold, easy to access, holistic and include peer-to-peer interactions are a priority for widespread implementation.

Finally, the report calls for more robust, timely and comparable data to guide policy action. Today, fewer than one-third of OECD countries collect regular, nationally representative data on young people's mental health. Without such information, it is difficult to track trends, assess the impacts of emerging policies – including policies such as school phone bans and age-based social media limits – or design effective prevention and support strategies.

This report aims to support OECD countries in strengthening their response to stemming the declining trend in youth mental health. Ensuring that young people can thrive, both today and in adulthood, is essential for building more resilient, equitable and prosperous societies.

Acknowledgements

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Executive summary

Youth mental health has been deteriorating for over a decade

Across most OECD countries, the mental health of children, adolescents and young adults has worsened over the past decade. National surveys and international data series show rising psychological distress, depressive symptoms, and reports of poor mental health among adolescents and young adults. In nine of 11 countries with comparable time-series data spanning 2012-2022, youth mental health indicators declined by an annual average of 3% to 16%. While the COVID-19 pandemic intensified these pressures, underlying declines were already evident from the mid-2010s onwards. Although a small number of countries show early signs of stabilisation or partial recovery in 2023-2024, it is too early to determine whether these reflect a more durable improvement or a return to already elevated post-pandemic levels.

Internationally comparable data reinforce this trend. Between 2014 and 2022, the proportion of adolescents reporting frequent low mood and multiple health complaints increased in every HBSC-participating OECD country. Girls and older adolescents show particularly poor outcomes; in 2022, more than two-thirds of 15-year-old girls reported multiple symptoms of poor well-being, and self-harm hospitalisations among girls aged 0-17 rose by 29% between 2015 and 2023 across 13 countries. Thankfully, suicide rates among young people have remained relatively stable in most countries.

Multiple interrelated drivers are shaping the decline in youth mental health

The analysis presented in this report, supported by scientific evidence and interviews with 29 clinical and policy experts, indicates that no single factor explains the deterioration in youth mental health. Instead, young people are navigating multiple, intersecting pressures that accumulate across different domains of their lives. Some of these risk factors, such as digitalisation and changing climates, are new while others, such as inequality, poverty, school pressures and bullying are long-standing drivers of poor mental health but may be worsening or exacerbated by contemporary trends.

Digitalisation plays a central but complex role. Excessive or late-night digital device use is strongly associated with disrupted sleep, which is itself a well-established risk factor for poorer mental health. Social media use has been linked with symptoms of anxiety, depressed mood and poor body image, although positive impacts, including access to peer support and communities, are also found. Online bullying, exposure to harmful content, and the “amplification” of distressing news contribute further to emotional distress. For example, young people are reported as being increasingly concerned about global instability and crises and are exposed to distressing content about often-distant events through digital media. Climate change, geopolitical instability and conflict can generate anxiety even among those not directly affected.

Longstanding risk factors for poor mental also remain very influential. Socio-economic disadvantage continues to shape young people’s mental health, influencing both exposure to risk factors and availability of supportive resources. Financial hardship, unstable housing, perceived downward social mobility, and

academic pressures all weigh heavily on well-being. Bullying and cyberbullying, which have increased in prevalence, are strongly associated with depression, anxiety and self-harm.

These mental health pressures interact rather than operate in isolation. Experts consistently highlighted cumulative exposure as a key characteristic of the current youth mental health landscape, with direct or indirect exposure to multiple risk factors resulting in a sense of persistent pressure and reduced optimism about the future amongst young people.

Stronger prevention, early support and multi-sectoral action are needed

Protective environments can substantially improve mental health outcomes across childhood and adolescence. Positive family relationships, supportive schools, secure housing, and opportunities for social connection all play vital roles. Evidence shows that social and emotional learning, mental health literacy, and early childhood interventions can strengthen coping skills and reduce the onset or severity of mental health conditions.

However, prevention and early intervention remain underdeveloped and uneven across OECD countries. Many young people often only access support once difficulties have escalated. Experts interviewed for this report judged that existing provision is often insufficient, and that the support structures that are in place often rely too much on high-threshold, clinical responses rather than early, accessible and youth-friendly support.

Promising models demonstrate alternative approaches to building mental health resilience and holistic mental health support. Community-based and peer-supported services, such as Australia's headspace network and the Netherlands' @ease centres, provide low-threshold, holistic and non-stigmatising support, reaching many young people who might otherwise disengage from traditional services.

Digital policies are expanding rapidly, including school phone bans, age-verification requirements and social media restrictions. The evidence base for their mental health impacts is mixed, with some early studies showing improvements in concentration or reduced online risk exposure, and others finding limited or no effects on well-being. As these policies multiply, careful evaluation will be essential to ensure that they are proportionate, effective and do not inadvertently reduce access to supportive online communities.

A major challenge for policymakers is the limited availability of timely and comparable data. Fewer than one-third of OECD countries collect regular, nationally representative time-series data on youth mental health. Measures of digital use remain coarse, and many countries lack detailed information on socio-economic vulnerabilities, school environments and service access. Improved monitoring will be essential for tracking trends, evaluating policies and understanding young people's lived experiences.

Decisive action is needed to stem the decline in youth mental health

Taken together, the findings of this report highlight the need for co-ordinated, cross-sectoral action to promote youth mental health, prevent the onset of mental health difficulties, and strengthen the systems that support young people. OECD countries should:

- Strengthen prevention and resilience-building, including school-based social and emotional learning, mental health literacy, and evidence-based parenting programmes in early childhood.
- Expand access to low-threshold, youth-friendly support, including community-based and peer-supported services that offer early assistance before difficulties escalate.
- Address upstream determinants of mental health, such as child poverty, housing insecurity and academic pressure, ensuring that broader social and economic policies actively support youth well-being.

- Evaluate digital policy interventions rigorously, ensuring that school phone bans, age-verification tools and social media restrictions are assessed for both intended and unintended effects on mental health.
- Improve data collection and monitoring, particularly through regular national surveys, more granular measures of digital engagement, and systematic inclusion of young people's perspectives.

A comprehensive approach that combines early action, holistic support and stronger evidence will be essential to safeguarding the mental health of the younger generation and enabling them to thrive in the decades ahead.

1 Trends and patterns in the mental health status of children, adolescents and young people

This chapter looks at trends and patterns in children, adolescents and young people's mental health status in OECD countries in recent years. The chapter draws on national data and international surveys to document a decline in young people's mental health status in most OECD countries. This decline was worsened in 2020-2022, but in most cases the declining trend pre-dated the COVID-19 crisis. The chapter also presents the perspective of expert youth mental health clinicians and policymakers in OECD countries who believe, nearly unanimously, that there has been a decline in young people's mental health status. While trends in suicide deaths amongst young people remain stable, in some countries rates of hospitalisation for self-harm have increased, especially for girls. Adolescents in their mid-to-late teens, and girls, appear to have poorer mental health than their younger and male peers.

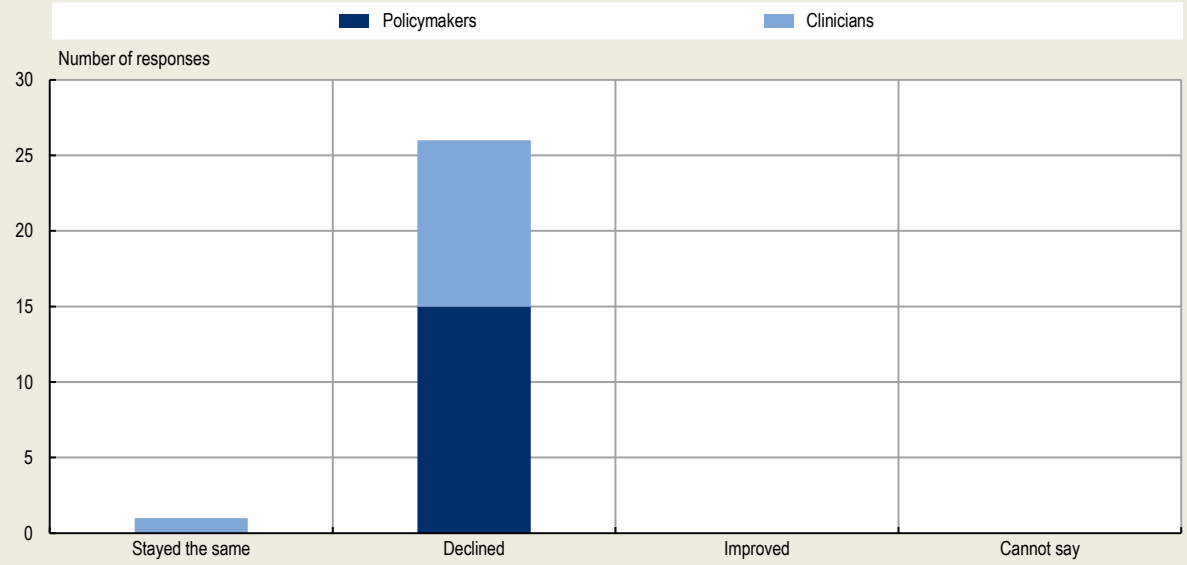
In Brief

Multiple signals point to declining youth mental health in OECD countries

- Mental health conditions are common amongst children and adolescents, affecting approximately one in five young people in OECD countries.
- Youth mental health has declined – and rates of anxiety and depression have increased – in almost all countries where relevant data could be found, including rising rates of depression symptoms, poor mental health, and psychological distress. Out of eleven countries with time series data, in nine countries there was an annual average decline in youth mental health status of between 3% and 16% between 2012 and 2022. Only Japan and Korea saw small improvements in mental health status.
- Measures from international surveys on adolescent well-being confirm this declining trend, and of 29 experts interviewed for this report, 28 said they believed young people's mental health had declined.

Figure 1.1. Expert assessment of trends in young people's mental health status over the past decade

Responses to interview question, "Over the last decade or so, do you think that young people's mental health has: 1) stayed the same 2) improved 3) declined 4) cannot say?"



Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

The COVID-19 pandemic worsened youth mental health, but the decline began earlier

- The COVID-19 pandemic worsened youth mental health, but the decline began earlier. Canada, the Netherlands, Norway, Sweden and the United States, who collect time series data on youth mental health, saw the highest rates of mental distress in 2021, but the rise in mental distress

started well before the COVID-19 crisis, in 2016-2019. A small amount of 2023-2024 data suggests a slight recovery from the 2021 peak, but it is not yet clear if this is an improving trend or a return to the high rates of distress already observed pre-COVID.

The mental health status of girls and older adolescents is particularly poor

- Self-harm rates may have increased, especially among girls, while youth suicide, based on latest available data from 2020, had not. Amongst the 13 countries able to submit data, self-harm hospitalisations for girls aged 0-17 increased by 29% between 2015 and 2023.
- Girls and older adolescents report poorer mental health than boys and younger children. In 2022, 68% of 15-year-old girls reported multiple health complaints, compared to 36% of boys; the proportion of girls "feeling low" more than once a week rose from 28.6% in 2014 to 45.4% in 2022.

Introduction

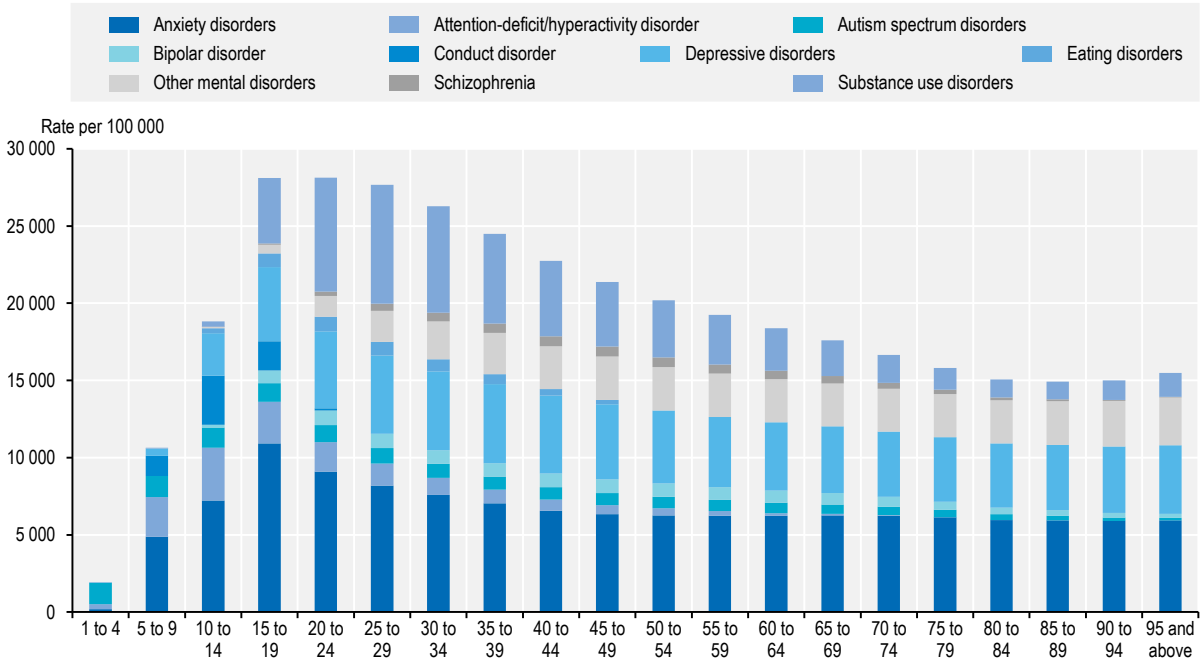
There are multiple signals, across OECD countries, of declines in young people's mental health status. Only very limited evidence of any improvements in mental health status of children, adolescents, or young people could be found, and only in a few countries. It is important to take a cautious approach when interpreting available data, which could for example be influenced by falling rates of stigma around mental health conditions and therefore greater willingness to disclose mental distress. Accurate understanding of cross-country trends in mental health status of young people – especially children and young adolescents – is held back by very limited comparable data. Nonetheless, the aggregate of available data and information suggest that young people's mental health has been on a declining trend for some time, and worsened further during the COVID-19 crisis. Older adolescents (in their late teens), girls, and young people in lower socio-economic groups appear to be in poorer mental health, and in many cases have seen more marked declines in their mental health status.

Many mental health conditions begin in childhood and adolescence

Mental health conditions are common amongst children and adolescents. Indeed, most mental disorders are understood to have a typical onset between age 12 and age 25 (Erskine et al., 2015[1]; Kessler et al., 2005[2]; Uhlhaas et al., 2023[3]). Peak age of onset across all mental disorders has been estimated at 14.5 years, with 62.5% of disorders having their onset before the age of 25 (Solmi et al., 2021[4]). Mental disorders are the main cause of disability among adolescents and young adults in high-income countries (Gore et al., 2011[5]; Erskine et al., 2015[1]). The Institute for Health Metrics and Evaluation (IHME) estimates suggest that the prevalence of mental health conditions peaks in adolescence and early adulthood (Figure 1.2); approximately one in five young people aged 10-to-25-year-old living with a mental or neurological disorder (prevalence rates may double-count some individuals who have more than one disorder), slightly higher than the all-ages estimate of one in six (IHME, 2026[6]).

Figure 1.2. Estimated Prevalence of Mental and Neurodevelopmental Conditions by Age Group, 2024

Rate per 100 000 population – OECD countries



Source: IHME (2026[6]), Institute for Health Metrics and Evaluation (IHME) at the University of Washington, www.healthdata.org, accessed on 19 January 2026.

Anxiety disorders are highly prevalent in childhood and early adolescence, while depressive disorders and substance use disorders tend to increase and peak in early to mid-adulthood (OECD, 2025[7]). Prevalence of schizophrenia and bipolar disorder begin to rise in late adolescence and early adulthood, with schizophrenia peaking in the 20-24 age group, which aligns with understanding that most cases of severe mental illness have their onset in late adolescence and early adulthood (although some symptoms may occur earlier) (Baldessarini et al., 2010[8]; Bolton et al., 2020[9]; Kessler et al., 2005[2]). There is a sharp increase in eating disorders starting in early adolescence (10-14 years) and peaking during the 15-19 age group. Substance use disorders are rare in childhood but increase in late adolescence, peaking in early adulthood (20-24 years).

Conduct disorder (primarily characterised by issues around disruptive behaviour, impulse control, violation of social norms and in some cases aggression) and attention deficit hyperactivity disorder (ADHD) (characterised by patterns of inattention and/or hyperactivity/impulsivity that interferes with functioning and impacts negatively on social and academic/occupational activities), and autism are also particularly prevalent in early age (American Psychiatric Association, 2013[10]).

Some new mental health conditions specifically related to new online risks have been recognised, specifically “video gaming disorder” which is defined in the Eleventh revision of the International Classification of Diseases (ICD-11) as a pattern of persistent or recurrent gaming behaviour (“digital gaming” or “video gaming”). Gambling disorder – a pattern of persistent and recurrent gambling behaviour – is also included in ICD-11, and can include predominantly online gambling. The Health Behaviour in School-Aged Children (HBSC) survey suggested that globally, 22% of adolescents played digital games for at least four hours on days when they game, and 12% are considered at risk of problematic gaming.

Problematic gaming risk is notably higher among boys (16% vs. 7% for girls) (Boniel-Nissim et al., 2024[11]). It should be noted that this survey cannot be used to estimate the rate of adolescents with a clinical diagnosis of gaming disorder. Increased accessibility through online platforms may have put more young people at risk of gambling disorder. The European School Survey Project on Alcohol and Other Drugs (ESPAD) data covering European youth suggests that online gambling is rising, and that in 2024 risky gambling affected 8.5% of student gamblers, up from 4.7% in 2019. Boys remain more likely to take part in online gambling than girls (30% in 2024, compared to 16% of girls), but girls' gambling behaviour increased between 2015 and 2024 while boys' declined slightly (ESPAD, 2025[12]).

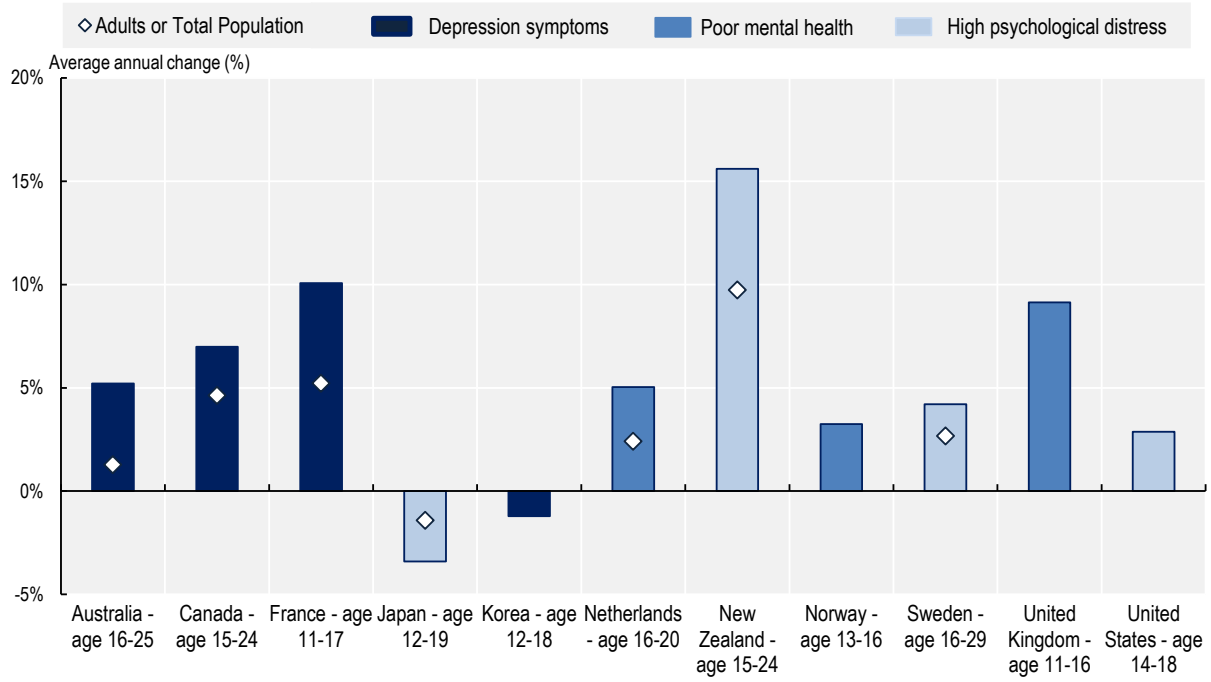
Mental distress is increasing amongst young people in most OECD countries

A range of recent international studies and commissions have pointed to declining mental health status amongst young people. The 2024 Lancet Psychiatry Commission on youth mental health highlighted that "*Accumulating research evidence indicates that in many countries, the mental health of emerging adults has been declining steadily over the past two decades*" (McGorry et al., 2024[13]), while the OECD has pointed to "*strong signs that the mental well-being of children and young people has declined*" (OECD, 2025[7]). In 2025, a systematic analysis of the Global Burden of Diseases highlighted an increase in the burden of mental health among adolescents and young people aged 10-24 between 1990 and 2021 (Wang et al., 2025[14]). In a review of global mental health prevalence and burden, McGorry et al. (2025[15]) point to increases in the prevalence of mental disorders amongst young people aged 15-19 from the early 2000s, while for other groups prevalence rates remained steady or declined, and show that prevalence of mental disorders increased amongst all age groups during the COVID-19 crisis in 2020-2021, and especially amongst people under age 29. A report by Eurofound found that between 2014 and 2019 self-reported chronic depression increased by more than 1 percentage point (p.p.). (from 4.4% to 5.7% for adolescents and young adults age 15-34 (Eurofound, 2025[16]).

Available national and international data also point to declines in young people's well-being, increases in psychological distress, and increases in mental health conditions such as anxiety and depression. Of the ten countries which have collected information on young people's mental health status over a multi-year period with at least one data point before 2020 and at least one after, only two countries – Japan and Korea – show an improvement in the mental health status of the young people covered Figure 1.3. In Australia, Canada, France, the Netherlands, New Zealand and Sweden, where comparable data was available for young people (of varying ages) and for the total or adult population, the increase in mental distress amongst young people was markedly higher than for the total or adult population. There are also important differences between the measures reported by different countries, and the age ranges covered making direct comparisons between prevalence rates within countries very challenging, and within countries survey instruments maybe have been modified slightly over time. Nonetheless, measures of psychological distress or symptoms of mental ill-health (such as the Kessler 6 or Kessler 10 scales), measured prevalence of mental disorders (for example in Canada), and self-perceived mental health problems or poor mental health status point to increases in mental distress, poor mental health status, and prevalence of anxiety and depression amongst adolescents and young adults in many OECD countries.

Figure 1.3. Average annual change in prevalence of poor mental health amongst young people across the past decade

Change between 2012 and 2022, or nearest available year(s) – positive growth indicates a rise in the measure of mental distress



Note: Caution should be taken when interpreting changes in mental health status across time. The rates of change cover different types of mental distress and/or disorder, and different age groups, and may therefore not be directly comparable. Some measures of mental health status may be more sensitive to fluctuation than others. In countries where the most recent year was during the COVID-19 pandemic, the increase may appear more significant given heightened distress in this period. For a full list of surveys and indicators used, please see the data table in Annex 1.A.

Source: OECD based on national sources. Australia (Australian Bureau of Statistics, 2008[17]; Australian Bureau of Statistics, 2023[18]); Canada (Statistics Canada, 2022[19]); France (Santé Publique France, 2023[20]; Léon, 2023[21]); Japan (Ministry of Health, Labour and Welfare (Japan), 2020[22]; Ministry of Health, Labour and Welfare (Japan), 2023[23]); Korea (Park et al., 2023[24]); Netherlands (Centraal Bureau voor de Statistiek, 2025[25]); New Zealand (New Zealand Ministry of Health, 2024[26]); Norway (Bakken, 2022[27]); Sweden (Folkhälsomyndigheten, 2025[28]); United Kingdom – England (NHS England, 2023[29]); United States (CDC, 2025[30]).

Caution should be taken when interpreting changes in mental health status across time; this data could for example be influenced by falling rates of stigma around mental health conditions and therefore greater willingness to disclose mental distress. In countries where there were only two data points and the second data point was taken during 2021 or 2022 – Australia, France, Japan, the Netherlands – part of the increase may be explained by higher levels of distress during the COVID-19 crisis. In Japan, change in psychological distress is between two data points, in 2019 and in 2022 (Ministry of Health, Labour and Welfare (Japan), 2020[22]; Ministry of Health, Labour and Welfare (Japan), 2023[23]); In Japan a few studies do point to well-being improvement amongst Japanese youth and adolescents during the COVID-19 period (Miyake et al., 2025[31]; Yamaguchi et al., 2024[32]), but other point to deteriorations (Takaku, Shobako and Nakata, 2024[33]; Hosozawa et al., 2024[34]), making the falling proportion of Japanese adolescents with psychological distress shown in Figure 1.3 difficult to explain. In Korea, data has been collected biannually between 2005 and 2020 (Park et al., 2023[24]), and in 2012 30.5% of surveyed adolescents reported depression symptoms in the previous two weeks (the highest rates of depression symptoms were recorded in 2007, at 41.3%, but are not shown in Figure 1.3). Like in other countries mental distress in Korea

increased in 2020, but did not return to the levels seen in 2012 and earlier. New Zealand also stands out as having a very high rise in psychological distress. The whole New Zealand population saw a rise in psychological distress between 2013/14 and 2023/24, but the increase was most dramatic amongst 15-24 year-olds, followed by 25-34 year-olds, and has been viewed with concern in New Zealand (Mental Health and Wellbeing Commission, 2025[35]; Mental Health Foundation, 2024[36]).

Internationally comparable data tracking young people's well-being also points to declines. The HBSC survey includes 27 OECD countries, and has been undertaken in 2014, 2018, and 2022. In all countries, the percentage of adolescents "feeling low" more than once a week, and "multiple health complaints", has increased (Cosma et al., 2023[37]; OECD, 2025[38]). The rate of 15-year-olds reporting at least two health complaints more than once a week increased from 37% in 2014 to 52% in 2022 (OECD, 2025[38]), and the rate of 15-year-olds "feeling low" more than once a week increased from 20.5% in 2014 to 32.5% in 2022, with girls seeing bigger increases in "feeling low" than boys (see Figure 1.9). Eriksson and Stattin (2024[39]), who used the HBSC survey to analyse the mental health of 15-year-olds across give Nordic countries from 2002 to 2022, found that while young people experiencing psychosomatic complaints (headache, stomach-ache, backache, dizziness) have increased, the rate of young people experiencing both acute physical and emotional distress has increased far less, and point to a need for caution to avoid ascribing all psychosomatic symptoms to mental health problems or equating them to psychiatric diagnoses.

Academic evidence from multiple countries also points to increases declines in young people's mental health status from around 2005 onwards, with most studies focussed on ages 15-25:

- In **Belgium,** anxiety and depression increased substantially between 2008 and 2013 for girls age 15-25 and to a lesser extent for boys the same age (Van Droogenbroeck, Spruyt and Keppens, 2018[40]), and a 2021-2022 report by the French Community of Belgium found that young people were reporting more stress and anxiety during and after COVID-19, and a shared sense of uncertainty about the future had increased (Fédération Wallonie-Bruxelles, 2022[41]).
- In **Finland**, research tracking the mental states of 15-year-olds suggested that after a stable period between 2002-2003 and 2012-2013, internalising symptoms including depression, social and general anxiety, stress and poor self-esteem increased between 2012-2013 and 2018-2019 (Knaappila et al., 2021[42]). Finland has also seen a rise in disability pensions due to mental health conditions among young adults, indicating long term consequences of worsening adolescent mental health (Sotkanet, 2025[43]).
- In **Iceland,** between 2006 and 2016 there a significant increase in self-reported symptoms of anxiety and depression among Icelandic adolescents age 14-16, particularly among girls, for whom anxiety and depression increased by 8.6% and 6.8% respectively (Thorisdottir et al., 2017[44]).
- In **New Zealand**, after a period of stable mental well-being between 2001 and 2012 a decline in the mental well-being of adolescents age 10-19, was clear between 2012 and 2019, with increases in symptoms of depression (13.0% in 2012 to 22.8% in 2019), and declines in emotional well-being (76.0% to 69.1% based on the WHO-5 survey) (Fleming et al., 2022[45]; Sutcliffe et al., 2022[46])
- In **Norway**, the HUNT study which was undertaken in 1995-1997, 2006-2008 and 2017-2019 showed an increase in symptoms of depression and depression amongst Norwegians age 13-29, while depression symptoms were stable or declined amongst most other age groups (Krokstad et al., 2022[47]).
- In **Poland**, a study of 15-year-olds in Warsaw found that between 2008 and 2016, the percentage of young people experiencing symptoms of depression increased significantly (Bobrowski, Ostaszewski and Pisarska, 2021[48]), whilst a study looking at the period 2000-2011 found a trend towards deterioration of the self-reported emotional and behavioural conditions of Polish 16-year-olds (Konowałek and Wolanczyk, 2018[49]).
- In the **United Kingdom**, several studies suggest stable mental well-being up to around 2014 (Pitchforth, Viner and Hargreaves, 2016[50]; Pitchforth et al., 2018[51]; Pitchforth et al., 2017[52]),

although prevalence of a self-reported mental health condition increased across the same period (Pitchforth et al., 2017[52]). Data from England for young people age 11-16 suggest an increase in "probably (mental) disorder" between 2017 and 2023 (see Figure 1.3.).

- In the **United States**, at least one study found that rates of depression and anxiety had increased amongst children under age 17 in the period 2016-2022 (Lachaab, 2024[53]), while others have found no change in prevalence but observed an increasing and shifting demand for mental health care for adolescents (Mojtabai and Olfson, 2020[54]), or highlighted shifts towards greater demands for care for depression, anxiety, trauma- and stressor-related disorders amongst individuals under 17 between 2013 and 2021 (Mojtabai and Olfson, 2025[55])

There is some evidence that externalising conditions, such as conduct disorder, substance use and violence decreased over the past two decades, with studies variously showing declines in absolute prevalence, or declines in demand for care for these disorders (Knaappila et al., 2021[42]; Bobrowski, Ostaszewski and Pisarska, 2021[48]; Mojtabai and Olfson, 2025[55]).

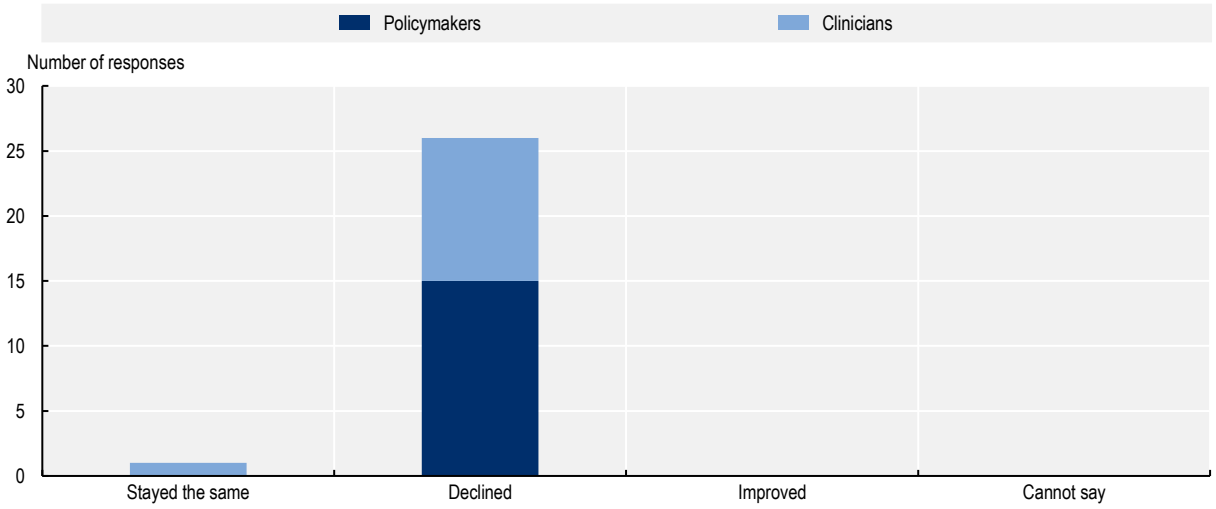
Although not all academic studies clearly indicates declines in young people's mental health status, almost no studies report any measurable improvement in young people's mental health or well-being. Nationally representative data for Korea and Japan suggest that there had been an overall improvement in depression and psychological distress, respectively, among young people (see Figure 1.3.). A number of studies from Korea suggest that young people's mental health improved during the COVID-19 pandemic specifically, before returning to pre-pandemic levels (Lee, Hong and Kim, 2022[56]), and that though overall adolescent mental health improved during the pandemic it declined for lower income adolescents (Cho et al., 2024[57]). Further studies were identified that seemed to indicate stable mental health status amongst at least some young people during the pre-COVID period. For the Netherlands, both Duinhof et al. (2014[58]) and de Looze (2020[59]) report emotional well-being amongst Dutch adolescents remain broadly stable up to 2017, with some small fluctuations over time.

A series of semi-structured interviews were undertaken with youth mental health clinical and policy experts to inform this report (Box 1.1). Expert clinicians and policymakers both consistently indicated that they believed the mental health status of young people had declined in recent years (Figure 1.4). Many experts did point to rising awareness of mental health conditions, and falling stigma, as factors that may influence the way in which young people respond to questionnaires measuring mental distress and prevalence, talk about their own emotional states, and their help seeking behaviour.

Nonetheless, experts generally said that they believed there had been an underlying deterioration in mental health status. One policymaker from Central Europe, when discussing trends in youth mental health, said: "*increases in reported symptoms are partially because youth self-identify as experiencing certain symptoms more often now than they did, let's say 20 years ago*… [regarding psychosomatic symptoms] *a significant or some portion of this increase can be attributed to higher mental health literacy and willingness to report mental health issues*… [but] *I believe that there is more distress in general in this population group*."

Figure 1.4. Expert assessment of trends in young people's mental health status over the past decade

Responses to interview question, "Over the last decade or so, do you think that young people's mental health has: 1) stayed the same 2) improved 3) declined 4) cannot say?"



Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

Box 1.1. OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025

To bring new insights into the state of young people's mental health in OECD countries, the key factors influencing young people's mental health status, and potential policy responses, a series of semi-structured interviews with policy and clinical experts were carried out in the course of 2025.

In order to connect with clinical experts in youth mental health, the European Psychiatric Association (EPA) sent out a call for expressions of interest in participating in the semi-structured interviews to their Board, Scientific Sections, and Early Career Psychiatrists Committee. Twelve experts were subsequently contacted to participate in interviews. Experts from the European Society for Child and Adolescent Psychiatry (ESCAP), and the European Federation of Psychologists' Associations (EFPA) also participated in interviews.

In addition, Delegates to the OECD Health Committee were invited to submit names of expert policymakers working on child, adolescent and youth mental health and mental health professionals working with children, adolescents and young people. All OECD countries were encouraged to nominate relevant policymakers who could participate in these semi-structured interviews. Non-European countries were encouraged to nominate relevant mental health professionals (e.g. President of Association of Psychiatrists or Psychologists), and it was noted that for European countries engagement with European-level professional associations was ongoing to inform the report.

Most interviews took place online, in a video interview. A small number of participants submitted written responses. The interview questions were a mix of open-ended questions, and "multiple choice" responses; the interview questions are included in Annex 1.B.

Interviewees were not asked to represent their country or region's perspective or policy, rather they were asked to respond based on their own expertise and experience. The small sample size for the interviews, and the fact that participants were speaking to their individual knowledge rather than a nationally representative perspective, means that interview responses should not be attributed specifically to countries. Therefore, when quoting expert responses, the text refers to the geographic region in which the expert is based and tabulated Figures do not list responses by country or region.

All experts who were interviewed were given the opportunity to review the draft report and provide comments, and if quotations taken from their interviews were included they were specifically asked if the agreed that this was accurate, and could be included in the text.

The COVID-19 crisis worsened youth mental health, but the declining trend started pre-pandemic

The COVID-19 pandemic had significant mental health impacts. As the OECD documented at the time, young people's mental health worsened significantly during 2020-2021; young people were 30% to 80% more likely to report symptoms of depression or anxiety than adults in Belgium, France and the United States in March 2021 (OECD, 2021[60]). Consistent evidence, including from Belgium, Chile, France, Germany, Italy, Mexico, Slovenia, Spain, Switzerland, Türkiye and the United States points to declines in young people's mental health during the COVID-19 pandemic compared to pre-pandemic levels (Ezpeleta et al., 2020[61]; OECD, 2021[60]; Ravens-Sieberer et al., 2023[62]; Bojórquez-Chapela et al., 2023[63]; Rus Prelog et al., 2022[64]; Parola et al., 2020[65]; Pedrini and Meloni, 2024[66]; Akkaya-Kalayci et al., 2020[67]; Caqueo-Urízar et al., 2023[68]).

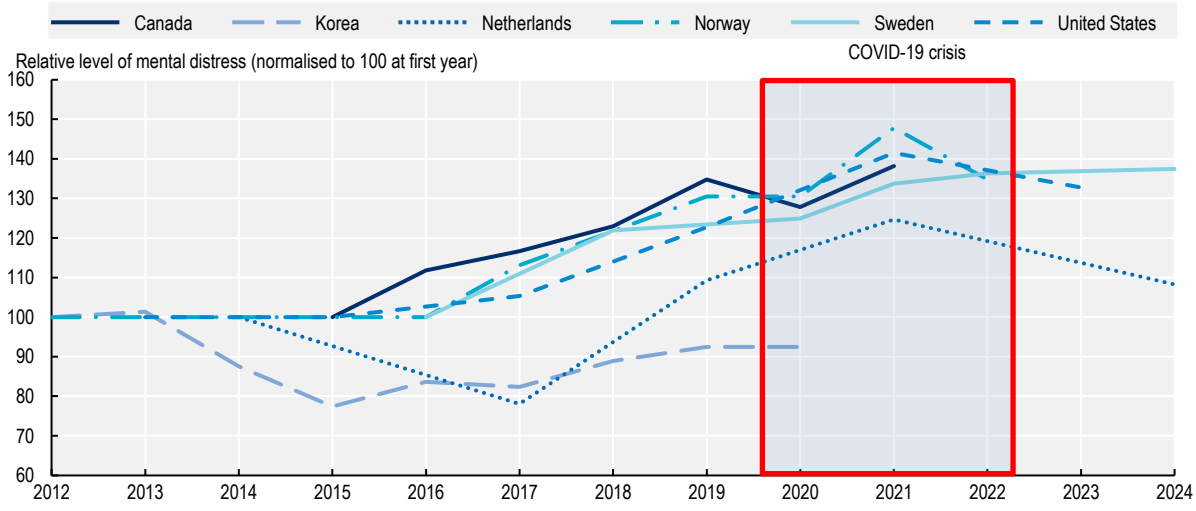
A number of studies found that the mental health status of young people – and the general population – worsened in 2020 and early 2021, before showing some improvements in late 2021 and early 2022. A nationwide survey of children and adolescents aged 7-17 years in Germany found that overall mental health problems increased during the pandemic, with levels of anxiety and depression as much as doubling in late 2020/early 2021 compared to pre-pandemic levels (from a pre-pandemic level of 15% to a high of 30% for anxiety, and a pre-pandemic level of 15% to a high of 24% for depression) before declining steadily in the following months. The last survey wave in autumn 2022 showed improvements, but not a return to pre-pandemic values (Ravens-Sieberer et al., 2023[62]). Bojórquez-Chapela et al. (2023[63]) found similar trends for Mexican youth age 15-24, with decreased prevalence of symptoms of common mental disorders in late 2021/early 2022, as compared to late 2020/early 2021. Demand for mental health services increased in Ireland and Portugal following the peak of the pandemic period (Barbabela, Duarte and Leão, 2023[69]; McNicholas et al., 2021[70]). In Ireland referrals to Child and Adolescent Mental Health Services fell in early 2020, before increasing consistently from September 2020, with both routine and urgent referrals increasing by as much as 50% compared with previous years (McNicholas et al., 2021[70]).

Only study could be found which suggested improvements in youth mental health during some periods of the COVID-19 pandemic. In Korea, Lee et al. (2023[71]) found that compared to pre-pandemic levels, the prevalence of stress, depression, and suicidal ideation, plans, and attempts for adolescents of both sexes age decreased in 2020 compared to the pre-COVID-19 period. By 2021, this prevalence had returned to a level similar to before the pandemic. The authors suggest that school closures could have relieved pressure on adolescents, in terms of reducing the burden of school work and reducing academic and social pressure. With regards to the increase in depressive mood and stress amongst adolescents in the second year of the pandemic (2021), the authors suggest that this may be related to both the enduring stress of the pandemic, and a return to school in person or in a hybrid mode. Furthermore, adolescents – and especially girls – from low-income families had poorer mental health status throughout the period studied (2017-2021), including comparatively poorer mental health during both years of the pandemic.

While there is solid evidence that the COVID-19 crisis worsened young people's mental health, some time series data suggest that the declining trend in youth mental health started prior to pandemic. Figure 1.5. shows trends in relative level of mental distress amongst young people over time in six OECD countries. To improve comparability between countries – given that different survey methods and different time periods are covered – the first value for each country was normalised to 100. Figure 1.5 therefore shows change relative to the first available value. In all countries except Korea, there is a clear increasing trend observable from around 2015-2017, which then appears to accelerate during the pandemic period in 2020 and 2021, before declining in 2022. Between-country differences in responses to the COVID-19 crisis, such as different levels of social restrictions or school closures, may have influenced patterns of mental distress during the 2020-2022 period. OECD analysis of the impact of the COVID-19 crisis on mental health (of all ages) suggested that mental distress was highest during periods of higher deaths and more stringent COVID-19 control measures (OECD, 2021[72]).

Figure 1.5. Relative level of youth mental distress over time in Canada, Korea, the Netherlands, Norway, Sweden and the United States

Nationally available measures of mental distress amongst young people between 2012-2016 and latest available year – the first value for each country was normalised to 100



Note: Data use different measures of mental distress, and cover different age groups, which limits comparability. For full details on data sources see Annex 1.A.
Source: OECD based on national sources. Canada (Statistics Canada, 2025[73]); Korea (Park et al., 2023[24]); the Netherlands (Centraal Bureau voor de Statistiek, 2025[25]); Norway (Bakken, 2022[27]); Sweden (Folkhälsomyndigheten, 2025[28]); United States (CDC, 2025[30]).

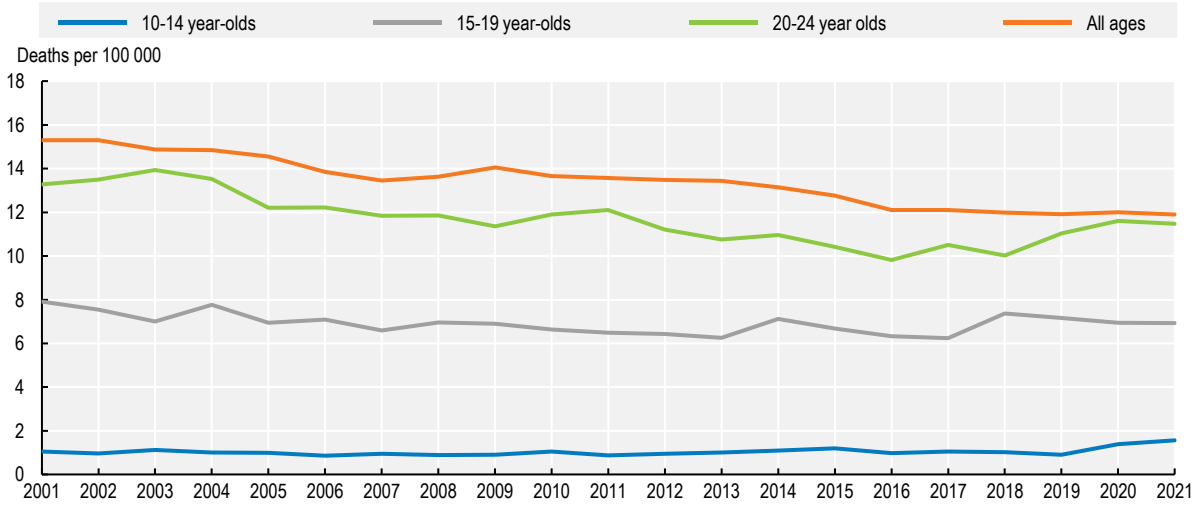
At the time of writing only a few countries had survey data that went beyond the immediate pandemic period. In two countries – the Netherlands and the United States – data appears to show an improvement in youth mental health following a peak of mental distress in the pandemic, which is consistent with the previously discussed academic literature looking at youth mental health specifically during different phases of the pandemic. Only in Sweden does the increasing trend of mental distress appear to continue to rise from 2021 onwards, with levels of 'anxiety, worry or distress" higher in 2024 (59% of young people age 16-29) than any preceding year (Folkhälsomyndigheten, 2025[28]). Sweden's measure of mental distress, which is relatively broad, may be more sensitive to fluctuations or changing norms around language on social and emotional states than other survey questions or instruments; however, measures of "severe psychological distress" using the Kessler 6 scale also suggest that the mental health of Swedes

age 16-29 was worse in 2024 (18% severe mental distress) than any preceding year (for example, 16.2% in 2022, and 12.8% severe distress in 2020) (Folkhälsomyndigheten, 2025[28]). It will be very important to track young people's mental health status in the coming years, as further data becomes available, to see whether the "improving" trend post-pandemic is maintained.

Trends in suicide deaths and intentional self-harm

With a few exceptions, there have not been notable increases in deaths by suicide amongst young people in OECD countries. Between 2001 and 2021, in OECD countries there was, on average, a steady-to declining trend in suicide deaths across all age groups, including amongst younger age groups, although suicide deaths amongst young people under age 20 did decline less than suicides in older age groups (see Figure 1.6). With some fluctuations between 2001-2019, deaths by suicide declined by 14% amongst 10-14 year-olds, by 9% amongst 15-19 year-olds, and by 17% amongst 20-24 year-olds and y 22% in the population as a whole.

Figure 1.6. Deaths by suicide by age in OECD countries, 2001-2021



Note: Due to gaps in data New Zealand, Norway, the Slovak Republic and Türkiye were excluded.
Source: World Health Organization (2026[74]), *WHO Mortality Database: Self-inflicted injuries* (Dataset), https://platform.who.int/mortality/themes/theme-details/topics/indicator-groups/indicator-group-details/MDB/self-inflicted-injuries, accessed 19 January 2026.

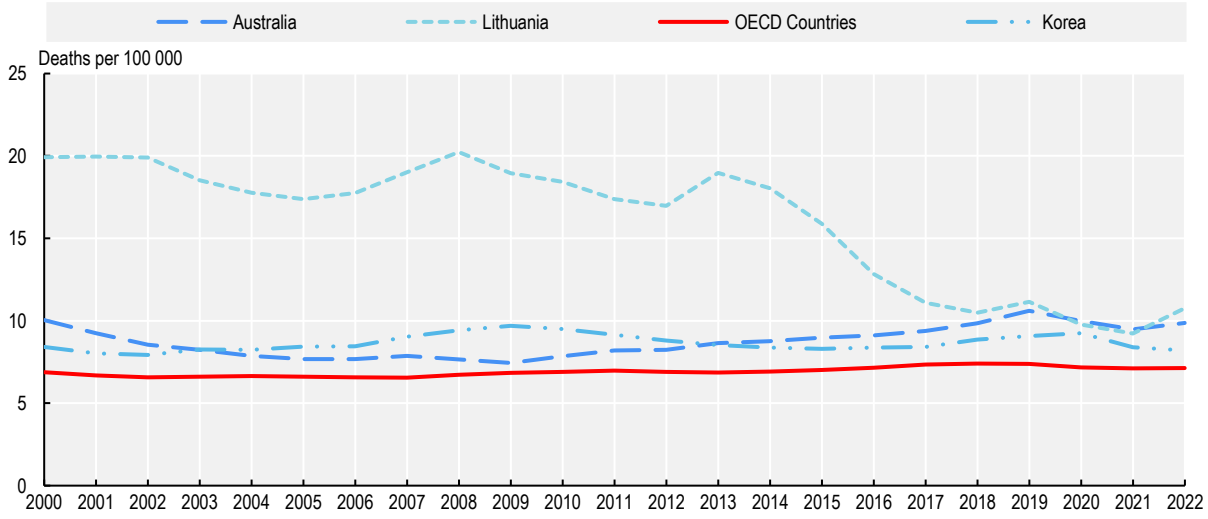
In 2020, the start of the COVID-19 crisis period, suicide death rates increased amongst under-25-year-olds, specifically, by 1% amongst 15-19 year-olds, and by 2% amongst 20-24 year-olds. Suicide deaths for 10-14 year-olds increased by a worrying 54%, but it should be stressed that these are very low absolute numbers, and therefore more sensitive to relatively small changes. All-age suicide deaths declined by 1% between 2019 and 2020, according to latest available data. At present, suicide data by age for the years post-2020 is available for only a limited number of OECD countries; it will be important to track data on suicide in the coming period to assess whether the apparent increases in youth suicides in 2020 are a trend specific to the COVID-19 crisis, or a broader pattern.

Death by suicide remains a rare event, especially amongst young children. This means that at the country level there can be significant fluctuations between years, especially in countries with small total populations or low overall suicide rates. However, at the country-level there are some distinct and heterogeneous patterns that appear in youth suicide trends across the last two decades, including countries that have

seen increases in suicide rates amongst some groups of young people (see Figure 1.7). In Lithuania, youth suicides (age 10-24) declined significantly, especially between 2008, when there were 20.2 suicide deaths per 100 000 population, and 2018, when suicide deaths had fallen to a rate of 10.5 per 100 000 (IHME, 2026[6]). In Australia, suicide deaths amongst young Australians, especially age 18-24, rose between around 2012 and reached a peak in 2020, before declining in the following period (Australian Institute of Health and Welfare, 2025[75]). In Korea, the youth suicide rate rose from 0.8 deaths per 100 000 population to 6.4 deaths for 10-14 year-olds between 2000 and 2019, and from 1.9 to 9.9 deaths for 15-19 year-olds across the same periods (Statistics Korea Statistics Research Institute, 2023[76]). Between 2017 and 2022, the suicide rate for adolescent girls aged 10-14 nearly tripled in Korea [ibid].

Figure 1.7. Youth suicide deaths in selected OECD countries, 2000-2022

Deaths per 100 000 amongst young people age 10-24

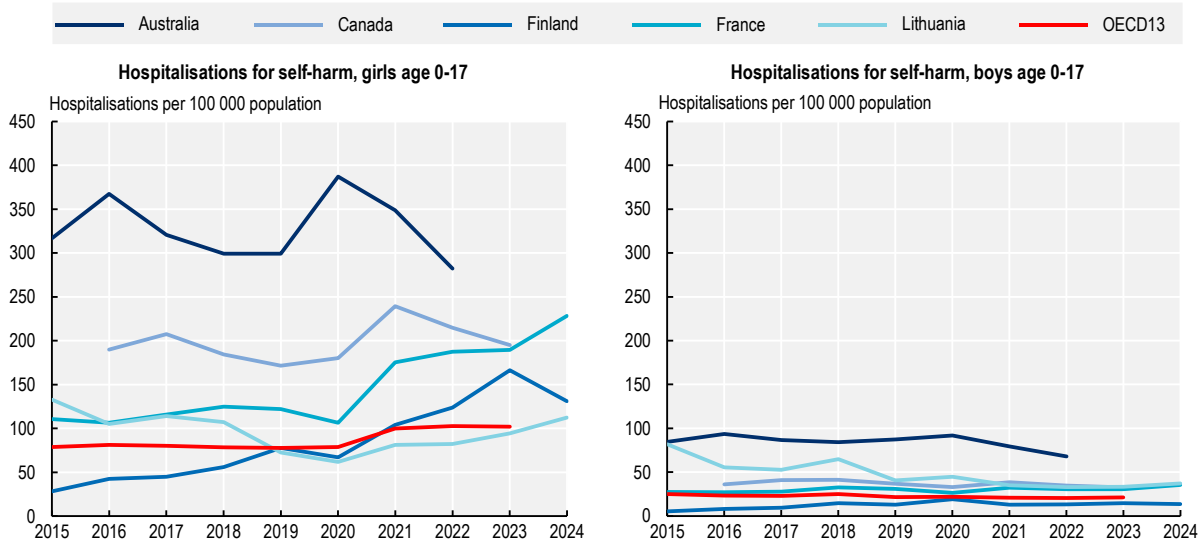


Note: To improve comparability between countries IHME data was selected, which "smooths" some variations between years. IHME data for "Self-harm mortality" was cross-checked with national data and/or WHO Mortality data to confirm overall trends.
Source: IHME, (2026[6]), GBD Compare, http://www.healthdata.org/data-visualization/gbd-compare.

During the expert interviews undertaken to inform this report, both clinicians and policymakers in OECD countries pointed to rises in self-harming behaviour as a concerning pattern amongst young people, especially during the COVID-19 and post-COVID period. National studies confirm worrying rates of self-harm and suicidal ideation amongst young people, including in England, Finland, France, Ireland, Spain, the United States (Dooley et al., 2024[77]; Varo et al., 2025[78]; Griffin et al., 2019[79]; McCabe, Egan and Theiler, 2023[80]; Mäkitie, Kosola and Ilmarinen, 2025[81]; Trafford et al., 2023[82]), with the COVID-19 crisis appearing to contribute to increasing rates and higher rates amongst girls and young women (Mäkitie, Kosola and Ilmarinen, 2025[81]; Trafford et al., 2023[82]; Drees, 2025[83]). In Ireland, a 2021 survey over a quarter of adolescents described their mental health as "bad" or "very bad", with high rates of self-harm (39%) and suicidal ideation (42%) (Dooley et al., 2024[77]).

Recently collected data on hospitalisations for self-harm in some countries suggest a rise in self-harming behaviour by girls in recent years (see Figure 1.8). The gender gap in self-harm hospitalisations is consistent across all age groups, as reported in Health at a Glance 2025 (OECD, 2025[38]). This indicator only captures a proportion of those exhibiting self-harming behaviours, notably those severe enough to warrant hospitalisations and/or where the individual is in a position to seek help.

Figure 1.8. Hospitalisations for self-harm for girls and boys age 0-17, 2015-2024



Note: OECD13 includes imputation of values for Australia for 2023 (carried forwards) and Canada for 2015 (carried backwards).
Source: OECD Mental Health Data Collection Pilot 2024-2025.

In France, there has been a particularly marked increase for suicide attempts or self-harm amongst adolescents, and young girls (Drees, 2025[83]). 2024 data show that compared to 2023 there has been an increase in self-harm hospitalisations of +22% amongst girls age 10 to 14, +14% amongst 15-to-19-year-old girls, and +4% and +9% amongst 20-24 and 25-29 year-olds, respectively. Looking at hospitalisations in psychiatric beds, women are twice as likely to be hospitalised as men for suicide attempts or self harm, and over half of the female hospitalisations are for women under 30. Amongst young women under 25, hospitalisations for self-harm in psychiatric beds have been significant and sustained since 2015-2017. There were smaller increases in self-harm hospitalisations amongst boys and young men, +17% among 15-19 year-olds, +8% among 20-24 year-olds and +7% among 25-29 year-olds. Women are also more likely to be re-admitted for repeated self-harm events than men.

Explorations of the explanations for self-harm amongst young people found that intrapersonal motivations (emotion regulation, anti-dissociation and self-punishment) were more common than interpersonal motivations (Tang et al., 2025[84]), and that non-suicidal reasons for self-harm include coping with distress and self-harm as a form of "personal mastery" (Edmondson, Brennan and House, 2016[85]). There are likely bi-directional links between self-harming behaviour and poor mental health (Tang et al., 2025[84]). It is also notable that some countries, such as England have seen prior peaks and then declines in non-fatal self-harming behaviour in prior periods (Bergen et al., 2010[86]).

Adolescents in their mid-to-late teens, and girls and young women, have poorer mental health

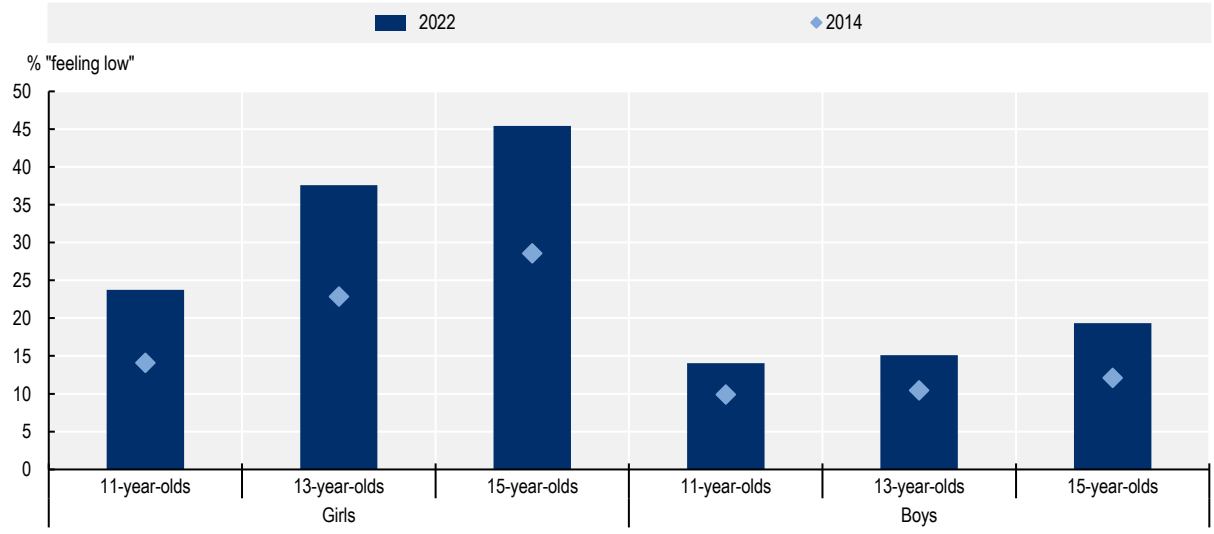
Overall, adolescents in their mid-to-late teens, girls and young women, and young people with lower socio-economic status have poorer mental health. Some of these dimensions are unsurprising given longstanding understanding of developmental pathways and risk factors for mental health; however, others, such as what appears to be a faster decline in adolescent girls' and young women's mental health as compared to boys', may be newer trends.

Data from the HBSC survey which covers 27 OECD countries show that girls had a lower well-being score across all ages, with a gap of 6.7 points at age 11 rising to a 13.6 point gap at 15 (Health Behaviour in School-aged Children study, 2023[87]). Overall mental well-being, as measured by the WHO Well-being Index, was first included in the HBSC survey in 2022 and shows that well-being declines with age; the average well-being score (out of 100, where 100 is the highest possible score) fell from an OECD average of 65.3 for 11-year-olds, to 57.4 for 13-year-olds, to 53.7 for 15-year-olds (Health Behaviour in School-aged Children study, 2023[87]). In 2022 68% of 15-year-old girls reported having multiple health complaints in OECD countries, compared to only 36% of boys.

The proportion of children and adolescents reporting "feeling low" at least once a week also rises with age, is consistently higher amongst girls than boys, but has increased faster amongst girls. In 2022, 15-year-old girls were on average more than twice as likely to report feeling low than boys of the same age (Figure 1.9.). Between 2014 and 2022, the proportion of young people reporting that they "felt low" increased across all age groups and for both sexes. The absolute increases in the number of girls feeling low were larger for girls at every age (+9.7, +14.7, +16.8 percentage for girls at 11, 13 and 15 vs. +4.1, +4.7, +7.3 percentage for boys), and proportional increases were larger for girls at age 11 and 13. At age 15, boys' proportional rise is slightly larger (59.9% vs. 58.9%), albeit from a higher starting point. The rise was also more pronounced among older adolescents. For both sexes, 15-year-olds experienced the largest proportional increase, with rates rising from 28.6% to 45.4% among girls and from 12.1% to 19.4% among boys (increases of around 59% for each), compared with smaller proportional rises among 11-year-olds (+69% for girls, +42% for boys) and 13-year-olds (+64% for girls, +45% for boys).

Figure 1.9. Percentage of girls and boys "feeling low" in 2022 and 2014

Percentage of girls and boys "feeling low" more than once a week, age 11, 13 and 15



Note: 27 OECD countries covered in the HBSC surveys 2014 and 2022.
Source: HBSC (2023[87]), *Health Behaviour in School-aged Children study – Data browser (findings from the 2021/22 international HBSC survey)*, https://data-browser.hbsc.org/.

These trends – girls and older adolescents reporting comparatively poorer well-being than younger children – are consistent with understanding of typical developmental pathways in adolescence. In adolescence, well-being tends to decline, coinciding with pubertal developmental shifts including neurobiological changes such as hormonal shifts and brain maturation, along with psychosocial stressors such as the

transition to secondary education and changing social dynamics with peers (Elgar et al., 2017[88]; Patalay and Fitzsimons, 2018[89]; Cyranowski et al., 2000[90]). Gender differences in well-being trajectories are also well-documented, and attributed to factors including earlier onset of puberty, and the interaction of hormonal and neurodevelopmental changes with social and societal factors which may impact girls more significantly than boys during adolescence (Bisegger et al., 2005[91]; Cyranowski et al., 2000[90]). Nonetheless, underlying biological pathways should not be seen as the only explanation for the well-being gap between girls and boys; research suggests that girls are more influenced by experiences in school and at home, by socio-economic disadvantage, by academic stress, peer relationships and body image than boys (Phillips et al., 2023[92]; Patalay and Fitzsimons, 2018[89]; Apsley and Padilla-Walker, 2020[93]; Patalay and Fitzsimons, 2018[89]).

National data on prevalence of anxiety and depression also suggest that there has been a greater increase for girls and young women than for boys and young men in a number of countries. For example, analysis of the Belgian health interview survey of adolescents aged 15-25 found that anxiety and depression increased substantially between 2008 and 2013 for girls and to a lesser extent for boys (Van Droogenbroeck, Spruyt and Keppens, 2018[40]). In Iceland, between 2006 to 2016, there was a significant increase in self-reported symptoms of anxiety and depression among Icelandic adolescents, particularly among girls. The proportion of girls reporting high anxiety symptoms increased by 8.6%, while for boys, it increased by 1.3% (Thorisdottir et al., 2017[44]). In the United Kingdom, incidence of eating disorders and self-harm increased amongst teenage girls – but not boys – during the COVID-19 pandemic (Trafford et al., 2023[82]).

In New Zealand, Sutcliffe et al. (2022[46]) found that declines in adolescent mental health and well-being between 2012 and 2019 had been "rapid and unequal", with adolescent mental health needs rising across all demographic groups but especially amongst females, Māori, Pacific and Asian students and those from high-deprivation neighbourhoods. A growing body of evidence also indicates that certain demographic groups face greater risk of mental ill-health amongst under-25s, notably young people with lower socio-economic status or family poverty, ethnic minority and Indigenous population groups, LGBTQI+ youth, though patterns can be expected to vary across countries (Sutcliffe et al., 2022[46]; Ahmad et al., 2021[94]; Oppedal, 2017[95]; Alexandre, Ribeiro and Cardoso, 2010[96]; Chen Wang and McLeroy, 2023[97]; Lothwell, Libby and Adelson, 2020[98]; Mustanski, Garofalo and Emerson, 2010[99]; Rich et al., 2022[100]).

These mental health inequalities are influenced by the accumulation and interaction of multiple forms of advantages and disadvantages in young people's living conditions and opportunities, including socio-economic circumstances, discrimination, community belonging, and access to timely, high-quality care (Public Health Agency of Canada, 2024[101]). Recent OECD analysis highlights persistent inequalities in access and quality of mental health care. In particular, ethnic minority and Indigenous populations often experience more limited access to appropriate and culturally responsive mental health services, alongside poorer experiences of care (Vargas Lopes and Llena-Nozal, 2025[102]). Despite this, inequalities affecting ethnic groups and Indigenous populations tend to receive limited attention in national mental health surveillance systems and policy framework (Vargas Lopes and Llena-Nozal, 2025[102]; Jamieson et al., 2025[103]). While the development of this report did not allow for a detailed examination of these vulnerabilities, including whether certain groups of young people have experienced more pronounced mental health declines than others, addressing these gaps represents an important priority for future research and policy analysis.

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Annex 1.A. National data sources on youth mental health status

Annex Table 1.A.1. Data sources for Figure 1.3. Average annual change in prevalence of poor mental health amongst young people across the past decade

Country	Measures used and data sources	Source or weblink
Australia	Data is for 2007 and 2020-2022 from the Australian Bureau of Statistic's National Study of Mental Health and Well-being, covering young people age 16-25 with any 12-month affective disorder.	https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2007; National Study of Mental Health and Wellbeing, 2020-2022 | Australian Bureau of Statistics
Canada	Data is for 2012 and 2022, based on Statistics Canada's surveys: the 2012 Canadian Community Health Survey – Mental Health (CCHS-MH) and the 2022 Mental Health and Access to Care Survey (MHACS), covering young people age 15-24 with any mood disorder. It is important to acknowledge the methodological factors that may influence representativeness and comparability when interpreting data from both surveys: MHACS survey had a lower response rate, which may affect representativeness. MHACS classified select disorders using the WHO Composite International Diagnostic Interview instrument (WHO-CIDI), which was based on DSM-IV criteria.	https://www.statcan.gc.ca/en/survey/household/5015
	The CCHS-MH data show the proportion of young people age 18-25 who report a mood and/or anxiety disorder. Data is also available for young people aged 12-17.	https://health-infobase.canada.ca/mental-health/youth-young-adults/data-tool.html?0=3&1=2&2=0&3=0
France	Data is for 2007 and 2021 from the Baromètre de Santé publique France, and includes young people age 18-24 who had experienced a "major depressive episode" in the past 12 months.	https://www.santepubliquefrance.fr/presse/2023/sante-mentale-des-jeunes-des-conseils-pour-prendre-soin-de-sa-sante-mentale; https://beh.santepubliquefrance.fr/beh/2023/2/2023_2_1.html
Japan	Data is for 2019 and 2022 from the Ministry of Health's Labour and Welfare Comprehensive Survey of Living Conditions, and covers young people age 12-19 with a score greater than 10 on the Kessler Psychological Distress Scale (6 Item Scale).	https://www.mhlw.go.jp/toukei/saikin/hw/k-tyosa/k-tyosa19/dl/14.pdf; https://www.mhlw.go.jp/toukei/saikin/hw/k-tyosa/k-tyosa22/dl/06.pdf.
Korea	Data is annual from 2010 to 2020 taken from analysis of the Korea Youth Risk Behaviour Survey reported in https://pmc.ncbi.nlm.nih.gov/articles/PMC10581890/, and covers young people age 12-18 with two week prevalence of depressive symptoms.	https://pmc.ncbi.nlm.nih.gov/articles/PMC10581890
Netherlands	Data is reported every 3 years from 2014-2024 in the Mental Health Inventory (MHI-5) score > 12 collected in the Health Survey ("Gezondheidsenquête") conducted by Statistics Netherlands (CBS), for young people age 16-20.	https://www.cbs.nl/nl-nl/cijfers/detail/85454NED

Country	Measures used and data sources	Source or weblink
New Zealand	Data is reported annually from 2011/12 to 2023/24 in the New Zealand Health Survey, and coveres young people age 15-24 with a score greater than 12 on the Kessler Psychological Distress Scale (10 Item Scale).	https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/_w_6ce984b4e7654aecbccabab0a4eb50ea/#!/explore-indicators
Norway	Data is reported bi-annually from 2010-2012 to 2022 in the Ungdata National Youth Survey, and covers young people in "lower secondary school" aged around 13-16 who had experienced many mental health problems in the last seven days.	https://oda.oslomet.no/oda-xmlui/bitstream/handle/11250/3011548/NOVA-rapport-5-2022.pdf?sequence=5&isAllowed=y
Sweden	Data is for anxiety, worry or distress (Ängslan, oro eller ångest), for the total population (16-84) and young people age 16-29. The indicator was collected regularly between 2018 and 2024 as part of the National Public Health Survey ["Nationella folkhälsoenkäten – Hälsa på lika villkor"].	https://fohm-app.folkhalsomyndigheten.se/Folkhalsodata/pxweb/sv/A_Folkhalsodata/A_Folkhalsodata/
United Kingdom (England)	Data is for 2017, then annually from 2020 to 2023 in the Mental Health of Children and Young People in England Survey, and covers young people aged 11-16 with a "probable (mental) disorder".	https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/data-sets
United States	Data is reported bi-annually from 1999 to 2023 in the High School Youth Risk Behaviour Survey from the CDC, and covers young people age 14-18 who felt "sad or hopeless" almost every day for 2 or more weeks.	https://www.cdc.gov/yrbs/index.html

Annex 1.B. Questionnaires

OECD semi-structured interviews on young people's mental health – policymaker

1. Introduction – could you briefly present yourself, and describe your role and area of expertise?
2. What trends have you observed in the mental health status, and mental health needs of young people in your country?

   e.g. any change in the type of disorder or condition you're seeing; any change in the severity; any change in the age, gender, or socio-economic profile.
3. Over the last decade or so, do you think that young people's mental health has: 1) stayed the same 2) improved 3) declined 4) cannot say?

   Please select one response:

   1. Stayed the same.
   2. Improved.
   3. Declined.
   4. Cannot say.
4. Have you been tracking or recording young people's mental health status in your country, e.g. through national mental health surveys.
5. Do you believe that there are any new drivers of good or poor mental health amongst young people?
6. Do you believe that awareness levels of mental health conditions in your country have changed, and/or that levels of stigma have fallen?
7. Do you have any views on the impact of smart phones, internet, social media, and digitalisation generally on young people's mental health?
8. Do you have any views or concerns about one type of technology in particular? Are you concerned about the impacts on any sub-group of young people in particular?
9. Do you believe that the impact of digitalisation, including social media, on young people's mental health is: 1) positive 2) negative 3) neutral 4) cannot say.

   Please select one response:

   1. Positive.
   2. Negative.
   3. Neutral.
   4. Cannot say.
10. What do you believe is the most effective way to build mental health and well-being resilience amongst young people?
11. Do you think that the mental health services in your country are sufficient to meet the mental health needs of young people at present?
12. What are the policy priorities for young people's mental health in your country?
13. Do you believe that the level of mental health support for young people in your country or region is: 1) the right level 2) too low 3) too high 4) cannot say.

    Please select one response:

    1. The right level.
    2. Too low.
    3. Too high.
    4. Cannot say.

14. Is there anything you think we have missed from this conversation, that you would like to add?
15. Final housekeeping:

- Do you agree we use the responses in this discussion in an anonymised, long-form format, e.g. a short text citation, attributed to “an expert policy maker from France”? [Yes/No]. Do you agree that we can use the responses in this discussion in an anonymised Figure, e.g. a yes/no table by country for the question on whether stigma has fallen? [Yes/No].
- If we include a thanks and acknowledgements section, would you like to be thanked or acknowledged by name? [Yes/No].”

OECD semi-structured interviews on young people’s mental health – practitioner

1. Introduction – could you briefly present yourself, and describe your role and area of expertise?
2. In your clinical practice, what trends have you observed in the mental health status, and mental health needs of young people?

   e.g. any change in the type of disorder or condition you’re seeing; any change in the severity; any change in the age, gender, or socio-economic profile.
3. Over the last decade or so, do you think that young people’s mental health has: 1) stayed the same 2) improved 3) declined 4) cannot say?

   Please select one response:

    1. Stayed the same.
    2. Improved.
    3. Declined.
    4. Cannot say.
4. Do you believe that there are any new drivers of good or poor mental health amongst young people?
5. Do you believe that awareness levels of mental health conditions have changed, and/or that levels of stigma have fallen?
6. Do you have any views on the impact of smart phones, internet, social media, and digitalisation generally on young people’s mental health?
7. Do you have any views or concerns about one type of technology in particular? Are you concerned about the impacts on any sub-group of young people in particular?
8. Do you believe that the impact of digitalisation, including social media, on young people’s mental health is: 1) positive 2) negative 3) neutral 4) cannot say.

   Please select one response:

    1. Positive.
    2. Negative.
    3. Neutral.
    4. Cannot say.
9. What do you believe is the most effective way to build mental health and well-being resilience amongst young people?

10. Do you think that the mental health services in your country or area are sufficient to meet the mental health needs of young people? If not, what changes would you want to see?
11. Do you believe that the level of mental health support for young people in your country or region is: 1) the right level 2) too low 3) too high 4) cannot say.

    Please select one response:

    1. The right level.
    2. Too low.
    3. Too high.
    4. Cannot say.
12. If you could send a message to your country's policymakers about youth mental health, what would it be?
13. Is there anything you think we have missed from this conversation, that you would like to add?
14. Final housekeeping:

- Do you agree that we can use the responses in this discussion in an anonymised format, e.g. "a psychiatrist from France"? [Yes/No].
- If we include a thanks and acknowledgements section, would you like to be thanked or acknowledged by name? [Yes/No]."

2 New and old drivers of young people's mental health status

This chapter explores the possible explanation for the declines in young people's mental health status across most OECD countries. While social media and digital device use have been pointed to as potential culprits of the youth mental health decline, this chapter highlights both expert perspectives and evidence from the literature that in fact show multiple, intersecting drivers of poorer mental health. This chapter shows that young people's mental health is shaped by a complex web of new and longstanding factors which are interrelated, and include social media and digitalisation, climate anxiety, economic insecurity, and global instability, bullying and academic pressure. The chapter gives particular attention to evidence of the impact of social media and digitalisation on youth mental health, and suggests the relationship is complex, context-dependent, and shaped by individual, social, and structural factors, although likely more negative than positive for mental health.

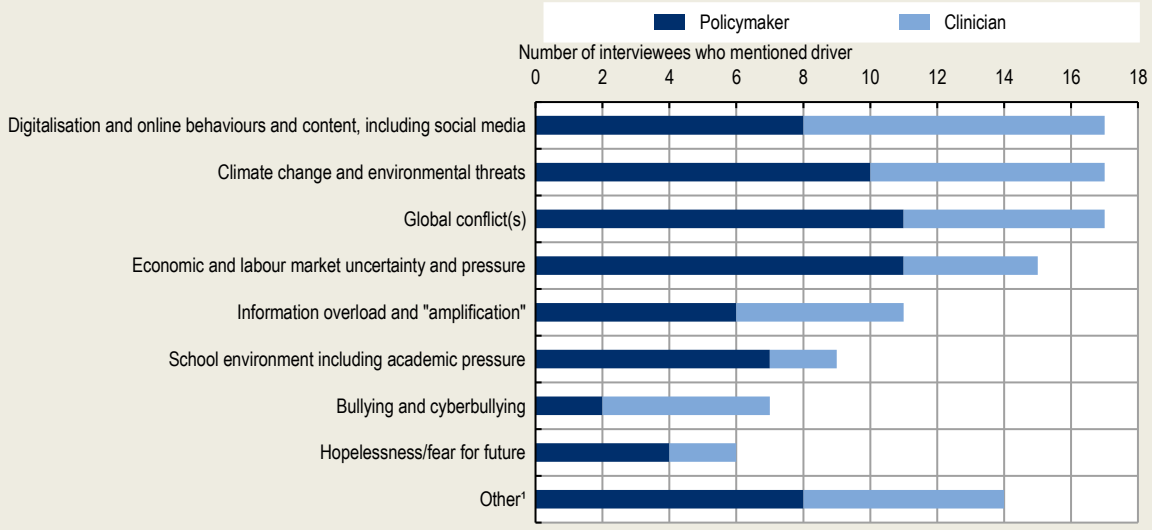
In Brief

There are intersecting new and older drivers of young people's mental health status

- Young people's mental health is shaped by a complex web of interrelated factors, both longstanding and emerging, including digitalisation, climate anxiety, economic insecurity, and global instability, bullying and academic pressure, with experts emphasising the cumulative impact of these overlapping stressors.

Figure 2.1. Expert-identified drivers of poor mental health amongst young people

Categories that were mentioned at least 5 times are shown in the figure



Note: 1. Alcohol use; housing insecurity; lasting impacts of the pandemic; political trends; peer relations; reduced physical activity; online misinformation; weakened family structures; child maltreatment. Experts were asked "Do you believe that there are any new drivers of good or poor mental health amongst young people?".
Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

- Both experts and the scientific literature point to a relationship between digital media use and young people's mental health that is complex, context-dependent, and shaped by individual, social, and structural factors. Overall, experts saw the impact of digitalisation including social media on youth mental health as more negative than positive, and scientific evidence that more time spent on digital devices is slightly associated with poorer mental health outcomes for adolescents.
- Among digital media, social media use is most often linked to poorer mental health outcomes, though effects are typically small and inconsistent. Active versus passive engagement and platform type appear to matter, suggesting that "social media use" is not a single, uniform behaviour, and current evidence remains largely correlational, underscoring the need for stronger causal research.

- While digital engagement can contribute to distress for some, it also offers meaningful opportunities for connection, identity formation, and mental health support – highlighting the need for policies that enhance protective environments and promote healthy, inclusive digital participation rather than imposing uniform limits.
- Experts stressed that young people are very concerned about global threats, in particular climate change and global conflicts, and this is also reflected in a small number of studies. These studies show that59% of young people report serious climate-related worry and that those exposed to conflict – as well as those exposed to more information about conflicts – tend to exhibit poorer mental health outcomes.
- Economic hardship and low socio-economic status are longstanding but increasingly pressing drivers of poor youth mental health, with experts highlighting financial insecurity, housing stress, and declining intergenerational mobility as priority concerns for this generation.
- Bullying, cyberbullying, and academic pressure are persistent risks to youth mental health, but recent data and expert insights suggest these stressors are becoming more intense and widespread.

Introduction

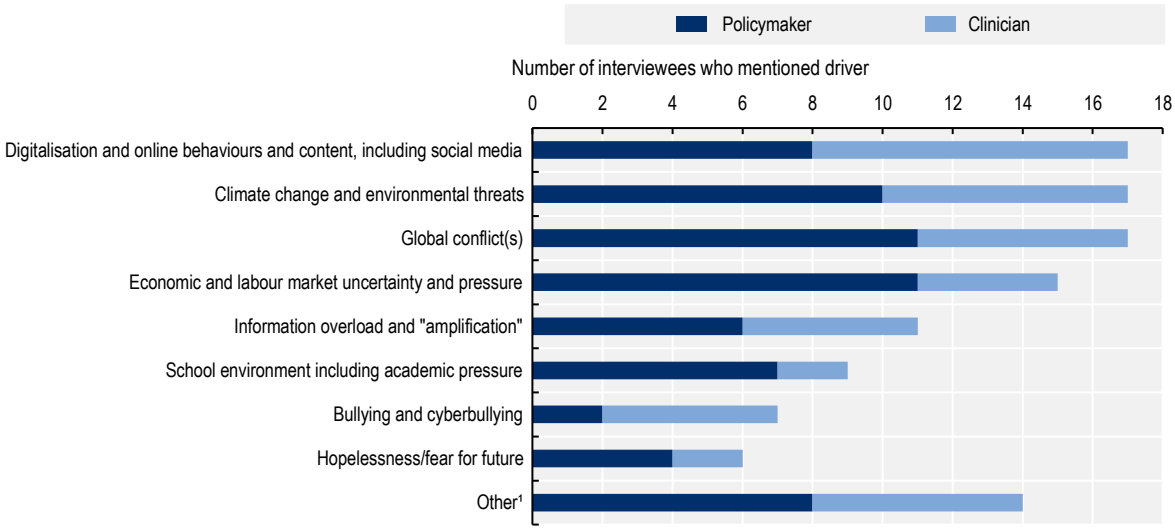
Neither the experts interviewed for this report, nor the scientific literature, point to a single driver of declines in young people's mental health. Instead, both experts and the scientific literature reported multiple drivers some of which are relatively new, including digitalisation and climate change, others of which are longstanding, such as economic insecurity or poverty. Other factors, such as global conflict and political instability, have always been a mental health risk to varying extents, but may be experienced differently and more widely by contemporary youth due to information availability.

There are multiple, intersecting risk factors for young people's poor mental health

The experts interviewed for this report identified more than 20 different risk factors driving recent declines in young people's mental health. Some of these were mentioned by most interviewees: different forms of digitalisation and "information overload", climate change, global conflicts, and economic insecurity; the school environment and academic pressure; bullying and cyberbullying; and hopelessness and fear for the future (Figure 2.2). New positive drivers on resilience and protective factors are highlighted in Chapter 3, Figure 3.2.

Figure 2.2. Expert-identified drivers of poor mental health amongst young people

Categories that were mentioned at least 5 times are shown in the Figure



Note: 1. Alcohol use; housing insecurity; lasting impacts of the pandemic; political trends; peer relations; reduced physical activity; online misinformation; weakened family structures; child maltreatment. Experts were asked "Do you believe that there are any new drivers of good or poor mental health amongst young people?". Experts were asked "Do you believe that there are any new drivers of good or poor mental health amongst young people?"
Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

Above all, experts saw the different possible drivers of poor mental health of young people as co-existing and often interrelated. The drivers listed in Figure 2.2 were always part of a list of multiple drivers, and no expert identified a single cause of declines in youth mental health. Experts pointed to some factors that affect young people's lives on an individual and material basis, for example the impact of screen use and relatedly less in-person socialising and exercise, exposure to harmful content online, poverty, the impact of bullying and cyberbullying, and academic or school-based challenges. Many, though, pointed to issues beyond young people's immediate lived experience, including the threat of climate change and environmental threats, global conflicts and perceived geopolitical instability, and economic pressures including labour market uncertainty and housing shortages. Many experts indicated that it was the cumulative effective of these different factors that they believed to be especially problematic; one Northern European policymaker stated, "*Today you're constantly confronted with all the world's problems… [that] is the major difference from the 1980s*," while another, from the Asia-Pacific region, commented, "*We talk about hope—and how the certainty of hope has deteriorated for young people.*"

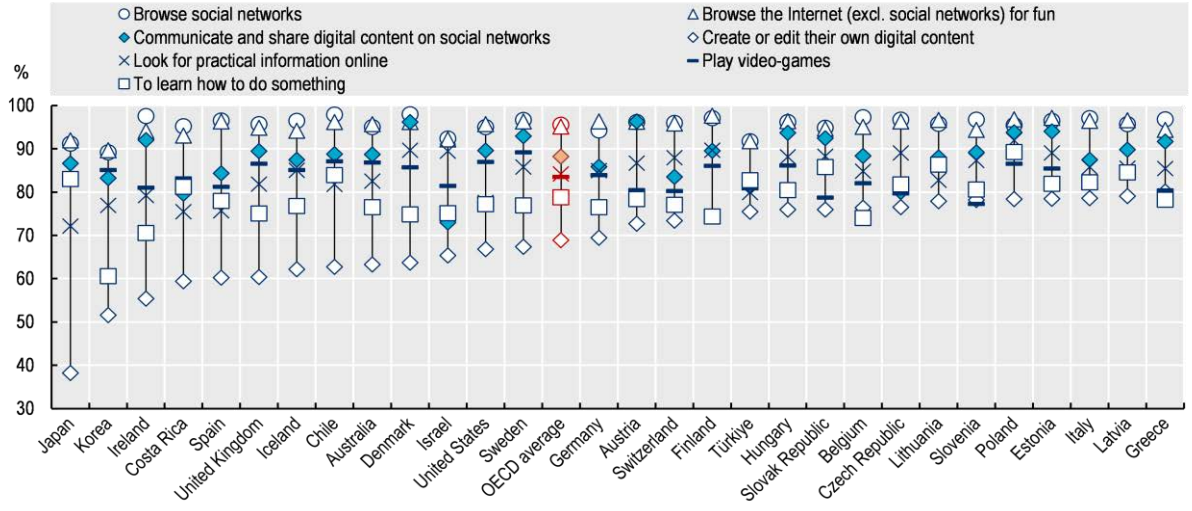
It is important to note that experts were asked about *new* drivers of poor mental health amongst young people. While new challenges have arisen, longstanding factors continue to influence young people's mental health including poverty and deprivation, adverse childhood experiences, exposure to violence, discrimination, stigma or conflict (McGorry et al., 2024[1]; Lund et al., 2018[2]; Kirkbride et al., 2024[3]; OECD, 2021[4]; OECD, 2021[5]).

Scientific evidence and experts do not give one clear picture of the mental health risks of digital devices and digital media

Young people – like the rest of the population – use digital technology for a large variety of reasons (Figure 2.3). Previous OECD work, and in particular *How's Life for Children in the Digital Age?* (OECD, 2025[6]), has explored the relationship between digital device use and well-being outcomes, and educational performance. This report found that that digital device use has both positive and negative impacts on children's well-being, educational outcomes, and mental health. On the positive side, moderate use of digital devices, particularly for educational purposes, can enhance learning and digital skills. However, the report also highlights that "excessive screen time", especially more than two hours per day of recreational use (e.g. social media or video streaming), is associated with lower life satisfaction and increased symptoms of anxiety and depression, and sleep disruptions. Indeed, when it comes to young people's mental health outcomes specifically, the type of digital media consumed or digital device used may matter, but existing scientific literature finds that effect sizes tend to be small and evidence is mixed.

Figure 2.3. Adolescents' digital device use for leisure activities

Percentage of 15-year-old students who report using digital devices during a typical week by type of leisure activity



Note: 15-year-old students were asked "[H]ow much time do you spend doing the following leisure activities?" for each "Browse social networks (e.g. <Instagram®>, <Facebook®>)", "Browse the Internet (excluding social networks) for fun (e.g. reading news, listening to podcasts and music or watching videos)", "Communicate and share digital content on social networks or any communication platform (e.g. <Facebook®>, <Instagram®>, <Twitter®>, emails, chat)", "Create or edit my own digital content (pictures, videos, music, computer programs)", "Look for practical information online (e.g. find a place, book a train ticket, buy a product)", "Play video games (using my smartphone, a gaming console or an online platform or Apps)" and "Read, listen to or view informational materials to learn how to do something (e.g. tutorial, podcast)". For each activity, students were asked to respond on their use during a typical weekday and during a typical weekend day. Data refer to the percent responding to use digital devices for a given activity on a typical weekday and/or on a typical weekend day.
Source: OECD Secretariat calculations based on the OECD Programme for International Student Assessment (PISA) 2022 Database. Originally published in OECD (2025[6]), *How's Life for Children in the Digital Age?* , https://doi.org/10.1787/0854b900-en.

The mental health and well-being impacts of amount of time young people (and their carers and wider entourage) spend on digital devices, and the type of activities they take part in and type of content they consume when using digital devices, has been a recurrent topic for policymakers, academics, clinicians, young people and their parents and carers, and the media in recent years. So far, evidence on the harms – or lack thereof – of "digitalisation" has been mixed (see Box 2.1. for a working definition of "digitalisation" and associated terminology).

Box 2.1. Key terminology – "digitalisation", "digital media" and "screens"

This report follows the definition included in the OECD Going Digital Toolkit, and considers that *"Digitalisation is the use of digital technologies and data as well as interconnection that results in new or changes to existing activities."* (Mitchell, 2021[7]).

Given the focus of this report, much of the discussion is on how young people interact with specific dimensions of digitalisation, and the following working definitions are adopted following recent OECD publications:

- "Digital technologies" are broadly defined to include networks (such as the Internet), hardware, software and technology-related services (OECD, 2023[8]);
- "Digital devices" are any hardware used to access, process, display, or transmit digital information (e.g. smartphones, tablets, computers, smart TVs);
- "Digital media" is content created, distributed and accessed through digital technologies (e.g. websites, streaming video, apps, games);
- Social media – social network sites and instant messengers, including content (image, video) sharing sites.

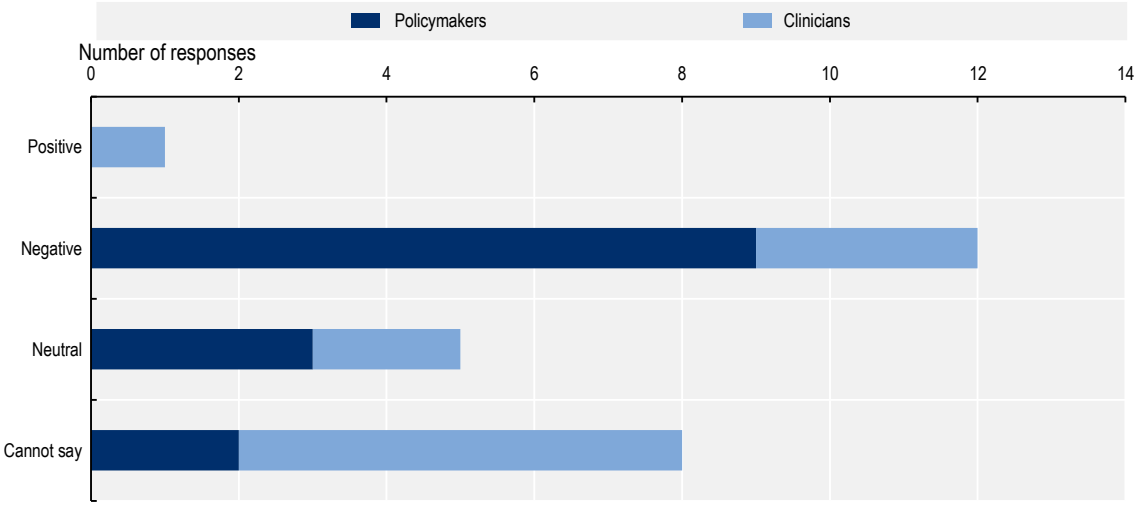
These terms were used to discuss general trends and patterns. Wherever possible, and wherever available evidence allowed, more specific terminology is used; however, exiting scientific literature is not consistent with use of terminology and also employs general terms such as "screen time" or "time online".

Source: Mitchell (2021[7]), "Digital supply-use tables: A step toward making digital transformation more visible in economic statistics", www.oecd.org/going-digital; OECD (2023[8]), *Shaping Digital Education: Enabling Factors for Quality, Equity and Efficiency*, https://doi.org/10.1787/bac4dc9f-en; OECD (2025[6]), *How's Life for Children in the Digital Age?*, https://doi.org/10.1787/0854b900-en.

When asked about the impacts of "digitalisation" on young people's mental health, the clinical and policy experts interviewed for this report consistently saw both positive and negative impacts, but for most the impacts tended towards being more negative (Figure 2.4). From the interviews undertaken, there was no single digital device or technology that was identified by experts as being particularly positive or negative; social media, (online) gaming, and accessing inappropriate content (for example violent or sexual content) were mentioned as being problematic for some young people. Clinicians in particular generally insisted that the impact of digital technologies varied significantly from individual-to-individual; for some young people online spaces including social media could be a valuable source of mental health information or community and peer-connection, while for others online activities (such as gaming, or social media scrolling) could harmfully disrupt other important activities such as sleep, schoolwork, or in-person socialising, and exposure to certain content (such as content on body image) could exacerbate some mental health conditions.

Figure 2.4. Expert clinicians and policymakers' saw mixed impacts of "digitalisation" on young people's mental health

Expert views expressed as part of semi-structured interviews



Note: Experts were asked "Do you believe that the impact of digitalisation, including social media, on young people's mental health is: 1) positive 2) negative 3) neutral 4) cannot say." The two preceding interview questions brought further context: Do you have any views on the impact of smart phones, internet, social media, and digitalisation generally on young people's mental health?; Do you have any views or concerns about one type of technology in particular? Are you concerned about the impacts on any sub-group of young people in particular?.
Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

Two areas of the impact of digital technology use which experts pointed to, which appear to be less-well covered in the current scientific evidence base were exposure to (mis)information on mental health in online spaces, and the "amplification effect" of digital media and technologies. Regarding information on mental health, some experts pointed to the benefits of discussion of mental health topics in online spaces including social media, which was see as contributing towards increased awareness and decreased stigmatisation. At the same time, several of the experts suggested that not all of the information on mental health that young people were consuming was accurate or helpful, and that it may contribute to over-pathologisation of "normal" human emotions and/or tendencies towards self-diagnoses. Research into "mental health content" on social media, especially on TikTok, has suggested that this can be a useful source of awareness and peer support, but also can lead to repetitive exposure to distressing content and misleading diagnosis and treatment information (Turuba et al., 2024[9]; Milton et al., 2023[10]; Pretorius, McCashin and Coyle, 2022[11]).

Nine experts also highlighted what they saw as the negative impact of information overload or "amplification" of negative content in online spaces (including news websites) and on social media (see Figure 2.2.). A clinician from central Europe noted, "*digital media amplifies everything; because humans are wired toward negative affect, the net effect is probably negative*," while two policymakers from another central European country stated, "*24/7 access to Internet media coverage, constantly informing about war, conflict, wars and so on. And they trigger an existential fear in children.* [Children] *just don't see the bright future*."

Multiple experts saw this "amplification" effect having a strong interplay with other global crises, such as climate change and global conflicts, with a cumulatively negative effect on young people's mental health, adding to a sense of hopelessness. The "amplification effect" highlighted by the interviewed experts tended to be more generalised in terms of the content (for example, distressing news and current events rather than graphic content), but research does point to the negative mental health impacts of exposure to

inappropriate or harmful content (such as unwanted sexual comments or material, coming across pornography and violent/gruesome material) in online spaces including social media (Mars et al., 2020[12]; Sumner et al., 2021[13]). Platform-specific studies show that apps featuring heavily curated or algorithm-amplified content (Instagram, TikTok, YouTube) are associated with more negative mental-health outcomes (Metzler and Garcia, 2023[14]).

The scientific evidence on use of digital technologies and digital media consumption and mental health outcomes for young people is extensive, and shows small negative outcomes for some patterns of use, but is limited by its reliance on correlational findings and self-reported measures prone to recall bias (Baird et al., 2025[15]; WHO Europe, 2025[16]; OECD, 2024[17]). It is also generally difficult to establish directionality between digitalisation and youth mental health; in particular, whether higher rates of digital technology use contribute to poorer mental health outcomes (with anxiety and depression the most commonly measured outcomes), or whether young people with poorer mental health use digital technologies more.

Baird et al. and Mansfield et al., both in the Lancet Child and Adolescent Commissions, underscore the complexities involved in distinguishing causality due to the multidimensional nature of both digital engagement and mental health outcomes (Baird et al., 2025[15]; Mansfield et al., 2025[18]). Considerable heterogeneity in findings across studies are evident that reflect the differences in methodologies, measures of digital exposure, and mental health assessments. The National Academies of Sciences, Engineering, and Medicine (2023) conducted a comprehensive review and concluded that, while there is growing concern, the existing evidence base is not yet sufficient to support categorical claims about a net harm (Galea, Buckley and Wojtowicz, 2024[19]). Vuorre and Przybylski (2024[20]), using large-scale longitudinal datasets from the United Kingdom, found no meaningful associations between digital engagement and adolescent mental health, even after testing hundreds of model specifications. Their work adds weight to the argument that previously observed associations may be overstated due to analytical flexibility and publication bias (Vuorre and Przybylski, 2024[20]).

At the same time, research suggests that digital communities can play a valuable supportive role. Studies show that young people with mental health conditions often build meaningful relationships online, where anonymity lowers barriers to connection (Batterham and Calear, 2017[21]; Gowen et al., 2012[22]). Peer-to-peer networks provide emotional support, practical advice, and a sense of belonging, helping reduce loneliness and encouraging help-seeking (Naslund et al., 2017[23]; Berry et al., 2017[24]). Digital interventions that combine peer support with clinical oversight have been shown to increase engagement in services, improve symptom management, and enhance recovery outcomes (Alvarez-Jimenez et al., 2019[25]; Gleeson et al., 2017[26]).

Nonetheless, despite methodological challenges and limitations, the existing academic evidence base suggests that for young people: there is a robust link between digital technology use and poorer sleep, with poor sleep a risk factor for poor mental health; there is some association between more time spent on digital technologies and poorer mental health outcomes, especially in cases of “excessive” use; that there may be some negative mental health impacts associated with social media use, but this relationship may well depend on individual user characteristics, and patterns of use. Most of the existing evidence base on digital technology use and mental health outcomes looks at older adolescents and young adults.

Digital technology use, especially before bed, is disruptive to children and adolescents’ sleep

The strongest evidence on the impact of digital technology use on child and adolescent well-being outcomes is on sleep amongst children and adolescents, and both the amount of digital technology use during the day and the timing of use (e.g. close to bedtime, during sleeping hours) appear to matter. Higher digital technology use – or, as much of the literature refers to, “screen use” – is associated with delayed sleep onset and poorer sleep quality regardless of when during the day the screen time happens (Hysing et al., 2015[27]; Lissak, 2018[28]; Carter et al., 2016[29]; Pagano, Bacaro and Crocetti, 2023[30]; Paulich et al.,

2021[31]). These findings extend to both very young and older children; children aged 6-36 months who frequently used touchscreens slept on average 15 minutes less per night and took longer to fall asleep (Cheung et al., 2017[32]), while 12-13 year-olds with devices in the bedroom reported significantly shorter sleep and more fatigue one year later (Falbe et al., 2015[33]). Multiple studies have found that when adolescents use screens in the two hours before bed they have more disturbed sleep (Yu et al., 2024[34]; Hartley et al., 2022[35]; Pagano, Bacaro and Crocetti, 2023[30]). A large-scale school-based survey of over 2 500 French adolescents aged 12-19 found that using screens for more than two hours in the evening doubled the odds of sleep deprivation, while night-time use increased the risk more than fivefold; both patterns were also linked to daytime fatigue, irritability, and poor academic concentration (Hartley et al., 2022[35]). Two studies from the United States (Burnell et al., 2024[36]) and from Scotland (Woods and Scott, 2016[37]) found that night-time digital media device use (e.g. checking feeds in bed, being woken by alerts) was a stronger predictor of poor sleep than overall daily use. Mechanisms for the disruption of sleep by screen use include the stimulating content of media (Cheung et al., 2017[32]), the displacement of physical activity and rest (Chahal et al., 2012[38]), and suppression of melatonin from evening exposure to bright LED screens, which disrupts circadian rhythms (Cajochen et al., 2011[39]; Figueiro and Overington, 2016[40]).

Intervention evidence is equally strong. In Switzerland, restricting screen use after 9 p.m. advanced sleep onset and increased total sleep duration, leading to measurable improvements in vigilance during the school day (Perrault et al., 2019[41]). U.S. nationally representative data on 16-19 year-olds showed that meeting the screen time guideline (≤2 hours daily) was associated with 55% lower odds of poor sleep quality, with especially strong protective effects among boys who also engaged in regular physical activity (Xu et al., 2019[42]).

These disruptions in physical activity and sleep have downstream effects on mental health. There is a direct relationship between sleep deficits and mood and cognitive problems (Barnett, 2008[43]); consistent evidence shows that in adolescents, reduced sleep duration or quality are associated with higher rates of mood, anxiety, substance use and behavioural disorders (Zhang et al., 2017[44]; Woodfield, Butler and Tsappis, 2024[45]; Qiu and Morales-Muñoz, 2022[46]). Short et al. (2020[47]) found that sleep loss related to evening screen use impairs mood regulation, increases emotional reactivity, and contributes to the onset of depressive symptoms in adolescents.

More time spent on digital devices is slightly associated with poorer mental health outcomes for adolescents

A significant amount of research has been done on amount of time spent on the impact of time spent on digital technologies – often referred to as “screen time” – on mental health and well-being outcomes, as well as on other important outcomes such as attention and educational performance. Much of this research has already been well-covered in recent OECD work (OECD, 2025[6]; OECD, 2024[17]; OECD, 2024[48]), especially the fact that some well-being benefits can be found at the lower end of screen time use and some negative outcomes found at the upper end of screen-time, so-called “excessive use”. This so-called “Goldilocks hypothesis” was first developed by Oxford University researcher Andrew Przybylski and colleagues (Przybylski and Weinstein, 2017[49]; Orben and Przybylski, 2019[50]).

Most recent evidence, both that summarised in systematic and meta reviews and that drawn from new cohort studies or national surveys, appears to confirm that there is a small relationship between higher amounts of screen use and symptoms of mental health conditions and/or poorer overall mental health status, primarily focussing on adolescents. These studies showed a correlational relationship, and were not able to prove causation. For example, a 2023 systematic review again found associations between “excessive screen time” in adolescents and mental health problems; only 12 of the 50 studies reviewed found no effects of screen exposure on adolescent mental health, and the authors stressed that the type of screen (i.e. mobile phone, computer, television) mattered for mental health outcomes making assessments of overall “screen time” less useful (Santos et al., 2023[51]).

Analysis of cohort data from the Adolescent Brain Cognitive Development (ABCD) Study of nearly 10 000 children age 9 and 10 in the United States also found small associations between "screen time" and depressive symptoms, including for screen use for video chat, texting, watching or streaming videos, and playing video games (Nagata et al., 2024[52]). The associations remained even after adjustments for sleep and physical activity, and effects were seen for each hour of screen time (ibid). Paulich et al. (2021[31]) also looking at the ABCD study found that more screentime is moderately associated with worse mental health, but that socio-economic status was found to be a more significant predictor of poorer mental health. Findings from a birth cohort study of 18-year-olds in the United Kingdom found associations between high levels of internet use with depression for females, and with increased risk of self-harm from males, but no association with risk of anxiety (Mars et al., 2020[12]).

A 2022 study amongst Canadian youths age 15-24 using the Canadian Community Health Survey (CCHS) found that anxiety, suicidal ideation, and mood disorder rose with screen time; those with "low" screen had better mental health outcomes than those with "average" screen time, who had better mental health outcomes than those with "high" screen time (Atwal and Browne, 2022[53]). Low socio-economic status was also strongly correlated with poorer mental health outcomes, and higher levels of screen time. Another Canadian study, this time from the COMPASS study of 17 000 adolescents aged 14-18 further showed that high baseline use of screens predicted poorer mental health one year later. Heavy phone use was linked to a 46% higher risk of depressive symptoms and a 57% higher risk of anxiety, while television viewing of three or more hours daily increased risks of depression by 23% and anxiety by 25%, particularly among girls. Video game use showed a 35% higher risk of depression in boys, while internet and messaging use also predicted elevated risks, with messaging tied to a 22% increase in depressive symptoms (Mougharbel et al., 2023[54]). A large-scale Canadian survey data confirm these associations, showing that adolescents with heavy daily screen use report markedly higher levels of depression and anxiety compared to peers with moderate or low use (Baiden, Tadeo and Peters, 2019[55]).

Some studies have gone further to link excessive or "addictive" use to more severe outcomes. Xiao et al. (2025[56]) analysed patterns of compulsive digital use in a US sample of early adolescents and found that youth with high and increasing addictive use of social media, mobile phones, or video games were significantly more likely to experience suicidal ideation and elevated internalizing and externalizing symptoms, despite no strong association with total screen time at baseline. For a wider discussion of the potential relationship between digital technology use and time spent online and suicide risks, see Box 2.2.

Two recent studies have found that reducing screen- or internet-use is associated with better mental health. In a randomised controlled trial in Denmark, families assigned to a two-week screen reduction intervention (≤3 hours/week of leisure screen use) showed notable improvements in internalizing symptoms and overall behavioural health in children aged 6-16 (Schmidt-Persson et al., 2024[57]). Similarly, a randomised controlled trial study found that short-term abstention from digital leisure activities led to modest improvements in mood and stress among adolescents, but these effects were not consistent across all participants (Pieh et al., 2025[58]).

One very recent global analysis on digital technology use and harms on mental health from UNICEF, based on cross-national survey data from over 250 000 children aged 9-17 across 40 countries from EU Kids Online 2019 data, found no consistent or strong association between overall screen time and mental health outcomes, such as depression, anxiety, or self-harm (UNICEF, 2025[59]). While adolescents who spent more time online tended to report higher exposure to risks, time spent itself was only weakly linked with well-being when risk exposure was controlled for. The most robust predictors of poor mental health were experiences of online bullying, sexual harm, and discriminatory content. Children who reported exposure to sexual threats or harassment online were significantly more likely to experience emotional distress, sleep difficulties, and depressive symptoms. The report also notes that for many young people especially those with limited offline social support digital platforms serve as sources of friendship, identity exploration, and mental health information, contributing positively to well-being.

Box 2.2. "Online harm" – do online spaces increase the risk of self-harm and suicidal behaviour?

The possible impact of online behaviours on self-harming behaviours and suicidality amongst young people has been raised as a concern and has been a topic of media coverage in multiple OECD countries. While at the population-level there has not been a marked rise in youth suicides, there have been notable rises in hospitalisation for self-harm amongst young girls in some OECD countries (see Chapter 1, Figure 1.8). It has been hypothesised that time spent online can increase the risk of self-harming and suicidal behaviour, with two possible pathways: that online behaviours can reduce overall mental health making self-harming more likely; and/or that content online can "encourage" and/or provide practical "ideas" for self-harming or suicidal means.

Some of the scientific literature does suggest some link between greater social media use for girls and higher odds of self-harming (without controlling for type of content), and that certain online content and settings can normalise or even encourage self-harming behaviour which can act as accelerants for suicidal behaviour (Marchant et al., 2017[60]; Balt et al., 2023[61]; Rodway et al., 2022[62]). Exposure to a range of online "harms", including cyberbullying, violence, sexual content, depression, and low-severity self-harm content has been found to increase odds of a suicide or self-harm activity (Sumner et al., 2021[13]). As with other mental health harms associated with digital technology use, individual, social and systemic factors influence vulnerability to such content (Thorn et al., 2023[63]). A qualitative study published in the Journal of Medical Internet Research highlights the importance of co-designing safety features with young people to ensure they are both effective and acceptable (Meyerhoff et al., 2025[64]).

Among digital media, social media use is most often linked to poorer mental health outcomes, though effects are typically small and inconsistent

Social media is likely the digital media type that has been most-examined for its impact on young people's mental health. Based on a keyword search on PubMed alone, 2 469 results on social media, mental health, and youth were found from the last decade, compared to 584 for video gaming, 218 for television, 115 for online gambling, 49 for online news, 33 for online pornography, and 30 for (video) streaming.[1] At the same time, where studies distinguish between different types of activities on digital devices, social media use does appears to be most consistently correlated with poorer mental health outcomes. For example, among UK adolescents aged 13-15, heavy use of social media and the internet was strongly linked to poorer mental health, especially depressive symptoms, self-harm, low self-esteem, and low life satisfaction, with girls showing significantly stronger associations than boys. In contrast, time spent on gaming or watching TV showed weaker or no consistent links to mental health problems, highlighting that different types of screen time have different psychological impacts (Twenge and Farley, 2020[65]). Amongst adolescents in Iceland, more time spent on social media was weakly but significantly associated with increased symptoms of depressed mood, social anxiety and symptoms of physical anxiety over time. The relationship was stronger for girls than boys. It was not clear, though, whether the relationship was causal, or the direction of the relationship (Thorisdottir et al., 2020[66]). A study of preadolescent youth in Australia found that users of YouTube, Instagram and Snapchat reported more body image concerns and eating problems than non-users, but did not show differences in terms of depressive symptoms or social anxiety (Fardouly et al., 2020[67]). Evidence does not universally draw the same conclusion. A 2025 meta-analysis of 46 studies concludes that current research does not support claims linking social media use to internalizing mental health disorders such as anxiety and depression in youth, pointing to methodological weaknesses in existing studies and recommending caution when attributing mental health issues to social media usage (Ferguson et al., 2025[68]). For example, a Norwegian cohort study of children age from 10-16 years, found

that changes in social media use was not related to changes in depression and anxiety symptoms (Steinsbekk, Nesi and Wichstrøm, 2023[69]).

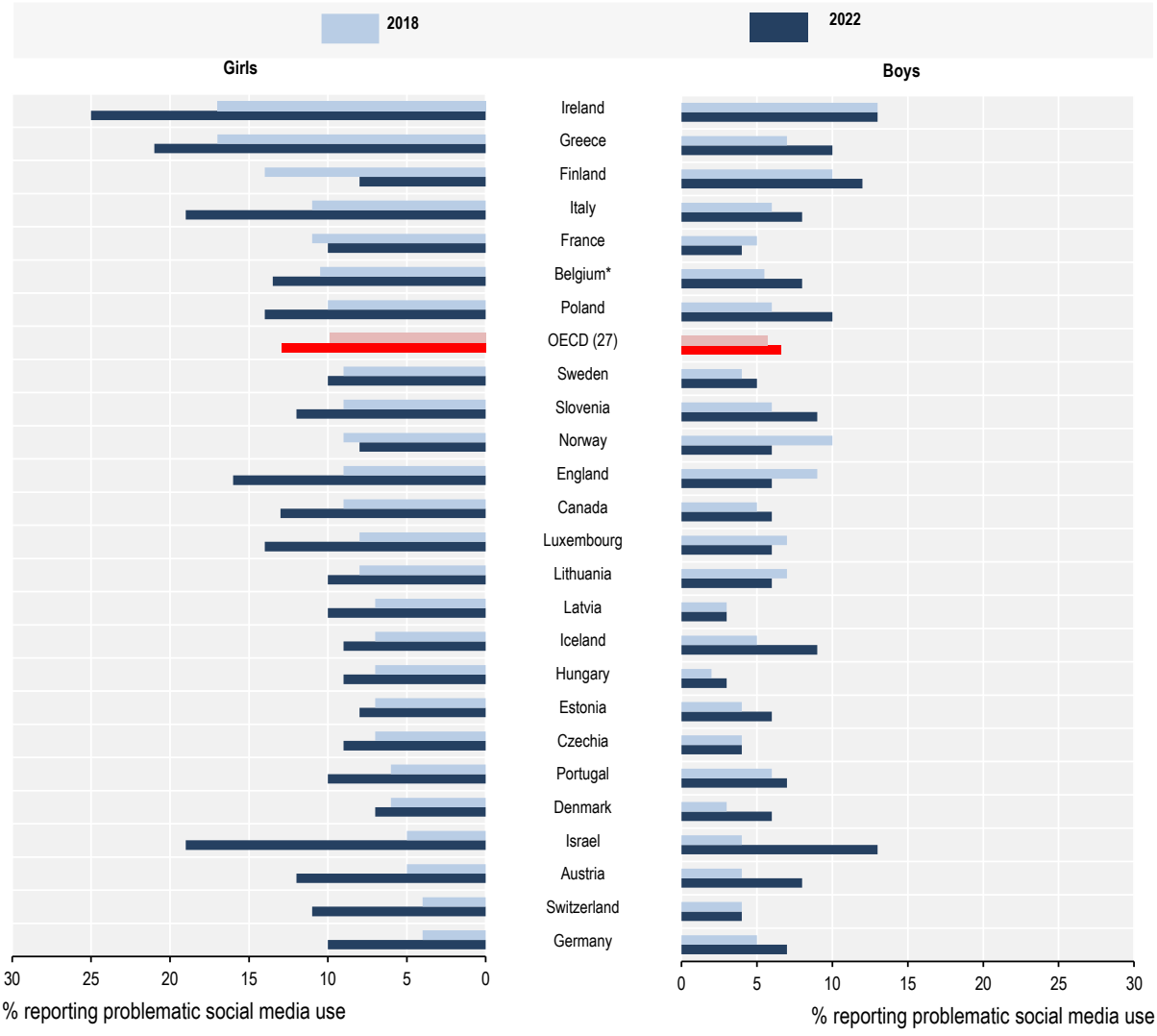
The type of engagement with social media may matter. Thorisdottir et al. (2019[70]) found that passive social media use, such as browsing without interaction, was linked to higher levels of anxiety and depressed mood. Active use, like posting or messaging, showed weaker associations, and its benefits disappeared once factors such as self-esteem and peer support were considered. Course-Choi and Hammond (2021[71]), in a review of 14 longitudinal studies, reported that passive social media use (scrolling, browsing) was consistently associated with increases in depressive symptoms of around 10-15% over 12 months, whereas active use (posting, messaging, commenting) showed no protective effect and in some studies tracked with later rises in distress. Other studies in the review found that daily social media use exceeding 3 hours predicted up to a 20% higher risk of body dissatisfaction and a 15% greater likelihood of desiring cosmetic surgery at follow-up. While a scoping review of 79 studies examining the relationship between social media use and mental health among adolescents found that most research focusses on negative outcomes such as depression, with limited attention to positive effects, the review also highlighted the need for more nuanced investigations into different types of social media interactions and their varied impacts on adolescent well-being (Schønning et al., 2020[72]).

Most of the research on the impact of "social media" use has not systematically distinguished between different platforms. Woodward et al. (2025[73]), who did examine mental health outcomes for 575 young adults based on self-reported time spent on X (formerly Twitter), TikTok, YouTube, Instagram, Reddit, Snapchat and Facebook found that greater use of TikTok and YouTube were consistently associated with more mental health issues (disordered eating, self-harm, suicidal thoughts, depression), while of Snapchat was associated with fewer mental health issues. A study assessing the use of four social networking platforms – LINE, Facebook, Twitter (now X) and Instagram – and their relationships with mental health amongst individuals aged 18-39 in Japan found that the frequent use of LINE, Facebook and Instagram was associated with positive mental health outcomes (with variations by age group), whereas the frequent use of Twitter was associated with distressed symptoms or feelings of loneliness across all age groups (Sakurai et al., 2021[74]). A small number of studies have looked at certain platforms specifically, but do not appear to find any one particular platform harmful or positive for youth mental health. For example, a systematic review on the relationship between TikTok and mental health in adolescents found that while TikTok can foster creativity and connection among teens, reviewed research highlights risks like reduced life satisfaction, psychiatric symptom contagion, and problematic use, even as study results vary widely (Conte et al., 2024[75]). Another systematic review is more negative in its conclusions, suggesting that frequent use of TikTok was closely linked with an increase in symptoms of anxiety and depression, especially in users aged under 24 years (Jain et al., 2025[76]). Adeyanju et al. (2021[77]) reviewed peer-reviewed journal articles looking at Instagram use and depressive symptoms, which they found mostly looked at young Instagram users age 19 to 35, and concluded that "there is a strong relationship between Instagram use and mental health disorders such as depression or depressive behaviour; however, no in-depth direct causality is proven yet." A review by Faelens et al. (2021[78]) found that most evidence could be found for the relationship between Instagram use and social comparison, body image, and disordered eating outcomes, but that evidence of a relationship between Instagram and other mental health variables is inconclusive.

Beyond looking at broad patterns of social media use and its impact on mental health outcomes, addictive-like social media use appears to have been rising, especially amongst girls (Figure 2.5). Young people with Problematic Social Media Use (PSMU) have been found to also be at higher risk of depression or anxious symptoms (Bányai et al., 2017[79]; Lopes et al., 2022[80]; Shannon et al., 2022[81]); PSMU is not currently considered to be a clinical condition, and is not included in either the DSM-5 or ICD-11.

Figure 2.5. Problematic Social Media Use amongst 15-year-old boys and girls, 2018 and 2022

Based on a nine-item measure, with six or more positive responses categorised as problematic users



Note: Problematic use is defined as answering "yes" to six or more of nine symptoms on the Social Media Disorder Scale. The OECD (27) average is unweighted. *Belgium is the average of its Flemish and French communities.
Source: HBSC (2023[82]), Health Behaviour in School-aged Children study – Data browser (findings from the 2021/22 international HBSC survey), https://data-browser.hbsc.org/.

Mental health risks of digital technology are moderated by family support, socio-economic conditions, and lifestyle patterns, and benefits should not be overlooked

Despite growing evidence on the potential mental health risks of digital media use, the current literature base is characterised by important limitations. Methodological weaknesses constrain the strength of inferences. Many studies do not distinguish between types of engagement (e.g. social media, gaming, messaging), nor do they account for contextual or individual factors that may moderate outcomes. Furthermore, observed effect sizes are often small, with practical significance debated. The field also faces challenges in isolating digital media as a causal factor, due to multicausality and the high likelihood of bidirectional associations between mental health and digital behaviours.

Most studies also do not take into account the impact of broader individual, social and structural factors on young people's mental health outcomes from digital technology use; when they do, determinants such as higher socio-economic status, stronger educational engagement, or family and social support are moderating factors on harms (Mansfield et al., 2025[18]; Sala, Porcaro and Gómez, 2024[83]; Ledel, Låftman and Landberg, 2025[84]; Lahti et al., 2024[85]). Kandola et al. (2022[86]) highlight in a longitudinal cohort study showing that associations between screen time and mental health are heavily mediated by sleep and physical activity. Their findings suggest that sedentary lifestyle factors may be stronger predictors of distress than screen use per se, highlighting the importance of lifestyle context in interpreting screen time data.

The discussion in this report has primarily focussed on the relationship between digital media use and young people's mental health, which tends towards finding small but negative effects, as part of exploring possible explanations for an apparent declining trend in young people's mental health status. Nonetheless, it is important to recognise that young people's digital engagement can support mental health, for example by widening social connection, identity exploration, and day-to-day emotional support. The OECD's How's Life for Children in the Digital Age? (OECD, 2025[6]) underscores that online spaces let teens "stay connected with friends and families" and build communities. Similarly, the OECD's Digital Economy Outlook 2024 spotlight on "Mental health and digital environments" (OECD, 2024[17]) notes that online communication "offers many benefits for mental health and well-being," while also acknowledging some of the risks associated with extensive use. Odgers and Jensen (2020[87]) argue that the dominant narrative of digital harm overlooks a more complex and often contradictory evidence base, that most young people engage with digital technologies in ordinary ways that do not lead to harm, and for particularly marginalised or isolated youth online platforms may provide crucial access to peer support and mental health information. OECD has previously emphasised moving beyond blunt screen-time limits toward improving the quality of engagement, digital skills, and supportive offline environments (family, school, peers), and it outlines a four-pillar policy approach that includes education systems, parents/caregivers, and incorporating children's voices (OECD, 2025[6]), and policies that foster benefits while mitigating risks – especially for groups at higher risk – rather than assuming uniform harms or benefits (OECD, 2024[17]). The specific mental-health benefits of digital technologies should also not be overlooked, including access to internet-based therapies, and potential for the use of new technologies including artificial intelligence, and immersive technologies such as virtual reality, as new therapeutic opportunities so long as the right safeguards are in place (Lehtimaki et al., 2021[88]; Dülsen and Baumeister, 2024[89]; Ma et al., 2024[90]; OECD, 2024[17]).

Climate change and increased global conflicts are seen by experts as mental health risks, amplified by the contemporary information environment

Compared to digitalisation, screen use and social media use, the effect of climate change and the indirect impacts of global conflicts on youth mental health have been relatively under-explored in the academic literature. These were, however, seen as part of a package of "global threats" that experts saw as negatively affecting young people's mental health status (see Figure 2.2).

In their interviews to inform this report, clinical and policy experts rarely singled out climate change or global conflict as single drivers of mental distress amongst young people, but rather stressed that they saw a cumulative effect of these perceived threats affecting young people's mental well-being. Experts saw these global events as mental health risk factors even when young people were not directly affected by them (for example, young people in these experts' constituencies were usually not directly exposed to conflict, extreme climate events, or displacement caused by conflict or climate events). Quotes taken from these interviews give an impression of how experts perceive this broad mental health risk factor:

- "The broader climate of hopelessness about the future and the constant sense of disasters—such as the climate crisis, genocides, and wars—make it difficult for them to project themselves into a secure future." Policy Maker from Southern Europe;
- "Young people are so, so aware of horrifying things happening throughout the globe… and… feel helpless and hopeless in their capacity to have impact." Clinician from North America;
- "We have the socioeconomic crisis... we have the global climate change discussion, and we have the new situation for this generation... of wars in the neighbourhood... Wars are a burden for mental health of young people because they have the anxiety that war will come to Europe, this wasn't an issue for the last 20 years... [For young people who are not directly exposed] It's completely different to Ukrainian children, who experience traumatic and post traumatic disorders." Clinician from Northern Europe.

Available academic evidence confirms that the global climate crisis appears to be affecting young people's mental health and well-being even when they are not experiencing direct material impacts. A large global survey of 10 000 young people aged 16-25 across ten countries, found that 59% were "very" or "extremely" worried about climate change, with more than 50% reporting feeling sad, anxious, angry, powerless, helpless and guilty, 75% describing the future as "frightening", and 45% reporting that climate-related worry negatively affected their daily life and functioning (Hickman et al., 2021[91]). Feelings of betrayal and abandonment were common, with more than half of respondents believing that governments were failing to protect them and future generations (ibid). Two surveys from Australia found that young adults aged 18-24 exhibited significantly elevated levels of eco-anxiety and PTSD symptoms in response to real or anticipated climate threats (Gunasiri et al., 2022[92]), and that 13% of Australian adolescents experienced persistent worry about climate change, which was strongly associated with depression (Sciberras and Fernando, 2021[93]). Evidence from a survey across 12 OECD countries indicates that young people aged 18-24 are more likely to be emotionally affected by climate change, reporting higher levels of fear, anxiety, guilt, shame, and depression compared with individuals aged 65 and over (OECD, 2023[94]). The same data reports that more than 30% of young people feel helpless and powerless in face of climate change. The sense of helplessness and hopelessness highlighted by the experts and the research evidence, may reflect a limited perceived agency – which may partly explain why global challenges that do not directly affect young people can nonetheless significantly harm their mental well-being.

Children, adolescents and young people living in conflict zones or who have fled conflict zones are at consistently greater risk of mental health problems, including PTSD and depression, than usual averages (Ferrara et al., 2025[95]; Amsalem et al., 2025[96]). War and conflict have also been shown to affect the mental health of populations in countries not directly engaged (Kalaitzaki et al., 2024[97]; Kaman et al., 2025[98]). Looking at the impact of the war in Ukraine on 11 countries (across all ages), including bordering countries (Romania and Poland) and (distal countries, including Greece, Italy, Ecuador and Peru), with populations in bordering countries having a higher change of poorer mental health outcomes including anxiety, depression and perceived stress. Ukrainians reported unequivocally poorer mental health, on all measures, compared to other populations. A study of German adolescents found that war-related distress was a predictor of anxiety (Lass-Hennemann et al., 2023[99]), while a study of Dutch adolescents and young adults (age 13-25 years) found that greater war-related media exposure predicted stress symptoms (Runze, Marten and Brinke, 2022[100]).

Risk factors including socio-economic status and economic opportunity are not new, but may be growing, and interact with vulnerability to other risk factors

Socio-economic status is a well-established determinant of mental health status (OECD, 2021[4]; Vargas Lopes and Llena-Nozal, 2025[101]; OECD, 2021[102]; OECD, 2023[94]); economic hardship and deprivation in childhood and adolescents contribute to poorer mental health outcomes across the life course (McGorry et al., 2025[103]; Reiss, 2013[104]).

Children and adolescents growing up in poverty, or experiencing financial stress such as unstable housing, food insecurity, or unmet basic needs, face a significantly higher risk of developing depression, anxiety, and behavioural problems (Edmunds and Alcaraz, 2021[105]; Gautam et al., 2024[106]; Bøe et al., 2017[107]; Golberstein, Gonzales and Meara, 2019[108]). As young people move into adolescence, their own perceptions of material deprivation, and financial stress are stronger predictors of depression/anxiety and behaviour problems (Miller et al., 2024[109]). Beyond individual hardship and family finances, macroeconomic conditions also play a role. The link between macroeconomic crises and population mental health – including suicide rates – has been well-covered (Karasoy, 2024[110]; van Gool and Pearson, 2014[111]; Huikari and Korhonen, 2020[112]), and youth mental health has been shown to deteriorate during periods of increasing cost of living, and higher unemployment or recession, and periods of family financial hardship (Bartelink et al., 2019[113]; Lager and Bremberg, 2009[114]; Klanšček et al., 2014[115]). In Sweden, a 20-year analysis of more than 17 000 adolescents aged 15-16 found that adolescents' own worry about family finances was strongly associated with poorer mental health. These effects were most pronounced during the mid-1990s recession, when worries about family finances peaked and accounted for much of the observed increase in adolescent psychosomatic symptoms (Kim and Hagquist, 2017[116]). The financial crisis in Greece also significantly affected youth mental health, with increased rates of depression and anxiety linked to economic hardship and parental unemployment, with adolescents experiencing worse mental health outcomes during periods of high parental unemployment (2011-2013) compared to later years (Kolaitis and Giannakopoulos, 2015[117]; Drydakis, 2022[118]).

Lower socio-economic status also leaves young people more exposed to other drivers of poor mental health, including the impacts of the COVID-19 crisis, and the impact of digital devices or social media. During the COVID-19 pandemic, nationally representative survey data from almost 55 000 adolescents in Korea showed that perceived family economic hardship was strongly associated with worse mental health outcomes; adolescents reporting severe hardship had more than twice the odds of anxiety, depressive symptoms and suicidal ideation compared to peers without hardship, with effects most pronounced in low- and middle-income families (Kim et al., 2022[119]). In a review of young adults' time spent on different social media platforms, socio-economic status was found to be a mediating influence on mental health (Woodward et al., 2025[73]). OECD (2025[6]) found that children from disadvantaged socio-economic backgrounds are more likely to experience negative mental health outcomes associated with digital media use, partly due to limited parental mediation, lower digital literacy, and greater exposure to online risks.

In many high-income countries, young people increasingly perceive themselves as economically worse off than their parents, reversing the postwar norm of steady upward mobility. Comparative surveys show that in the United States, the United Kingdom, and several European countries, fewer than half of young adults now expect to achieve the same standard of living as their parents, compared to majorities who did so a generation ago (Chetty et al., 2017[120]; OECD, 2018[121]). This decline in intergenerational mobility has been directly tied to mental health outcomes. A systematic review and meta-analysis of 21 studies covering 157 763 participants across North America, Europe, Asia and South America found that downwardly mobile youth reported significantly higher rates of depression and anxiety than peers from stable high socio-economic backgrounds (Islam and Jaffee, 2024[122]).

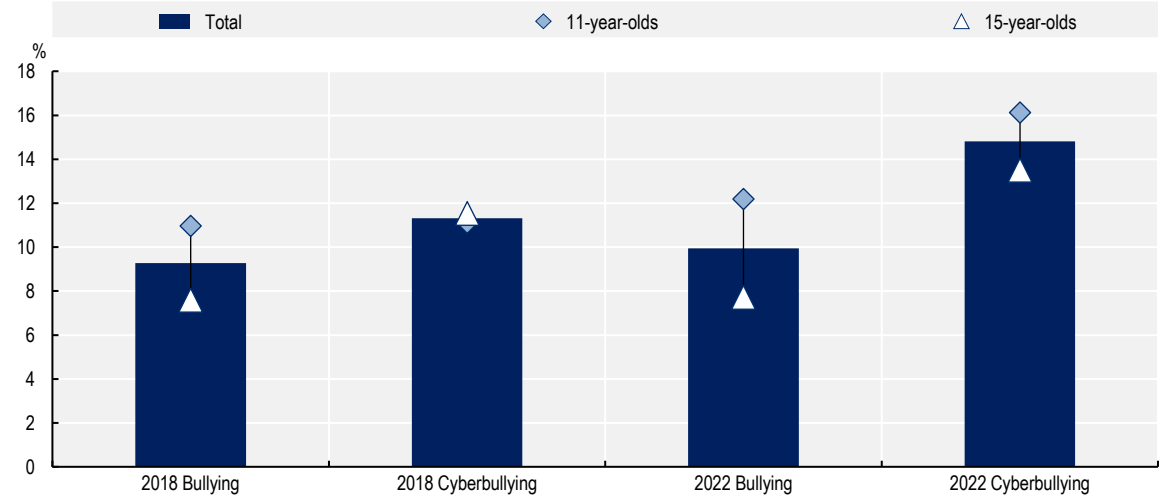
Experts interviewed for this report did not overall point to socio-economic status or other economic factors most frequently as a driver of poor youth mental health (see Figure 2.2.), but several experts did point to economic, employment, and housing insecurity as primary concerns. Policymakers from the Asia Pacific said, "*Top drivers young people name now: climate anxiety, economic uncertainty, housing and lately cost of living*." A policymaker from Southern Europe, similarly, stated, "*Surveys and both quantitative and qualitative studies carried out with this population show that lack of access to housing and precarious employment are the two factors with the strongest impact on the psychological distress of young people in my country.*" This assessment is consistent with broader evidence highlighting growing economic pressures on well-being (OECD, 2024[123]).

Bullying, cyberbullying, schools and academic pressure can all worsen children and adolescent's mental health

Bullying and cyberbullying are pointed to by the scientific literature, and by some experts, as risk factors for poor youth mental health, and possible drivers of worsening youth mental health. Frequent victims of bullying in childhood are more than three times as likely to develop depression and suicidal ideation in adolescence or early adulthood (Moore et al., 2017[124]). Man et al. (2022[125]), analysing data from 167 286 adolescents across 65 countries, found that verbal and psychological bullying including online harassment had the largest negative effects on mental health. The severity of harm increased sharply for those bullied more than 20 days per month, reflecting the toxic effects of chronic exposure. Cyberbullying introduces distinct and compounding mental health risks; cyberbullying can occur at any time, extend beyond school hours, and is often anonymous making it harder for victims to escape or seek timely support. Lee et al. (2026[126]) found that adolescents exposed to cyberbullying had significantly higher odds of self-harm and suicidal thoughts. Girls were especially vulnerable, with gender-stratified analyses revealing stronger associations between cyber-victimisation and emotional symptoms among female adolescents. Data from the HBSC surveys show that adolescents' reporting having been victims of cyberbullying increased between 2018 and 2022 (Figure 2.6), especially amongst younger adolescents. Over the same period, bullying victimisation also rose, though to a lesser extent.

Figure 2.6. Cyberbullying and bullying have both increased in recent years, especially amongst younger adolescents

Adolescents who have been cyberbullied or bullied at school at least once or twice in the past couple of months, average across OECD countries



Source: HBSC (2023[82]), Health Behaviour in School-aged Children study – Data browser (findings from the 2021/22 international HBSC survey), https://data-browser.hbsc.org/

The school environment, increased academic pressure, or less clear academic expectations of children and adolescents were also highlighted as mental health risk factors by policy and clinical experts. One policymaker from a Nordic country said, "[in school] *it has become much more difficult for children to know what is expected of them*," while a clinician from a Southern European country said, "[schools] *are outdated*… [they are not] *fostering coexistence, desire, and critical thinking."* Reflecting on pressures on young people more broadly, a policymaker from a Central European country said, "*there's growing*

pressure to perform and to 'self-optimise' in order to adapt to a faster tempo of life, high expectations, and constant social comparison. Young people feel it, and social media makes the comparison immediate."

The academic literature suggests that school and academic pressure can be a risk for young people's mental health, and may be growing. A 2023 systematic review found that 92% of studies identified a positive link between academic pressure and mental health problems, including anxiety, depression, and psychosomatic symptoms (Steare et al., 2023[127]). The impacts of academic stress appear to start early in childhood. In children aged between 5-12, a meta-analysis covering on 76 studies 20 years of data and over 50 000 participants showed that higher test anxiety was strongly associated with depressive symptoms and lower academic self-concept (Robson et al., 2023[128]). A number of studies suggest a link between rising academic stress and pressure, and rising mental distress amongst adolescents. In Norway, longitudinal survey data of upper secondary students (ages 16-19) between 2006 and 2019 showed that the proportion of adolescents reporting high psychological distress increased by approximately 30 p.p. among girls (from around one-third to over one-half) and by about 10-15 p.p. among boys (from roughly 10-15% to around one-quarter), with school-related stress identified as a key explanatory factor, particularly among girls (Haugan, Frostad and Mjaavatn, 2021[129]). In Sweden, repeated cohort surveys of more than 20 000 adolescents between 1988 and 2011 showed that rising self-reported school stress statistically accounted for the long-term increase in psychosomatic complaints (Högberg, Strandh and Hagquist, 2020[130]). Analysis of nearly 1 million 11-, 13- and 15-year-olds across 36 countries and regions in Europe and North America from the HBSC surveys (2002-2018) showed that the share of 15-year-olds reporting schoolwork pressure increased from about 39% in 2002 to 54% in 2018. This rise was sharper among girls (45% to 63%) than boys (32% to 43%), widening the gender gap (Cosma et al., 2020[131]). Perceived pressure from schoolwork intensified further between 2018 and 2022. In the 2021/22 survey, 63% of 15-year-old girls and 43% of boys reported feeling pressured by schoolwork, up from 54% and 40% respectively in 2018 (Health Behaviour in School-aged Children study, 2023[82]).

Existing OECD work points shows that academic pressure can be a key structural determinant of well-being for children and adolescents. 2022 PISA data showed that students across OECD countries report high levels of mathematics-related anxiety, with 65% of all students worrying about getting poor marks, and 55% feeling anxious about failing (OECD, 2024[132]). Test anxiety is not simply a function of the volume of exams; countries such as Finland, despite mandatory standardised testing, report the lowest levels of test anxiety, while others like Portugal report the highest despite less frequent testing (Cignetti and Piacentini, 2024[133]). This suggests that education systems' framing and support structures play a more decisive role in modulating stress than assessment frequency alone. A 2018 OECD paper points to how school climate, teacher-student relationships, and broader curricular approaches all influence student well-being (Choi, 2018[134]). Evidence from the OECD Survey on Social and Emotional Skills (SSES) underscores that competitive school climates and high expectations from parents and teachers are associated with increased anxiety, especially where social-emotional supports are weak (OECD, 2021[135]). The 2023 SSES edition reports a marked decline in social and emotional skills – such as optimism, stress resistance, and emotional control – as children grow older, suggesting that adolescence is a particularly vulnerable period (OECD, 2024[136]).

Mental health risk factors differ by age and stage of young people

In the context of this report, it was not possible to look in detail at how each mental health risk factor plays out for different age groups. Nonetheless, a rapid appraisal of the evidence does underscore how mental health risk factors can differ quite significantly between children, adolescents, and young adults. For example, very young children are more sensitive to impacts of their caregivers' socio-economic status, or their parents' mental health status, while young adults are more vulnerable to labour market or housing market insecurity. Orben et al. have suggested that the potential mental health risks of social media might also be age-specific; drawing on longitudinal analysis of data from the United Kingdom, Orben et al. suggest that there are "windows of developmental sensitivity to social media", and that during these

windows – age around 11 to 13 for girls, and 14 to 15 for boys, more social media use predicts a decrease in life satisfaction a year later, while lower use predicts greater life satisfaction (Orben et al., 2022[137]).

Table 2.1 gives a very high-level overview of how some of mental health risk factors influence young people at different ages, using very broad age categories, based on the evidence cited as part of this report. Effects also very likely vary between and within countries (for example by gender, by socio-economic group).

Table 2.1. Mental health risk factors by age

	Children (age 0 – 10)	Adolescents (age 10 – 19)	Young Adults (age 19 – 25)
Digitalisation, screen use, and social media	Less available evidence, especially for social media. At least one study found small associations between "screen time" and depressive symptoms (Nagata et al., 2024[52]).	Mixed evidence across a broad range of evidence, that suggests small negative associations with some digital and social media on adolescent mental health. Adolescence may be a period where social media has bigger life satisfaction and mental health risks (see, for example, (Orben et al., 2022[137])	Mixed evidence across a broad range of evidence, that suggests small negative associations of some digital and social media on young adult mental health.
Climate change and global conflicts	No direct evidence.	Climate change and global conflicts appear to be priority concerns for adolescents, with some evidence of poorer mental health outcomes.	Climate change and global conflicts appear to be priority concerns for young adults, with some evidence of poorer mental health outcomes.
Socio-economic pressures, including poverty and employment.	Economic insecurity indirectly affects younger children, for example through parental unemployment or poverty.	Adolescents experiencing poverty or economic insecurity tend to have poorer mental health outcomes. Socio-economic inequality also affects adolescent mental health outcomes (Elgar, Pförtner and Rothwell, 2024[138]).	Young adults experiencing poverty or economic insecurity tend to have poorer mental health outcomes. Socio-economic inequality also affects young adults' mental health outcomes (Elgar, Pförtner and Rothwell, 2024[138]).
Bullying, cyberbullying, and school-stress.	Data sparse for bullying and cyberbullying for young children, but many 11-year-olds report bullying or cyberbullying victimisation (Health Behaviour in School-aged Children study, 2023[82]). Limited evidence on school-stress, but text anxiety may begin in primary school (Robson et al., 2023[128]).	Bullying and cyberbullying are mental health risk factors, and cyberbullying may be rising. Academic stress and school-pressure can be mental health risks. Perceived pressure from schoolwork rose between 2018 and 2022 (Health Behaviour in School-aged Children study, 2023[82]).	Academic pressure correlates with poorer mental health for at least some college students (Beiter et al., 2015[139]).

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Notes

[1] Based on a keyword search of "youth AND [digital media type] AND mental health" in October 2025, on https://pubmed.ncbi.nlm.nih.gov/. Similar results were found when "youth" was substituted for "adolescents" and "children", and when the same search was undertaken in ScienceDirect.

3 Responding to the youth mental health crisis

This chapter looks at effective policies and practices to protect and improve the mental health of young people in OECD countries, in light of the clear declining trend in youth mental health. A multi-sectoral approach is essential: strong, resilient mental health depends not only on clinical services but also on supportive environments in families, schools, communities and the health system. Targeted mental health support must still play a major role, particularly by strengthening social and emotional learning, improving mental health literacy, and providing accessible, holistic services with an emphasis on peer-to-peer support. Better and more consistent data are needed to monitor the youth mental health crisis and to assess the impacts of emerging policies aimed at shaping children's and adolescents' online behaviour, including social media age limits and school phone bans.

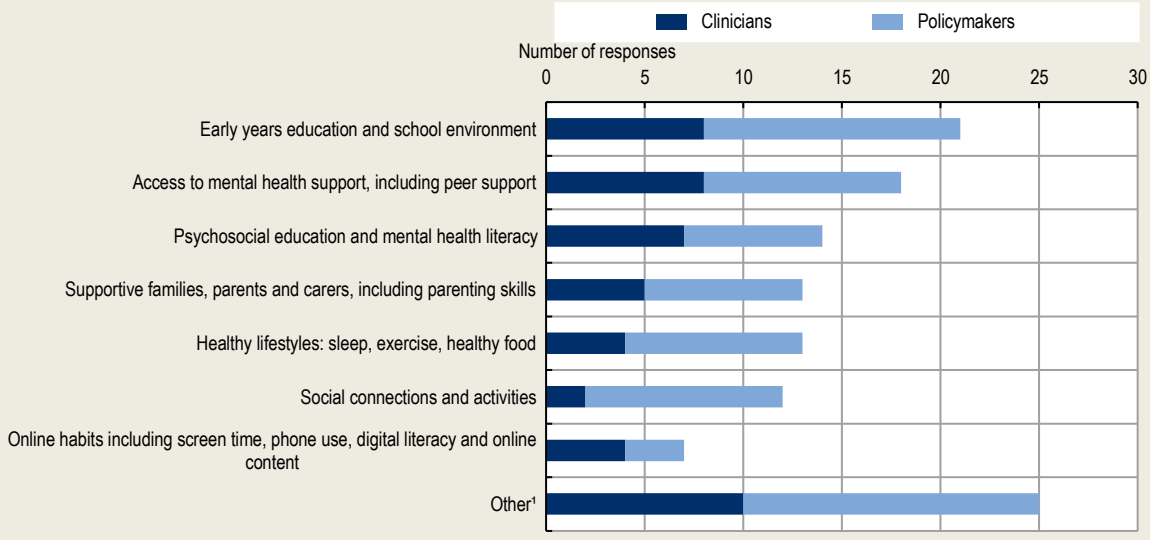
In Brief

Responding to the youth mental health crisis

- A multi-sectoral response is essential to address the youth mental health crisis. Experts interviewed for the report consistently emphasised that mental health services alone are insufficient, and that instead, a broader approach involving education, families, digital policy, and community support is needed to tackle the complex and interrelated drivers of poor mental health among young people.

Figure 3.1.Expert-perspectives on effective ways to build mental health and well-being resilience amongst young people

Categories that were mentioned at least 5 times are shown in the Figure



Note: 1. Addressing economic inequality, preventing mal treatment, parental mental health knowledge, maternal mental health, mental health tracking surveys. Experts were asked "What do you believe is the most effective way to build mental health and well-being resilience amongst young people?"
Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

- Low-threshold, holistic mental health services with a peer-support component should be a policy priority. While most experts agreed that mental health support is currently too limited, they did not call for a major expansion of specialist services. Models like Australia's headspace and the Netherlands' @ease, which offer accessible, community-based support and integrate peer involvement to reduce stigma and improve engagement, should be made widely accessible to offer well-rounded support to a large number of young people.
- Digital regulation policies are expanding, but their mental health impacts remain unclear. Many OECD countries have introduced school phone bans and age restrictions for social media, often citing concerns about youth well-being. However, evaluations of these policies have produced mixed results; future impact evaluations should go beyond academic performance and include,

mental health and broader well-being outcomes, and also consider ways to mitigate potential unintended consequences, such as reduced access to online support.

- Improved data collection is critical to understanding and addressing youth mental health trends. Fewer than one-third of OECD countries have nationally representative time-series data on young people's mental health, making it difficult to track changes over time or evaluate policy impacts. Strengthening data infrastructure would help governments respond more effectively to what may be a sustained and widespread decline in youth mental health.

Introduction

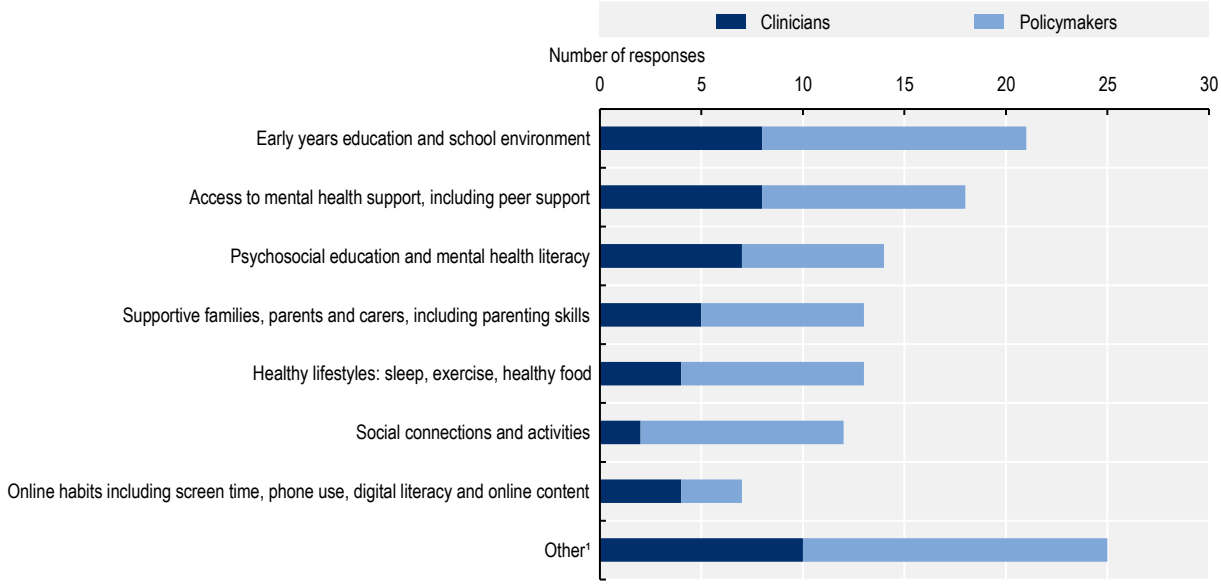
It is clear though from the drivers is that interventions in the health or mental health sector alone will probably not be enough. Teaching mental health literacy in schools, teaching social and emotional learning and coping skills, ensuring access to the right kind of support for young people with mental health care needs are all critical, but given the current scale of mental distress amongst OECD youth are unlikely to significantly transform current trends. The impact of broader policies, and in particular efforts by countries to limit potential harms from unhealthy patterns of digital device use, should be evaluated carefully including to watch for any impacts on mental health outcomes. But, the evidence seems to support the views of one Nordic policymaker, who said, "*screen use is a driver [of poor mental health], but just one out of many... removing the screens is not going to solve all of the problems*".

Supporting good mental health for young people requires a multi-sectoral approach

As discussed in this report, there are strong signs that youth mental status has declined, and yet there is no single, provable driver that can fully explain this trend. Instead, it is likely that multiple factors interact in complex ways to influence young people's mental health outcomes. Risk factors, such as digitalisation and social media use, global instability, socio-economic turbulence, and exposure to bullying or academic pressure, do not operate in isolation. The impact of mental health risk factors can be moderated by protective factors, which help buffer young people against adversity. These protective factors, when strengthened, can play a critical role in promoting resilience and well-being among youth. As part of the semi-structured interviews to inform this report, clinical and policy experts were asked what they saw as the most effective ways to increase mental health resilience and support for young people (Figure 3.2).

Figure 3.2. Expert-perspectives on effective ways to build mental health and well-being resilience amongst young people

Categories that were mentioned at least 5 times are shown in the Figure



Note: 1. Addressing economic inequality, preventing mal treatment, parental mental health knowledge, maternal mental health, mental health tracking surveys. Experts were asked "What do you believe is the most effective way to build mental health and well-being resilience amongst young people?"
Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

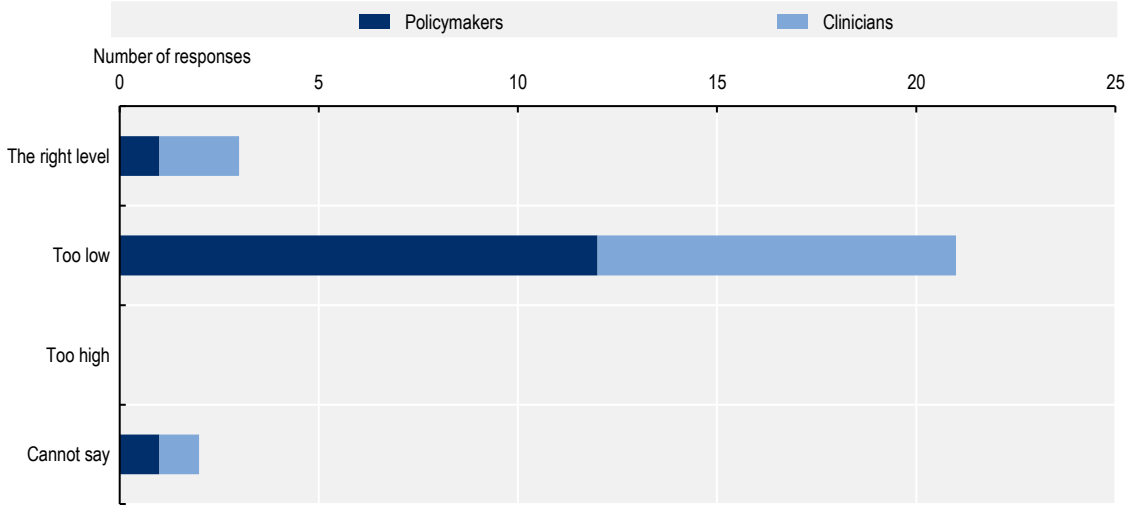
The most frequently mentioned approaches included improving early years education and school environments, enhancing access to mental health support (including peer support), and promoting psychosocial education and mental health literacy. Experts also emphasised the importance of supportive families and parenting skills, healthy lifestyle habits (such as sleep, exercise, and nutrition), fostering social connections, and managing online habits through digital literacy and balanced screen time. All experts interviewed pointed – to varying extents – to a holistic, multi-sectoral approach to building youth resilience, with an important but nonetheless limited role for specialist mental health support.

The response to increased demand for services should prioritise lower threshold, holistic support, with an emphasis on peer-to-peer services

Even though they saw a holistic, multi-sectoral approach as key to building young people's mental health resilience, clinical and policy experts did nonetheless agree that the level of mental health support in their country or region was, for the most part, too low (Figure 3.3). The three experts who said that they thought the support in their country was the "right level" nonetheless stated that they thought the support available was not well-distributed, with too little focus on prevention and promotion, lower-threshold disorders, or with other inefficiencies in access.

Figure 3.3. Expert-assessment of the level of mental health support in their country or region

Responses to interview question, "Do you believe that the level of mental health support for young people in your country or region is: 1) the right level 2) too low 3) too high 4) cannot say?"



Source: OECD Semi-Structured Interviews with Clinical and Policy Experts on Young People's Mental Health, 2025.

In terms of mental health-specific support, the services that experts most-frequently brought up as missing from existing provision, or as being in short-supply, were lower-threshold support or mid-level services, rather than necessarily investment in specialist or acute services. Experts pointed to growing demand for youth mental health support – which is certainly borne out by data for at least Australia (Kids Help Phone, 2024[1]), Canada (Kids Help Phone, 2024[1]), France (Santé Publique France, 2021[2]), Norway (fhi.no, 2023[3]), Sweden (Sveriges Kommuner och Regioner, 2024[4]), the United Kingdom (Royal College of Psychiatrists, 2024[5]), and the United States (Leyenaar et al., 2025[6]) – but did not suggest significant increases in existing specialist services in most cases.

Experts emphasised the importance of peer-led support, stepped care approaches, and – for some experts – less medicalised approaches. A clinician from Southern Europe said, for example, "*I believe that resources are insufficient, but more importantly, I think the model of care itself should be reformed—shifting toward a more community-based approach, less medicalized, and one that respects the subjectivity of children and adolescents*." A clinician from Central Europe stressed, like many experts, the value of peer-support: "*Young people won't listen to me... I'm already too old for them. The best option is good examples among their peers… peer programmes make a huge difference*." Some experts did also insist on shortages in specialist care, especially on workforce shortages for example low numbers of child and adolescent psychiatrists.

One service model that has received considerable recognition, has inspired similar models in other countries, and which prioritises a holistic, stepped, peer-to-peer approach is Australia's headspace centres. Established in 2006 by the Australian Government in response to growing concerns about the mental health service offer for young people, headspace offers holistic health and mental health support for young people aged 12 to 25, mixing low-intensity support and more intensive clinical services as needed, and integrating peer-led initiatives (Box 3.1). Headspace has also inspired similar models elsewhere, including "headspace Denmark" and the Netherland's @ease programme. Headspace Denmark was founded in 2013, is volunteer-led (using trained volunteers and peer workers), and focusses on low-intensity, low-cost interventions (Bjørkedal et al., 2025[7]). @ease was launched in the Netherlands

in 2018, and was directly inspired by headspace Australia, offering free, anonymous, walk-in and online peer-to-peer support for young people aged 12-25. @ease was included in the OECD's Best Practices in Mental Health Promotion and Prevention (OECD, 2025[8]), and was found to improve psychological distress and functioning improve over time for young people and reduce school absences, and to be an effective way to remove barriers to accessing mental health support, reaching people who may not have otherwise received formal mental health support.

Box 3.1. Holistic mental health support in Australia's headspace centres

Australia's headspace programme is a national youth mental health initiative providing early intervention services for young people aged 12 to 25. Having been established in 2006 in response to rising rates of youth mental illness and suicide, headspace offers a holistic, integrated model of care across four domains: mental health, physical and sexual health, alcohol and other drug use, and vocational support. headspace operates through a network of 172 centres nationwide, built on a stepped care framework, ensuring that young people receive the right level of support based on their needs – from low-intensity interventions to more specialised clinical care. Additional services delivered via eheadspace (online and phone support), outreach in schools and communities, and enhanced models like headspace Plus for young people with more complex needs.

Headspace also incorporates a peer-led dimension, including trained peer workers and online peer support communities that provide safe, anonymous spaces for young people to connect and share lived experiences. Evaluations commissioned by the Department of Health and conducted by UNSW's Social Policy Research Centre, KPMG, and batyr have found the programme to be effective in improving mental health outcomes, accessibility, and service appropriateness (Unsw, 2015[9]). A 2023 peer-reviewed study reflecting on 16 years of headspace centres reported that over 70% of clients showed significant improvements in psychological distress, psychosocial functioning, or quality of life after engaging with headspace services (Rickwood et al., 2023[10]).

As well as having inspired headspace Denmark, and @ease in the Netherlands, headspace Australia was also part of the inspiration for programmes including "Jigsaw" in Ireland (O'Reilly et al., 2021[11]), "Foundry" in Canada (Barbic et al., 2024[12]), "soulspace" in Berlin, Germany (Bechdolf et al., 2024[13]), and Peaasi in Estonia.

Source: https://headspace.org.au/.

Programmes to promote social and emotional learning and mental health literacy in schools should be part of building mental resilience

Many experts pointed to the importance of teaching children social and emotional skills, and mental health literacy, in school settings. For example, a Finnish study found that adolescents with higher levels of health literacy also exhibited a more positive mental health profile, underscoring the value of developing stronger health literacy skills among young people (Gustafsson et al., 2023[14]). In recent years, OECD countries have made school-based mental health support, and promotion activities, a priority. In 2021, 19 OECD countries indicated that mental health training was provided to teachers (OECD, 2021[15]), while a report assessing the implementation of the OECD Council Recommendation on Integrated Mental Health, Skills and Work Policy found that there had been widespread efforts to increase the understanding of mental health among teachers and educators (OECD, 2021[16]). There are also multiple evidence-based programmes for teaching mental health skills in schools that have shown good potential for transferability between countries (see Box 3.2). Beyond specific programmes, broader policy action has an important

role to play in supporting youth mental health. This includes fostering inclusive learning environments that support student well-being, provide tailored support based on individual needs – including mental health needs – and ensure access to services such as school psychologists and counsellors (OECD, 2023[17]). It also includes raising hope and agency – through meaningful participation, civic engagement – to equip young people with a sense of purpose and collective efficacy to face global challenges.

Box 3.2. Teaching social and emotional learning – Zippy's Friends, This Is Me, and lessons from the OECD Survey on Social and Emotional Skills

Zippy's Friends is one of the best-known school-based programmes which teaches social and emotional learning to children age 5-7. First established in 1996, Zippy's Friends is a series of 24 sessions of 45-60 minutes which aims to improve emotional literacy, resilience, social and coping skills. OECD (2025[18])has found that the programme can increase active coping strategies and reduce oppositional coping strategies (e.g. opposition and withdrawal behaviours reduced by 9% and 15% respectively) amongst children.

This is me (To sem jaz) is a Slovenian programme designed to strengthening social and emotional skills amongst adolescents, and help adolescents build positive self-image. The programme consists of two different types of interventions – access to anonymous, simple, rapid, and free access to online expert advice, and a series of ten workshops that help the development of social and emotional competencies and realistic self-evaluation. The workshops are mostly delivered by trained teachers or school counsellors. OECD (2025[18]) found that the programme helped improve classroom climate, as rated by the teachers, and may help measurable student outcomes (interpersonal difficulties, coping and self-concept). This intervention also has the advantage of being universally applicable, given the school setting, and highly accessible, given the additional online expert advice component.

Findings from the OECD's Survey on Social and Emotional Skills (SSES), one of the first international efforts to collect data from students, parents and teachers on the social and emotional skills of students at ages 10 and 15, show that students' social and emotional skills are strongly related to students' psychological well-being after accounting for socio-economic status and gender (OECD, 2021[19]; OECD, 2024[20]). This report also included examples of school curricula that include teaching social and emotional skills, for example Ontario, Canada's "Health and Physical Education curriculum" for 6- to 14-year-olds. This curriculum includes aspects like: teaching students to identify and manage their emotions, develop self-awareness and learn how to express their feelings; strategies to cope with stress such as deep breathing and guided imagery; and practices to foster motivation and perseverance through difficulty such as expressing gratitude and reframing negative thoughts.

There are other ways to teach mental health skills or foster mental resilience outside of school settings, for example through parenting programmes. For example, the "Incredible Years Parent Training" programme is in place in at least 12 OECD countries, and is designed for parents of young children (often ages 3-8) who display early signs of challenging behaviours. The programme teaches positive parenting practices, behaviour management strategies (e.g. logical consequences, monitoring), and promotes parent – child relationship building, through weekly group sessions led by trained facilitators. Incredible Years has a strong evidence base, including from Randomised Control Trials, that supports its effectiveness for improving children's behaviour, gains in children's emotion-regulation skills and social problem-solving skills; the programme is designed to address externalising disorders (e.g. conduct disorder, ADHD), rather than to address internalising conditions such as anxiety or depression (Trillingsgaard, Trillingsgaard and Webster-Stratton, 2014[21]; Menting, Orobio de Castro and Matthys, 2013[22]; Gardner and Leijten, 2017[23]).

Broader population-wide mental health resilience programmes are also important; many young adults, whose mental health has also seen a decline, are out of school and not in formal educational settings. For example, 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 (OECD, 2025[8]). Aimed at the general public, the programme tries to improve mental health literacy, reduce stigma, and increase confidence in helping someone experiencing mental distress or crisis. MHFA started in Australia, but is now widely used internationally, in schools, workplaces and institutions, as well as by private citizens. The French Government has been supporting MHFA ("secourisme en santé mentale") as part of its Mental Health and Psychiatry Roadmap; as of December 2024, there were already 165 000 trained mental health first aiders in France (sante.gouv.fr, 2025[24]).

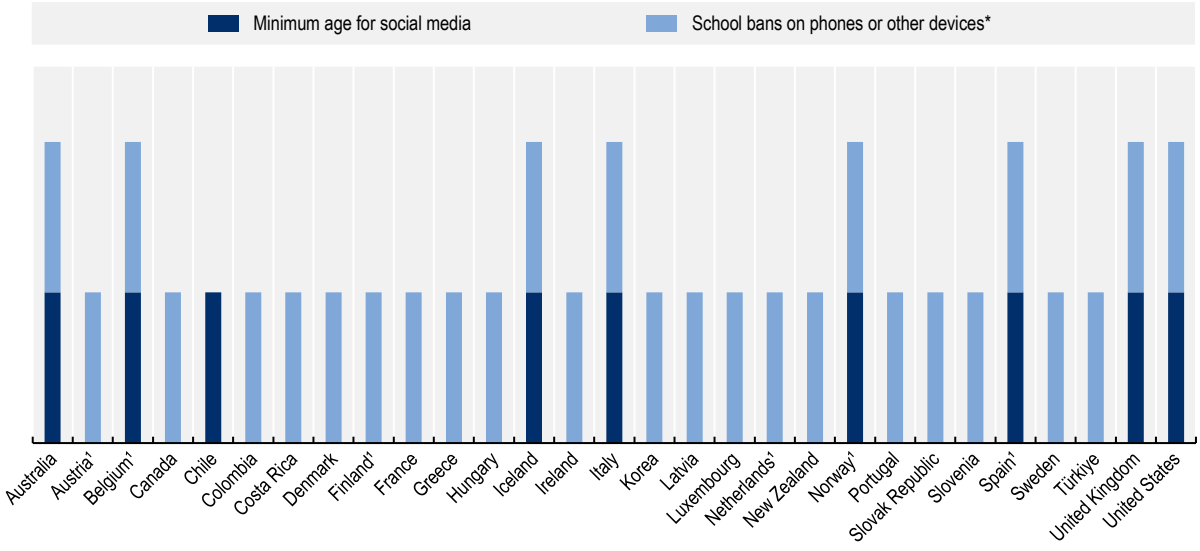
A growing number of policies targeting children and adolescent's online behaviours, but mental health impacts aren't yet clear

As well as policies to support young people's specific mental health needs, OECD countries have been looking at ways to protect children and adolescents from potential harms associated with digital device use and digital media consumption. Policies such as phone-bans in schools, enhanced age restrictions on access to certain digital technologies (e.g. social media, video gaming), and efforts to remove or limit harmful online content have become widespread in recent years (see Box 3.3). A recent legal development may further accelerate such efforts: in March 2026, a California jury ruled that Instagram and YouTube were liable for designing addictive platforms that harmed a young woman's mental health (Taylor, 2026[25]), setting a major legal precedent likely to prompt further claims and potentially accelerating efforts toward stronger federal regulation of social media platforms.

Phone-bans in schools are now widespread across countries, whereas enhanced age-based restrictions on access to social media remain less common. As of October 2025, 29 countries had national or regional restrictions on phone use in schools in place, which mostly focussed on children and younger adolescents (see Figure 3.4). Since June 2025 alone 7 countries have introduced or announced new legislation regulating phone or other device use in schools (Costa Rica; Denmark; Ireland; Korea; Luxembourg; Portugal; Slovenia).

Figure 3.4. Phone bans in schools and age-based social media limits in OECD countries

Based on policies in place or upcoming as of October 2025.



1. Reported to the OECD as part of the *OECD Survey on National Policies Regulating Digital Advertising to Children and Adolescents for the Prevention of Cardiovascular and Related Noncommunicable Diseases, September 2025.*

It is often difficult to identify the specific drivers of these new regulations and policies, and the extent to which children and adolescent's well-being and mental health are considerations. For example Denmark, Ireland, New Zealand, Portugal and Slovenia, when explaining the restrictions on personal phones during the day in primary schools refer to improving concentration and focus on learning and improving the educational environment (Irish Government, 2025[26]; Portuguese Government, 2025[27]; Eurydice, 2025[28]; New Zealand Government, 2024[29]). Ireland and Portugal also refer to reducing cyberbullying and improving well-being and socialisation. The ban on mobile phones and other digital devices in classrooms in Korea will take effect in 2026, and concerns about phone-addiction and how social media can increase youth anxiety were mentioned as motivating factors by lawmakers (Reuters, 2025[30]).

In the very small number of published evaluations of school phone bans or restrictions so far, mental health outcomes have not necessarily been the focus, and findings have been relatively mixed. The OECD has previously concluded that smartphone bans can be effective for supporting learning outcomes and supporting a positive school environment, but enforcement matters (and can be difficult), and that many students still report daily use even where bans exist (OECD, 2024[31]). In Norway, an event-study found that smartphone bans reduced healthcare use for psychological symptoms among adolescent girls (Abrahamsson, 2024[32]). In South Australia, a one-year review reports less time spent on phone-related discipline, fewer cyber incidents, and more positive peer interaction, though this is not a causal impact study (Government of South Australia, 2025[33]). In the Netherlands, early school-level reviews note better cognitive functions, concentration and less online bullying, alongside student concerns about practicality and uneven implementation (Brummer and Achterberg, 2025[34]). In England, the *SMART Schools* study of 30 secondary schools found that restrictive policies lowered in-school phone and social media use, but showed no evidence of improved overall well-being, sleep, attainment or behaviour compared to permissive schools (Goodyear et al., 2025[35]). An evaluation from several schools with phone bans in Sweden found no significant effect on anxiety or depression symptoms (PHQ-4), but students did report better general well-being, spent 33 minutes a day less on phones outside school work, slept 10 minutes longer on average, and reported fewer incidents of problematic online behaviour (Nutley, 2025[36]).

Along with school-based phone and device restrictions, a number of OECD countries have introduced, or are planning to introduce, enhanced age restrictions on access to online content and developed efforts to remove or limit harmful online content to protect children. An OECD review of age assurance online for child safety and well-being found that the legal environment for such limits is complicated, that some protections for children (e.g. regarding access to pornography, purchasing age-restricted goods online) are uneven in terms of the specificity of legislation, and that a lack of specificity on how to comply with age assurance requirements is common across the laws analysed (OECD, 2025[37]). Australia, the European Union and the United Kingdom are developing enforceable implementation guidance for online age restrictions that may create express requirements for different age cohorts (OECD, 2025[37]), while the European Union is also leveraging the EU Digital Services Act to encourage online platforms to take more steps to protect minors' health (see Box 3.3).

Box 3.3. Enforceable online age limits in Australia and increased regulation of online content and platform design to protect minors in the EU

Australia's mandatory minimum age for social media accounts

From December 2025 Australia's online Safety Amendment (Social Media Minimum Age) Bill 2024 will come into effect, introducing a mandatory minimum age of 16 for accounts on certain social media platforms. The Australian Government has cited the risks of social media to young people's mental health and well-being as primary motivators of the ban, including exposure to cyberbullying, harmful content, and online predators (UNICEF Australia, 2025[38]). The Social Media Minimum Age framework (SMMA) highlights evidence that adolescent social media use can predict decreased life satisfaction in key developmental stages, particularly among girls aged 11-13 and boys aged 14-15.

The EU Digital Services Act

On 27 May 2025, the Council of the European Union issued a call for greater efforts to protect the mental health of children and teenagers in the digital era, highlighting both the potential benefits and harms of digital technologies for youth: *"Digital technologies … have the power to negatively affect mental health, notably among children and adolescents" and there is a "pressing need to foster the safer and healthier use of digital tools by children and adolescents which prioritises protecting their mental health"* (Council of the EU, 2025[39]). The Council urged Member States to curb problematic online design practices, and to embed attention to the user's well-being into the design process from the outset.

EU Digital Services Act (DSA), in force since 2024, also makes this link explicit by identifying the systemic risks that large platforms must address, including risks to minors' health: *"[The DSA] aims at ensuring a safe, predictable and trusted online environment, which f*or large online platforms extends to assessing and mitigating "any actual or foreseeable negative effects for the exercise of fundamental rights, including … the rights of the child" and to addressing "systemic risks stemming from the design or functioning of their services, including … negative effects on the protection of minors" (European Union, 2022[40]).

What sets the Digital Services Act (DSA) apart is how it moves the EU from a relatively light regulatory framework under the e-Commerce Directive (2000/31/EC) to a binding, enforceable regime with new oversight and accountability powers. Under the e-Commerce Directive, intermediaries (hosting services, caching, mere conduits) were largely exempt from liability for user-posted content so long as they acted when made aware of illegal content (the "notice-and-takedown" model) and operated via largely self-regulation and national enforcement. The DSA preserves certain safe-harbour protections, but adds obligations for "very large online platforms" to conduct systemic risk assessments, submit to transparency requirements (including around recommender systems, advertising, and user reporting), and allow oversight by national Digital Services Co-ordinators as well as the European Commission.

Including mental health and broader well-being outcomes in evaluations of digital device restrictions, such as phone bans in schools or broader social media and content regulations like Australia's under-16 social media ban or actions taken under the EU's Digital Services Act, should be a priority. Given the very mixed evidence on the links between digital technology use and young people's mental health outcomes, and a general focus on academic performance in existing evaluations, this is a critical opportunity to gather more insights and build a stronger evidence base to inform future policy decisions. Evaluations should also give due consideration to whether new limits reduce access to supportive online communities, mental health resources, or social connections that can be important for adolescents. For example, a study from the United Kingdom found that 16% of teenagers used apps or online services to look after their mental health, 14% to get support when feeling anxious, and 32% to "improve their mood", although the accuracy of information found and/or usefulness of support obtained was not assessed (Ofcom, 2025[41]).

Finally, while beyond the scope of this report, digital education and skill-building have been frequently referred to as an important part of helping children and adolescents build a healthy and balanced relationship with digital technologies, and reducing divides in digital skills.

A series of recent OECD papers and reports – including "Policies for the Digital Transformation of School Education" (Boeskens and Meyer, 2025[42]); "School partnerships addressing child well-being and digital technology" (OECD, 2025[43]); "OECD Digital Education Outlook 2023" (OECD, 2023[44]), and "How's Life for Children in the Digital Age?" (OECD, 2025[45]) – give an overview of how digital skills and healthy device use are included in school curricula, and are highly relevant for this discussion.

More and better data on the youth mental health crisis and its drivers is needed to guide policymaking

The findings of this report reinforce the challenge facing policymakers in OECD countries: young people's mental health appears to be declining, and the multiple, intersecting, suspected drivers of this decline are far from straightforward to address. There are some policy responses that can be taken to support young people with mental health needs, and build mental resilience. However, if the data and expert insights set out at the start of this report are accurate – and the decline in youth mental health is widespread, and sustained over time – policies in the health and mental health sector alone will likely be insufficient to turn the tide of this trend. To give policymakers the best possible insights with which to tackle what could reasonably be called a youth mental health crisis, there are several key data and information gaps that should be addressed.

Firstly, it will be very important to track young people's mental health status in the coming years, as further data becomes available, to see whether the "improving" trend post-pandemic is maintained. Less than a third of OECD countries have nationally representative time series data on mental health outcomes amongst young people; often that data which is available is only collected infrequently. More frequent monitoring of youth mental health status across a broader set of countries is needed to better inform national policymaking, service planning, and research. While methodologically challenging, efforts to improve international comparability of these data would be particularly valuable. The HBSC survey remains an excellent source of information on adolescent well-being, strengthened further by the addition of the WHO-5 indicator on well-being in the 2022 edition, and should be watched carefully for insights into this evolving trend.

Second, more and better information is needed on the relationship between young people's digital technology use, and mental health outcomes. Despite the huge policy attention being given to this topic, significant data weaknesses in underlying research remain. The OECD Digital Economy Outlook (2024[46]), for example, emphasises the limited reliability of data drawn from subjective reports of time spent online, stressing the need for more precise and objective measures that differentiate clearly between the duration,

type, and intensity of digital activities. At present, samples and datasets in current research are limited, primarily sourced from high-income countries, and tend to be unrepresentative and lacking the depth and granularity that data held by the technology industry itself could provide (Sanders et al., 2023[47]). Further insights into young people's interactions with digital technologies and associated mental health impacts should aim to address current limitations in data collection and analysis, particularly the reliance on self-reported measures, lack of specificity beyond "screen time", and limited understanding of causal direction. Future research should also prioritise capturing moderating factors such as socio-economic status, daily routines, family and peer support, and access to mental health services.

Third, and perhaps most importantly, every effort should be made to consult young people about their own mental health, what they see as drivers of good and poor mental health, the support they need but might be struggling to get. Young people should also be meaningfully involved in the design and implementation of policies and programmes that foster positive mental health. Box 3.4 gives some insights into what young people in a few countries say about their own mental health. In the context of this report specifically, many of the surveys tracking young people's mental health rely upon self-reported measures, and therefore capture some of young people's own beliefs about their mental health. Additionally most if not all of the experts interviewed for this work were in contact with young people in their country, and therefore brought insights into young people's own views on their mental health and its drivers; for example, some experts had taken part in focus groups with young people to discuss mental health issues, and others were clinicians regularly seeing young people. However, it was not possible as part of this report to speak directly with young people, which is a limitation that could be addressed if this work was expanded further.

Box 3.4. What do young people say about their own mental health?

A range of studies from different OECD countries have highlighted young people's own views about their mental health. Many young people are clearly aware of the importance of good mental health, and some are concerned about how their mental health is affecting their daily life. A study from the UK-based Mental Health Foundation found that 86% of young people age 18-24 years who they surveyed had felt anxious in the previous two weeks, and 58% said that this had stopped them undertaking day-to-day activities (Mental Health Foundation, 2023[48]). A report by the American Psychological Association in 2023 found that 72% of people age 18-34 saw "mental health" as a stressor, the highest single health stressor for this group, and the group that pointed most significantly to mental health as a stressor (American Psychological Association, 2023[49]). In 2024 Pew Research found that 35% of adolescents age 13-17, and 55% of parents, were very or extremely worried about teen mental health, and only 23% of adolescents and 11% of parents were not worried about teen mental health (Pew Research Center, 2025[50]).

What do young people say is driving good and poor mental health?

Multiple reports have been developed which reflect young people's own perspectives on their mental health. UNICEF's 2025 report on youth perceptions of mental health covers 14-25 year-olds in seven countries (Japan, Mexico, Malaysia, Switzerland, the United Kingdom, the United States and South Afrida), and looks at how global challenges affect this generation's mental health. Fifty-two per cent of young adult respondents, and 29% of teen respondents, said they had needed help with their mental health; 80% of adults and 92% of teens said they needed help had sought mental health help, which is encouraging (UNICEF Global Coalition for Youth Mental Health, 2025[51]). Sixty per cent of youth participants reported being "overwhelmed by news and events", especially young adults, and many felt worried about the future.

A 2024 report that gathers youth mental health perspectives from 13 countries pointed to a wide set of factors shaping youth mental health: Family functioning; Mental health literacy and stigma; Bullying;

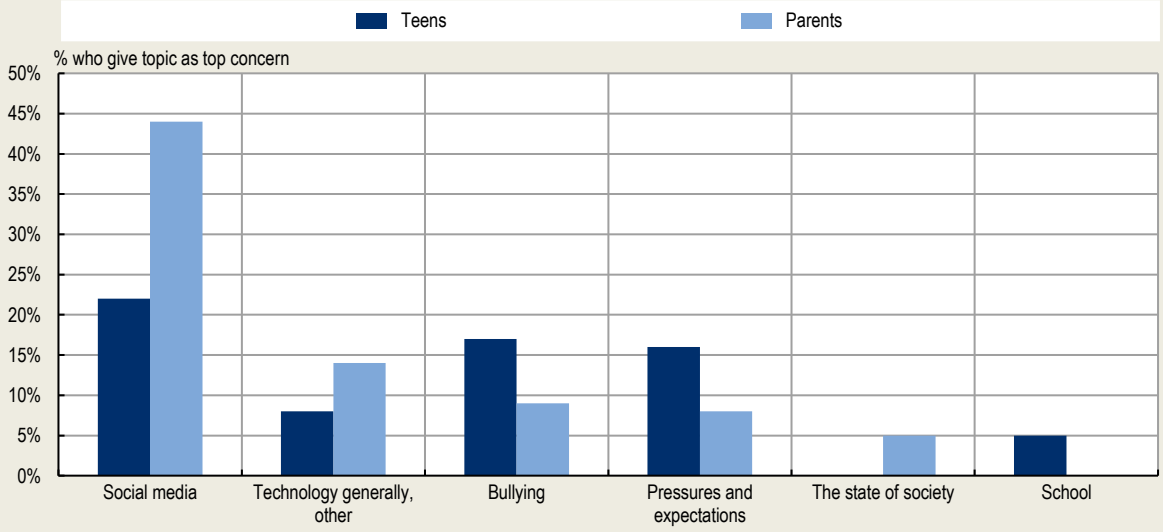
Youth exposure to violence; Academic pressure; Self-esteem; Cyberbullying and excessive social media use; Substance use; and Poverty and unemployment (Being, 2024[52]).

A report on the mental health of young people in the United States (age 18-25), adolescents and their parents, based on a nationally representative sample in December 2022, found that young adults reported twice as high rates of anxiety and depression than teens, and that they were concerns about diver challenges including a lack of meaning, purpose and direction, financial worries and achievement pressures, global challenges, relationships, and social and political issues (Making Caring Common, 2023[53]). A 2025 poll of young people age 16-29 in the United Kingdom also suggested that young people felt that mental health problems were common amongst their age group, and that issues that concerned them included fears for the future, especially when it came to financial security (37% said this contributed to feeling nervous, anxious or on edge), and employment prospects (20%) and work pressures (23% worried) (John Smith Centre, 2025[54]). Concerns about finances, work, and employment were more significant worries than those about social media (14%) or climate change (10%).

The OECD's "Risk that Matters for Young People" (2024[55]) report doesn't address mental health drivers explicitly, but does offer key insights into what young people age 18-29 are most worried about. The 2022 wave included 27 countries, and pointed to short term financial insecurity (69% of respondents worried), housing (64-68% worried), and job insecurity (29% worried) as among some of young people's primary concerns.

When it comes to mental health and social media specifically, both adolescents (age 13-17) and parents in the United States appear to have concerns, but parents are comparatively more concerned than adolescents and see fewer of the positive effects (Figure 3.5) (Pew Research Center, 2025[50]).

Figure 3.5. What "teens" (age 13-17) and parents in the United States say they think most negatively impacts teen mental health, 2024



Note: Survey conducted in September-October 2024, only responses that were given by at least 5% of respondents were reported.
Source: Pew Research Center, (2025[50]), "Teens, Social Media and Mental Health", https://www.pewresearch.org/internet/2025/04/22/teens-social-media-and-mental-health/.

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Child, Adolescent and Youth Mental Health in the 21st Century

Young people's mental health is getting worse, with rising rates of depression, anxiety, psychological distress and poor well-being. Drawing on international data, recent scientific literature and insights from clinical and policy experts, this report shows that deteriorating youth mental health is a long-running trend that predates the COVID-19 pandemic, but that has intensified in recent years. The report highlights the complex, intersecting drivers behind this decline, from digitalisation and social media, to climate anxiety, fears about global conflicts, socioeconomic pressures, bullying and academic stress, and inequality and poverty. The report shows the importance of a comprehensive, multi-sectoral response including strengthening early prevention, improving access to low-threshold and peer-supported services, embedding socioemotional learning in schools, and developing balanced policies around digital technology. It also stresses the need for better, more frequent data collection and for listening directly to young people to understand their needs and priorities. The report aims to support OECD governments in designing more effective, evidence-informed strategies to stem the decline in young people's mental health.

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