RESEARCH REPORT

Eurofound

Living conditions and quality of life

# Mental health: Risk groups, trends, services and policies

# Mental health: Risk groups, trends, services and policies

Eurofound

European Foundation for the Improvement of Living and Working Conditions

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While Eurofound acknowledges that the concepts of gender and sex are different, in this report, unless otherwise stated, gender is used to denote female and male characteristics.

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.

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# Country codes

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|---|---|---|---|---|---|
| **AT** | Austria | **ES** | Spain | **LV** | Latvia |
| **BE** | Belgium | **FI** | Finland | **MT** | Malta |
| **BG** | Bulgaria | **FR** | France | **NL** | Netherlands |
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*If you are experiencing poor mental health, or are worried about someone who is, seek support. Talking about it helps and can be done anonymously, for instance by calling a helpline in your country.*

# Executive summary

## Introduction

Poor mental health affects many adults and children in the EU. Long-term trends affecting mental health include the shift from physical to digital working and living environments and climate change. Social insecurity, inequality and people's concerns about their economic situation also play a role, notably during the cost-of-living crisis. Refugees escaping international conflicts have a higher risk of poor mental health. Furthermore, as the Great Recession illustrated earlier this century, the COVID-19 pandemic made it clear that even groups deemed less vulnerable to poor mental health are also at risk.

This report seeks to better understand the prevalence of poor mental health for different population groups, identify time trends and map barriers to accessing services. It also investigates policy measures directed towards mental health services, and actions taken in other environments (importantly, schools and workplaces) to prevent or address poor mental health. In this report, Eurofound brings together evidence from the literature, EU-level surveys, expert reviews and national administrative and survey data collected by the Network of Eurofound Correspondents and through desk research.

## Policy context

The European Commission's communication on a comprehensive approach to mental health aims to put mental health on an equal footing with physical health and ensure a new cross-sectoral approach to mental health issues. EU action on mental health follows three guiding principles: adequate and effective prevention; access to high-quality and affordable mental healthcare and treatment; and reintegration into society after recovery. The EU also contributes more generally by, for instance, establishing the right to social protection benefits and services (through the European Pillar of Social Rights) and improving working conditions through occupational health and safety regulations.

## Key findings

- In the EU, in 2021, poor mental health caused at least 11.1 million life years to be lost or lived with disability; of these, depression and anxiety accounted for 7.4 million.

### Prevalence trends

- The proportion of people at risk of anxiety or depression increased during the pandemic, but seems to have levelled off since then.
- Among 15- to 29-year-olds in the EU, suicide is the main cause of death (18.9 % in 2021), followed by traffic collisions (16.5 %). Suicide death rates fell in recent decades. Between 2011 and 2021, the annual rate dropped from 12.4 to 10.2 per 100 000 people. However, the decrease has stalled since 2017 and there have been some increases, especially from 2021 to 2022.

### Population groups

- People with lower incomes or levels of education, people who are separated or widowed, people who experience homelessness, and refugees are among the groups at higher risk of poor mental health.
- Women are more likely than men to report poor mental health in surveys and are over-represented among primary mental healthcare service users. Suicide death rates are over three times higher for men than for women, and in several EU Member States men are over-represented among mental-health-related hospitalisations.
- There are signs of increased poor mental health at both ends of the age spectrum, and over the past decade suicide deaths increased among women aged under 20 years and men aged 85 years and over.
- One in four people working in human health and social work activities often or always feel emotionally exhausted by their work, more than in any other sector. Rates are also relatively high in education and in accommodation and food service activities, with one in five people reporting the same levels of emotional exhaustion.

### Access to care

- Concerns about quality are a key barrier to accessing support. In the EU, 46 % of people who had experienced emotional or psychosocial problems in the previous 12 months scored the quality of mental healthcare services at below 5 on a scale from 0 (poor) to 10 (excellent).
- Mental healthcare usage was already increasing in the EU before the pandemic and considerable increases in care usage have been observed in several Member States since the pandemic. Several Member States have increased care capacity and entitlements over the past decade, and stigma seems to have decreased.

- People in the EU are generally entitled to free or low-cost mental healthcare, especially for particularly urgent needs. However, stigma and discrimination against people with poor mental health discourage people from seeking support. Furthermore, capacity limitations make these formal entitlements meaningless for many people.
- Timely access to care for mild or moderate needs, such as psychotherapy, usually requires out-of-pocket payments, and is often unaffordable for people on a low income and without supplementary insurance.
- Access to mental healthcare tends to be particularly difficult in rural areas and for certain types of specialist care, such as child psychiatry.

# Policy pointers

## Improve population mental health

- Improving population mental health is key to preventing poor mental health. This can be achieved by improving living and working conditions; enhancing social inclusion and cohesion; addressing and preventing poverty, over-indebtedness and homelessness; stimulating physical health; and stopping domestic violence, bullying and discrimination.
- Addressing stereotypes of caregiving roles can prevent poor mental health due to work–life balance problems (especially for women). Addressing other, usually gendered, stereotypes (e.g. about breadwinner responsibilities) can also help to reduce poor mental health.
- Schools, workplaces, social workers, primary care providers and medical specialists in areas other than mental healthcare can play a key role in early intervention and improving population mental health.

## Improve access to high-quality support

- Access to high-quality mental health support should be improved. Services need to be trustworthy, respect human rights and be person-centred. People who have experienced poor mental health should be involved in designing mental health policies and services.
- While waiting lists for mental healthcare should be addressed, instant support that can identify the most urgent cases and direct people to the appropriate help must be prioritised. This may include referral to support beyond mental healthcare (e.g. debt advice) and, in non-emergency cases, to group sessions, peer support and online mental health promotion and therapy services.
- Addressing stigma and discrimination against people with poor mental health is key to ensuring access to care. Addressing stereotypes about toughness can reduce care-seeking stigma (especially for men).
- Care seeking can be encouraged by ensuring that people are not discriminated against based on having had poor mental health in the past (e.g. in the area of insurance). Because of such negative consequences, people with poor mental health may not seek support. These consequences also contribute to additional mental health risks for people who have previously had poor mental health.
- Lack of access to care in underserved areas can be addressed by financing mobile service provision, strengthening the mental healthcare capacity of primary care posts and making better use of digital services.

# Introduction

Poor mental health, especially anxiety and depression, affects many people in the EU. Long-term trends affecting mental health include climate change and the shift from physical to digital working and living environments. Social insecurity, inequality and people's concerns about their economic situation also play a role, notably during the cost-of-living crisis. Before the COVID-19 pandemic, poor mental health was already prevalent, but the pandemic made it clear that even groups deemed less vulnerable socially and economically are at risk of poor mental health. The arrival of refugees escaping the Russian war of aggression against Ukraine and other international conflicts has added a population group at high risk of poor mental health.

This report seeks to better understand the key trends in and prevalence of poor mental health for different population groups and identify problems hindering access to mental health support. It also investigates policy measures directed towards mental health services, and actions taken in other environments (importantly, schools and workplaces) to prevent or address poor mental health. In the discussion in Chapter 4, particular attention is paid to the need to improve population mental health, a key factor in preventing poor mental health.

## Scope

The report considers mental health in general, but focuses on the two most common types of poor mental health: anxiety and depressive disorders. Occasionally, however, it is necessary to address other important aspects of mental health (including when disaggregated data are unavailable).

Mental health is a complex issue with many interconnections. For instance, poor mental health can cause exclusion from social life and employment, drug/alcohol addiction and homelessness, but can also be caused by these issues. This report does not focus on studying such interconnections.

The report acknowledges the importance of quality of life broadly, but focuses on data and research that directly relate to mental health(care). It refers to more in-depth research on underlying issues, including Eurofound's work on living and working conditions.

Suicide is discussed in this report. While it may be seen as an extreme outcome of poor mental health, it can be used to identify groups experiencing poor mental health that have been insufficiently identified by other means. Furthermore, suicide attempts and suicidal thoughts are not as rare as one might expect and can signal a failure of support.

## EU policy context

The EU's 2022 'Healthier together' non-communicable diseases initiative provides the general framework for addressing non-communicable diseases, including poor mental health. The initiative complements EU Member States' policies, shares best practices and knowledge and allocates funding for services. The European Commission communication on a comprehensive approach to mental health aims to put mental health on an equal footing with physical health and ensure a new, cross-sectoral approach to mental health issues (European Commission, 2023a). It establishes 20 flagship initiatives and allocates EUR 1.23 billion in funding from different funding instruments. EU action on mental health follows three guiding principles: adequate and effective prevention; access to high-quality and affordable mental healthcare and treatment; and reintegration into society after recovery. A tracking framework, updated in 2024, allows the implementation of the flagship initiatives to be monitored. The European Commission collects best and promising practices on mental health, available on the EU Best Practice Portal [1]. The European Pillar of Social Rights states that '[e]veryone has the right to timely access to affordable, preventive and curative health care of good quality'.

Digitalisation is transforming working environments and affects mental health both positively (e.g. teleworking facilitating work–life balance) and negatively (e.g. blurring the boundaries between working and non-working time). The European Pillar of Social Rights Action Plan states that, in this context, 'psychosocial and organisational risk factors may give rise to higher levels of work-related stress, poor mental health as well as ergonomic and safety risks'. The European Parliament study *Minimum health and safety requirements for the protection of mental health in the workplace* argues that EU-level legislation on work-related psychosocial risks is needed to set minimum health and safety requirements for mental health at

[1] See https://health.ec.europa.eu/events/best-and-promising-practices-mental-health-2024-03-11_en.

work (European Parliament, 2023a). A European Parliament resolution on the topic, which includes recommendations to the Commission on the right to disconnect, sees the right to disconnect from digital tools for work purposes as important in improving the mental health of workers (European Parliament, 2021). A European Parliament report on mental health emphasises the need to prevent mental health conditions and promote mental health for all, especially among groups in vulnerable situations, including children (European Parliament, 2023b).

More broadly, the EU plays a role in shaping societies that promote mental health, for instance through its work on social protection, such as the European Child Guarantee, the European Care Strategy, the EU Directive on fair and adequate minimum wages and the Council conclusions on strengthening minimum income protection to combat poverty and social exclusion in the COVID-19 pandemic and beyond. It also plays a role in opposing discrimination, primarily through the EU Charter of Fundamental Rights, and addressing gendered risk factors through the Gender Equality Strategy and the EU Directive on combating violence against women and domestic violence.

## Societal impact of mental health problems

The failure to improve population mental health comes with financial and non-financial costs for those with poor mental health, the people close to them and wider society. The latest estimate of the financial cost to society of poor mental health dates from 2015 and excludes several cost aspects, but does give a rough idea of its magnitude (OECD and European Commission, 2018). The estimate amounts to at least 4.1 % of the EU's gross domestic product (GDP) in terms of direct spending on health systems (1.3 %) and social security programmes (1.2 %) and indirect labour market costs (lower employment and lower productivity) (1.6 %) (OECD and European Commission, 2018). The estimate excludes social benefit expenditure, the risk of lower educational outcomes, less ideal decision-making, justice system costs and the impact on the working lives of informal caregivers who look after people with poor mental health. It also ignores non-financial costs (e.g. reduced well-being).

In the EU, in 2021, poor mental health accounted for 7.2 % of all disability-adjusted life years (DALYs) lost or lived with disability or illness, most (4.8 %) due to depression or anxiety. To these 11.1 million DALYs (3.9 million and 3.5 million due to depression and anxiety, respectively), one could add 2.6 million DALYs lost or lived with disability or illness due to substance use and 1.9 million DALYs lost or lived with disability or illness due to self-harm, often caused by poor mental health. At least 1.8 million life years are lost due to premature death caused by self-harm (Eurofound analysis of the World Health Organization's (WHO) Global Health Observatory data).

National evidence provides a deeper understanding of the cost to society in terms of sick leave. Increased sick leave may be due to the increased prevalence of poor mental health; on the other hand, it may be due to the increase in the number of options for (or decreased stigma around) using sick leave for poor mental health. Poor mental health is usually among the three most common causes of sick leave and tends to last longer than sick leave for physical disorders (e.g. Hinkov et al., 2012; CES, 2024). For instance, in the Netherlands, poor mental health (especially when it is related to stress) has become the most common reason for long-term sick leave, up from 26 % in 2013 to 40 % in 2023 (VZinfo, 2025). Increases in poor mental health among young people especially raise concerns about future increases in disability pension payments; for example, in Finland, depression was already the most common reason for disability pension receipt in 2023. In Austria, 45 % of disability pensions in 2023 were due to 'mental and behavioural disorders'.

Many people with poor mental health are or could be involved in paid work, and many are informal carers or volunteers. However, those who receive social benefits may face rules impeding engagement in paid work, and stigmatisation and discrimination also form barriers to employment.

## Methods

The research draws on:

- national and international research and policy literature;
- input from the Network of Eurofound Correspondents ([2]);
- EU survey data, mainly from the Eurobarometer on mental health (European Commission, 2023b), the European Health Interview Survey (EHIS) (2009, 2014, 2019) ([3]), various iterations of Eurofound's Living, Working and COVID-19 e-survey and the European Social Survey (ESS) (2006/2007, 2014/2015, 2023/2024) ([4]);

([2]) Detailed unpublished reports from the 27 Member States and Norway can be requested. Where national evidence is mentioned without reference to a source, the information comes from these reports.

([3]) For ease of reading, only these years are mentioned, but data collection occurred in 2006–2009, 2013–2015 and 2018–2020, respectively, depending on the Member State.

([4]) The data for the 2006/2007 survey were collected between 21 August 2006 and 2 September 2007; the data for the 2014/2015 survey were collected between 1 August 2014 and 13 December 2015; and the data for the 2023/2024 survey were collected between 8 March 2023 and 4 July 2024.

- Eurostat's online data (on suicide and healthcare resources);
- national data, especially on topics for which international comparative data could not be identified, and to uncover more recent trends than can be assessed using EU-level data;
- expert feedback.

## Word choice: poor mental health

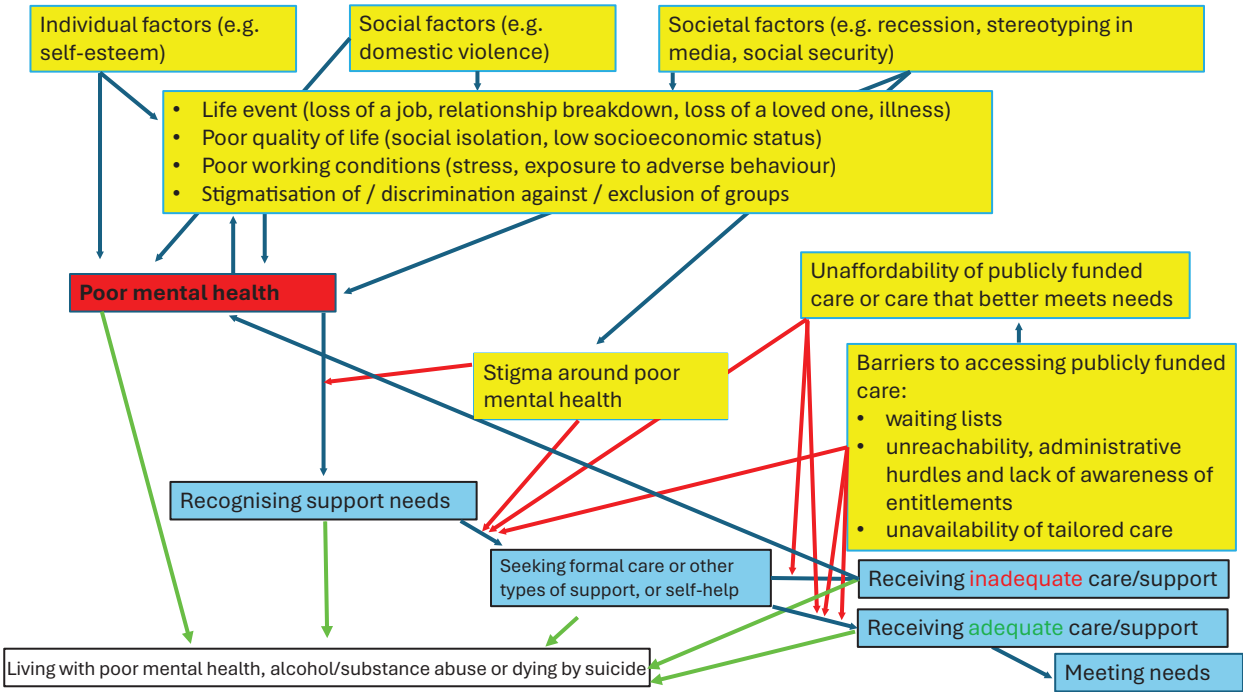
The preferred word choice in this report is 'poor mental health', just as one would speak of 'poor physical health'. The term 'mental health problem/issue' can be seen as understating seriousness and suggesting brevity and no need for care. The term 'mental disorder/illness' can be particularly stigmatising, emphasising dysfunction (Mental Health Europe, 2023). Furthermore, whether certain forms of poor mental health are treated as illnesses or not is subject to discussion. In particular, treating more moderate forms of poor mental health as illnesses can challenge people's dignity and signals that they are in need of mental healthcare or medication and can be cured (Conrad and Slodden, 2013). However, the report refers to disorders and illnesses when reporting data on diagnoses or survey questions worded in this way. Data often refer to the ICD-10 (10th revision of the International Classification of Diseases) category of 'mental and behavioural disorders', which includes (among others) anxiety and depression (data following the terminology of the revised ICD-11, effective since 2022, were still seldom observed).

Developmental disabilities are sometimes confused with poor mental health in the literature. Poor mental health can be a disability if it leads to barriers to equal participation in society. While people with disabilities are among the groups at higher risk of poor mental health, many of them do not have poor mental health. For instance, people with attention deficit hyperactivity disorder (ADHD) or autism often face disabling barriers to equal participation in society and are at higher risk of poor mental health but do not necessarily suffer from it.

## Framework

Figure 1 provides a framework for poor mental health and access to support. It emphasises the importance of improving mental health in society (preventing poor mental health), how mental health responds to external factors (yellow boxes), the role of support inside and outside mental healthcare (blue boxes) and the limitations of support if it does not adequately meet people's needs.

**Figure 1: Framework for poor mental health, access to support and policy-responsive causal factors**




**Notes:** *Red arrows: barriers/negative impacts; blue arrows: possible consequences; green arrows: consequences if needs are not met/inadequately met.*
**Source:** *Adapted from Eurofound, 2020a.*

# 1 Poor mental health: Trends and groups at risk

After discussing measurement challenges, this chapter presents an overview of the prevalence of poor mental health and its trends over time. It then examines various external factors that in recent years have driven changes in the prevalence of anxiety and depression and draws attention to both long-standing and emerging groups at high risk of poor mental health.

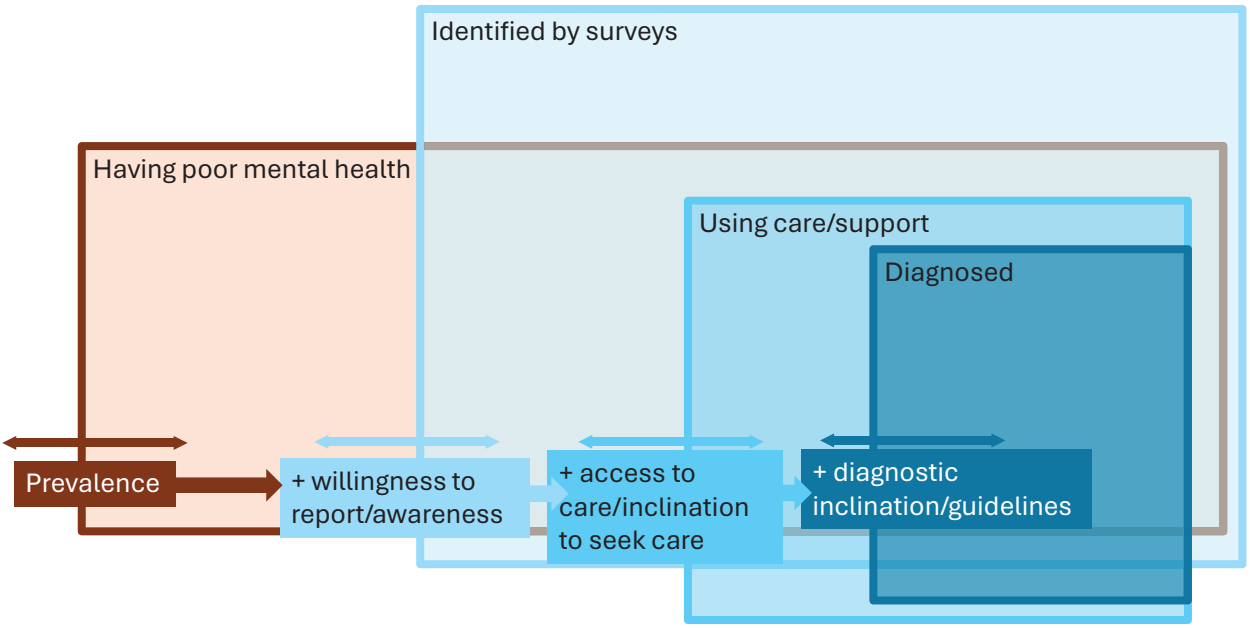
## Measuring poor mental health

Data on usage of mental health services and (especially) on diagnoses are problematic measures of the prevalence of poor mental health. People with poor mental health may not have access to care/support or may not seek it. They become more likely to seek and receive care/support (and to be diagnosed) when access to it and the quality of it improve, and when stigma and discrimination are reduced. For instance, in Cyprus, psychiatric visits decreased year on year from 64 105 in 2014 to 42 072 in 2019, but increased steeply to 150 517 in 2022. This was mainly due to enhanced access to outpatient psychiatric care from 2020 onwards, not to increased prevalence. In Germany and Sweden, the increase in mental healthcare patients has partly been attributed to the increased accessibility of care and – especially among young people – decreased stigma, enhanced education and a cultural change in dealing with mental health (FHM and Swedish National Board of Health and Welfare, 2023; Thom et al., 2024). Not all mental healthcare users are diagnosed with poor mental health. There may also be overdiagnosis. Diagnostic inclinations and the understanding of what is considered a mental illness change over time, with the definitions of disease categories generally expanding and treatment limitations for when a person is sick decreasing (Jønsson and Brodersen, 2022; see Chapter 3). Usage and diagnosis data are therefore used in this report only to illustrate care capacity developments. However, differences in diagnoses between population groups and changes over time are discussed in this chapter when it seems they may reveal something about prevalence.

Survey data capture non-users of care and give people a voice about their own experiences. However, people with poor mental health may be reluctant to share their feelings in surveys. Reduced stigma and greater awareness of mental health can increase the inclination to report. In contrast, people (especially those with mild or moderate depression or anxiety) may report more severe symptoms than observed by clinicians (Yamada et al., 2023). In existing EU-wide surveys, some groups in particularly vulnerable situations are often under-represented in, or excluded from, samples (children, people who experience homelessness or are in institutions such as prisons, hospitals or residential care). People with (or at risk of) poor mental health may be identified using indexes based on indirect questions, or by asking respondents directly whether they experience poor mental health; these approaches can identify different groups. For instance, in 2024, 34 % of adults in the EU were at risk of depression as determined by an index (the eight-item Center for Epidemiological Studies Depression Scale, CES-D-8), where their risk of depression was calculated as CES-D-8 ≥ 7. This was about equal to the percentage reporting in the ESS that they felt depressed at least some of the time in the previous week (35 %) (6.1 % said they felt depressed most or almost all the time). However, of those at risk of depression according to the index, 33 % did not report feeling depressed at least some of the time, while 26 % of those who reported feeling depressed in the ESS were not judged to be at risk of depression by the index.

Altogether, these proxies give a rough picture of the prevalence of poor mental health, even if it cannot be precisely measured (Figure 2). Data on suicide deaths and attempts and suicidal thoughts add to the picture. While suicide is an extreme outcome of poor mental health, the data on suicide are relatively robust, including with regard to groups in particularly vulnerable situations not captured by surveys and care use/diagnosis data.

**Figure 2: Measuring the prevalence of poor mental health: Survey, care use and diagnosis data**




**Source:** *Authors.*

## Prevalence and time trends

It is difficult to distil trends in the prevalence of poor mental health in the EU from the scattered data available, on a topic with many measurement challenges. However, taking together the harmonised cross-national data, national data and literature presented below, the following picture emerges.

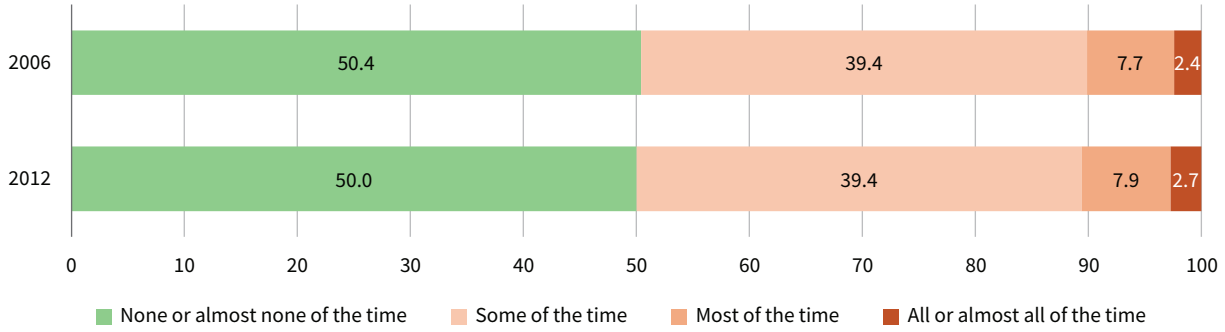
Poor mental health increased during the Great Recession, but decreased in the years leading up to the COVID-19 pandemic. During the pandemic, poor mental health increased, but it has since levelled off at or just above prior levels.

### EU harmonised survey data

EU-level harmonised surveys show that prevalence remained stable in the period before the pandemic and suggest that increases in depression during the pandemic stalled rapidly afterwards. During the pandemic, there were large variations in the levels of poor mental health, which were higher when measured during lockdown periods (see 'COVID-19 pandemic').

In 2019, 6.2 % of the EU population [5] aged 15 years and over was at risk of depression, measured by scoring at or above the threshold (10 on a scale of 0–24) of the Patient Health Questionnaire (PHQ)-8 scale, compared with 6.3 % in 2014. In the case of anxiety, only self-reported (rather than index-based estimates) and older cross-country data were identified. In 2009, 2.8 % of respondents reported suffering from chronic anxiety in the previous 12 months (EHIS). ESS data indicate a slight increase between 2006 and 2012 (Figure 3).

**Figure 3: Feelings of anxiety, 2006 and 2012, EU (%)**




**Notes:** *Data are weighted. Excluding countries for which there were insufficient data for 2006 and/or 2012 (Austria, Croatia, Czechia, Greece, Italy, Latvia, Lithuania, Luxembourg, Malta and Romania). Survey question: 'Please tell me how much of the time during the past week you have felt anxious.'*
**Source:** *Eurofound analysis of ESS microdata.*

(5) Excluding France.

The proportion of people at risk of depression was lower in 2014 than in 2006, but proportions were similar in 2014 and 2024 (Figure 4). Among the 13 Member States for which time comparisons can be made, 7 had higher proportions in 2024 than in 2014, and 6 had lower. Among people aged 50 years and over, depression rates decreased from 28.4 % pre-pandemic (2020) to 28.2 % in 2022 (Survey of Health, Ageing and Retirement in Europe data, also examined in Figure 13).

## National evidence

National survey-based estimates of poor mental health tend to show slight upward trends over the past two decades. While steep increases have been observed since the pandemic, upward trends were often present before it.

### EU compilations of national survey data

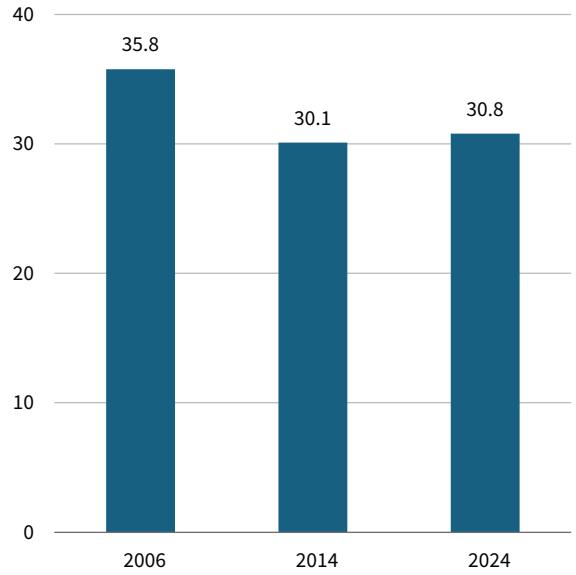
Rates of anxiety and depression increased during the Great Recession before peaking in 2015 and 2011, respectively, according to a compilation of national survey data (Figure 5). Anxiety rates decreased again after 2015, but both anxiety and depression have remained above pre-recession levels. Both surged during the pandemic. A meta-analysis of national survey data suggests that early in the pandemic, both anxiety and depression increased, but later levelled off (Ahmed et al., 2023).

### Detailed national survey-based evidence

Detailed national survey-based data give further insights, often showing increased prevalence.

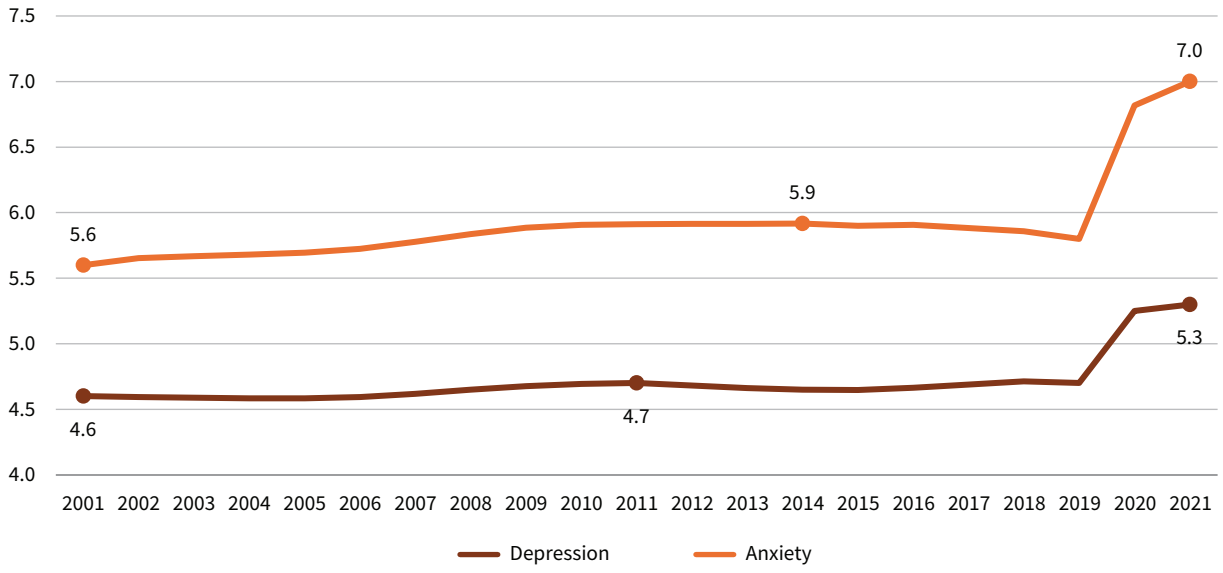
- In Czechia, the proportion of people with mental disorder symptoms increased from 20 % in 2017 to 30 % in May 2020, decreasing to 27 % by late 2022. Major depression and anxiety increased respectively from 4.0 % and 7.8 % in 2017 to 12 % and 13 % in 2020, decreasing to 8.8 % and 12 % in 2022 (Potočár et al., 2024).
- In Estonia, the proportion of people who reported feeling more unhappy/depressed in the previous 30 days than they had before increased from 22.2 % in 2014 to 29.7 % in 2022 (Reile and Veideman, 2023).

**Figure 4: Share of the population at risk of clinical depression, 2006, 2014 and 2024, 13 Member States (%)**




**Notes:** *Data are weighted. Including countries for which data were available for 2006, 2014 and 2024 (Austria, Belgium, Finland, France, Germany, Hungary, Ireland, the Netherlands, Poland, Portugal, Slovenia, Spain and Sweden). Depression risk is calculated as CES-D-8 ≥ 7.*
**Source:** *Eurofound analysis of ESS microdata.*

**Figure 5: Prevalence of anxiety and depression among adults, EU estimates, 2001–2021 (%)**




**Source:** *Eurofound compilation of data from the Institute for Health Metrics and Evaluation (undated).*

- In France, the share of people aged 18–75 years reporting symptoms of major depression had been increasing since 2010, but surged particularly between 2017 and 2021, from 9.8 % to 13.3 % (especially among people aged 18–24 years, where it rose from 11.7 % to 20.8 %) (Santé Publique France, 2024).
- In Germany, around 20 % of the population reported depressive symptoms from summer 2022 to spring 2023 in each quarterly survey in that period, almost double the proportion that did so in 2019. From 2021, the proportion of people reporting anxiety also increased, from 8 % in 2021 to 12–15 % from the second half of 2022 to 2023 (Robert Koch Institute, 2024).
- In Sweden, people aged 16 years and over with light (feeling nervous and anxious) or difficult (stronger worries, felt in the body) anxiety increased by 5 percentage points between 2006 and 2022 (Busch, 2023).

## Suicide deaths and attempts and suicidal thoughts

Reasons for suicide are hard to disentangle. In high-income countries, mental disorders are present in up to 90 % of people who die by suicide. The remaining 10 % also have symptoms of poor mental health, albeit without a diagnosis (WHO, 2014). Suicide can happen impulsively in moments of crisis linked with a breakdown in the ability to deal with life stresses, such as financial problems, relationship disputes or chronic pain and illness. Experiencing conflict, disaster, violence, abuse, loss, discrimination or isolation is associated with death by suicide (WHO, 2014). Additional risk factors have been identified in national research. In France, these include being single, divorced or widowed, professional inactivity and exposure to traumatic events in childhood. In the Netherlands, the risk factors for middle-aged men include divorce, job loss or disability, and feelings of shame or failure due to not living up to the expectations of male role models (ZonMw, 2023). Research from Lithuania suggests that suicide often stems from the disruption of coping mechanisms (triggered by repeated traumatic events resulting in feelings of deficiency) due to exhaustion or an emotional event. Sexual abuse, emotional neglect and cultural norms restricting emotionality and promoting regressive attitudes towards psychological help are key factors (Rimkevičienė et al., 2024).

Some countries collect information on reasons for recorded suicide attempts.

- In Denmark, the main reasons cited are loneliness (36 %) and bullying (25 %).
- In Poland, the main (direct) reasons include mental illness (28.1 %), disappointment in relationships (9.5 %) and domestic violence and family problems (8.6 %). However, reasons are often undetermined (35.4 %).

Suicide is under-reported as a reason for death. Whether death was intentional or not is determined by assessing the circumstances and testimony. A limited number of autopsies are conducted to determine the cause of death. Some suicides are probably misclassified as accidents (e.g. poisonings, drug overdoses or traffic collisions). Others may be classified as 'intent unspecified' or 'unknown cause of death' (Värnik et al., 2021). In countries where the main religion sees suicide as a sin, misclassification is more likely, especially among women (Pritchard et al., 2020). For such reasons, Luxembourg's statistical office groups deaths of undetermined intent and self-inflicted injuries together. In Sweden, 300 people die from suspected suicide annually (in addition to around 1 200 confirmed suicides) (FHM and Swedish National Board of Health and Welfare, 2023). There have been changes in prevalence of deaths with unspecified intent or unknown causes. For instance, in Ireland, deaths with undetermined causes decreased from 2015 while the number of recorded suicide deaths increased (Cox et al., 2022). In Lithuania, unexplained and unspecified deaths increased over time (Rimkevičienė and Misevičius, 2020). Assisted suicide legislation affects the data. In Germany, assisted suicides are not recorded separately. A February 2020 constitutional court ruling (Bundesverfassungsgericht, 2020), resulting in a legal grey zone for assisted suicide, could explain the 42 % higher rates of suicide by medication in 2021 and 2022 compared with 2020. In Austria, the recent increase in suicide may have a similar explanation in part.

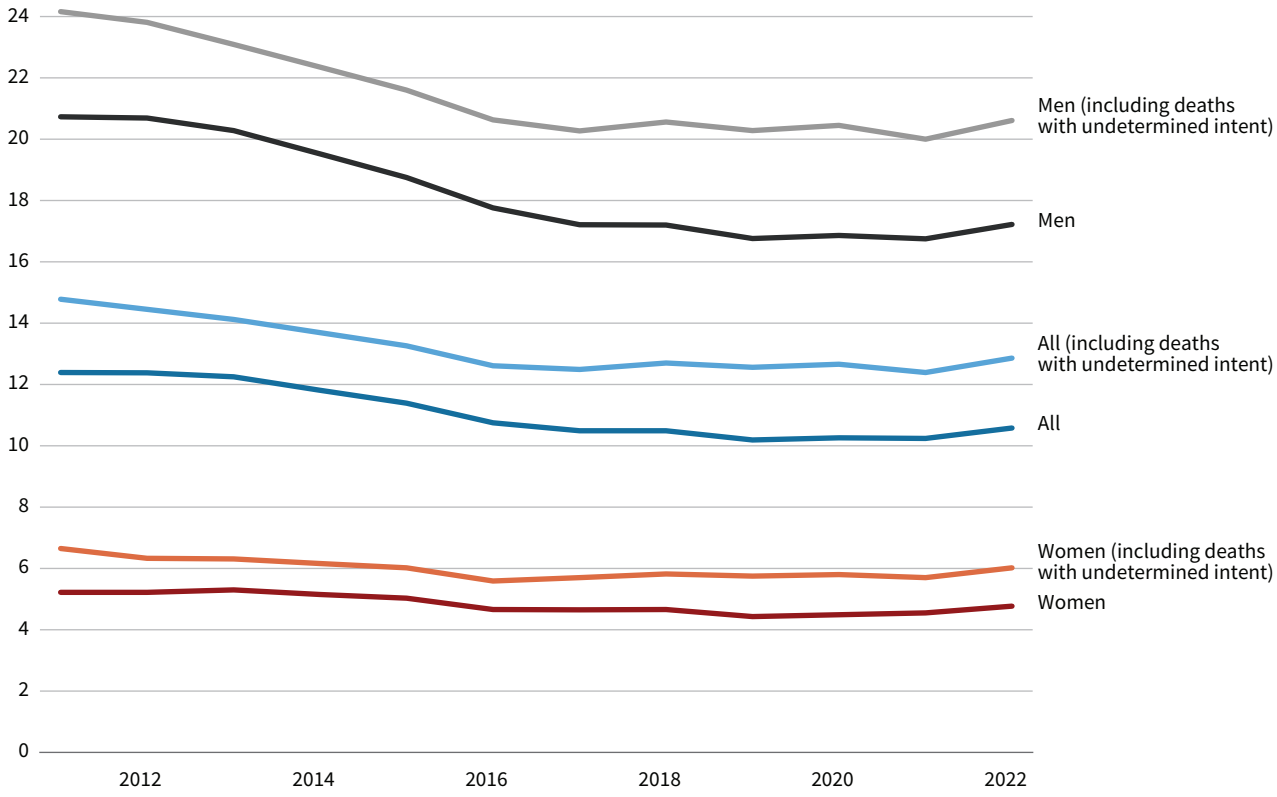
In 2021, the EU's suicide rate was 10.6 people in 100 000, accounting for 0.9 % of deaths (Eurostat [hlth_cd_acdr2]). Among people aged 15 to 29 years in the EU, suicide is the main cause of death (18.9 % in 2021), followed by traffic collisions (16.5 %) (Eurostat [hlth_cd_aro]). Deaths recorded as 'events of undetermined intent' (2.9 %) and some recorded accidents (e.g. drowning, falls or poisoning, together 7.6 %) may also be suicide. In countries with fewer traffic collisions and undetermined deaths, particularly high proportions of deaths are classed as suicide, especially among young people. For instance, in the Netherlands, 31 % of people aged 20–29 years who died between 2020 and 2023 died by suicide.

Suicide rates have decreased dramatically over the past few decades, probably due to better access to care and improvements in working and living conditions. From 2011 to 2021 (the period for which EU-wide data are

available), standardised [6] suicide death rates, not including events of undetermined intent, decreased from 12.39 to 10.24 per 100 000 people (Figure 6). The downward trend was mainly driven by a decrease among men, for whom suicide is still much more common than for women (Figure 6; see also 'Women'). From 2011 to 2021, Hungary, Latvia, Lithuania and Luxembourg showed the strongest decreases (by over 5 suicides per 100 000 people). In four countries, suicide rates increased: Sweden (by 0.09 suicides per 100 000 people), the Netherlands (by 0.56), Spain (by 1.19) and Malta (by 2.10). Decreases have mainly been observed in the middle age group, while rates among those aged 15–19 years and 85 years and over have decreased only marginally in the past decade. Suicide rates among both these age groups even increased from 2020 to 2021, while that of the middle age group kept decreasing. There are differences between countries. In the Netherlands, decreases have been observed mainly in those aged 60 years and older, especially women, possibly because improvements in care services have helped them more than men. National data reveal longer-term decreasing trends, for instance since the mid-1980s (Austria, Hungary) or the 1990s (Norway).

However, the decrease has stalled since 2017, and especially since 2019 (Figure 6). More recent national data show that in some countries, increases can be observed from 2021 to 2022 (Cyprus, Estonia, Hungary (no data for 2023) and Spain) and from 2022 to 2023 (Latvia, Lithuania and Poland). In Germany, Greece and Malta as well, 2022 and 2023 numbers were higher than they had been before. Portugal saw an increase from 952 deaths by suicide in 2021 to 984 in 2023. In Lithuania, deaths by suicide per 100 000 people decreased year on year from 32.85 in 2015 to 18.6 in 2022, but, in 2023, for the first time in years, they increased to 19.6. Austria saw an increase from 2021 to 2022, but a decrease from 2022 to 2023. In Denmark, the number of deaths by suicide increased from 547 in 2021 to 572 in 2022, still below the 605 in 2019. Updated data, made available shortly before publication of this report, confirmed that the number of (standardised) suicide deaths increased in the EU: by 0.34 persons per 100 000 between 2021 and 2022 (from 10.24 in 2021 to 10.58 in 2022), and by 0.47 if including deaths of undetermined intent (from 12.39 to 12.86). The increase was considerably greater among both men and women compared with other increases observed in some of the preceding years (Figure 6).

## Figure 6: Suicide deaths, standardised numbers per 100 000 people, EU




**Source:** *Eurofound's analysis of Eurostat data [hlth_cd_asdr2], extracted 14 May 2025.*

[6] Adjusted to a standard age distribution.

Many countries do not systematically collect data on suicide attempts, and data are often internationally incomparable. Emergency calls or hospitalisations often serve as a proxy for attempts, but this underestimates attempts, as not all attempts result in calls or hospitalisations. Sometimes, diagnostic data related to suicide attempts and suicidal thoughts are not recorded by doctors to protect patients from negative consequences, such as their driver's licences being jeopardised (Strička et al., 2021). However, illustrative data presented below show that estimated attempts outnumber suicide deaths:

- in Germany, suicide attempts were estimated at 100 000 in 2022, 10 times the number of suicide deaths that year (Müller-Pein et al., 2023);
- in Luxembourg, suicide attempts are estimated at around 700 annually;
- in Malta, there were 340 reported suicide attempts from 2020 to 2022 (compared with 73 suicide deaths);
- in the Netherlands, around 15 700 emergency department visits were due to self-inflicted harm in 2022;
- in Slovakia, 724 suicide attempts were recorded in 2022.

In some countries (France, Lithuania, Poland, Portugal and Spain), estimated suicide attempts have increased in recent years (within different time frames), usually regardless of decreasing suicide rates. This may be due in part to suicide attempts less often resulting in death. For instance, in Poland, in 2017, 47 % of estimated attempts ended in death, while 35 % did in 2023 (Komenda Główna Policji, 2024a, 2024b). In some other countries (Czechia, Denmark and Sweden), there are downward trends in attempts. Note the following data:

- in Czechia, 2 850 people were hospitalised due to a suicide attempt in 2021, down from a 2014 peak (3 575);
- in Denmark, suicide attempts (as the reported reason for hospitalisation or hospital visit) declined from 3 274 in 2019 to 2 613 in 2023;
- in France, between 2016 and 2022, in a study among patients aged 25 years and under, hospitalisations due to suicide attempts increased (by 14 %), especially among women (Fond et al., 2025);
- in Latvia, there are 1 100–1 500 emergency calls relating to suicide annually;
- in Lithuania, recorded suicide attempts decreased from their 2015 level to 3 245 in 2017, after which they increased to 3 734 in 2019 (Strička et al., 2021);
- in Poland, there were 15 888 recorded suicide attempts in 2022, up from 11 679 in 2017;
- in Portugal, emergency calls related to risky behaviours, especially suicide attempts, increased by 39 % from 2019 to 2021;
- in Spain, during the pandemic, suicide attempts increased, especially among girls (Fond et al., 2025);
- in Sweden, suicide attempts recorded per 100 000 people decreased from 114.6 in 1994 to 80.4 in 2022 (National Centre for Suicide Research and Prevention, 2024).

Suicidal thoughts are even more widespread. In the Netherlands, in March 2024, 13 % of people aged 12–25 years sometimes or often thought about suicide, down from 17 % in September 2023. In December 2023, 8 % of adults had seriously thought about ending their life in the previous three months or had these thoughts very often. In Czechia, taken as a whole, rates of suicidal thoughts and behaviours climbed from 3.9 % in 2017 to 14 % in 2020, declining to 10 % by 2022 (Potočár et al., 2024). In Estonia, the proportion of adults having had suicidal thoughts in the previous 12 months increased steadily from 5 % in 2012 to 9 % in 2022, and suicidal thoughts were especially common among those aged 16–24 years (20 % in 2022) (Reile and Veideman, 2023). In Latvia, in 2020, 5.6 % of adults reported thoughts of physically harming themselves. In France, in 2017, 5 % of those aged 18–75 years said they had thought about suicide in the past year. In Poland, 28 % of those aged 9–21 years said they lacked the desire to live and 40 % had considered suicide (Dębski and Flis, 2023).

## Prior experiences

People with good mental health may have had poor mental health at some point in their lives (especially older people, with more life experience). Survey data provide information on this, although comparison with national administrative data suggests underestimations (people who have experienced poor mental health may not always report this). Data from the 2009 EHIS in 13 Member States, among people aged 15 years and over, provide the most recent cross-EU picture available:

- 4.7 % reported they had experienced chronic anxiety at some point in their lives (ranging from 1.0 % among people aged 15–19 years to 7.7 % among people aged 70 years and over), and 2.8 % reported they had been diagnosed with it;
- 4.3 % reported they had experienced chronic depression (ranging from 0.6 % among people aged 15–19 years to 7.2 % among people aged 70 years and over), and 2.9 % reported they had been diagnosed with it.

National survey data give further insights:

- in Austria, an estimated 25–30 % of the population has had poor mental health at some point (ÖBVP, undated);

- in Bulgaria, analysis of 2017 survey data suggests that 14.5 % of the population has had one or more common mental disorder: 8.4 % anxiety, 4.5 % mood disorder, 4.4 % alcohol abuse/dependence and 0.4 % drug abuse/dependence;
- in Greece, in 2019, 19 % of people aged 19–65 years reported having sought help from mental health professionals at least once in their life; 45 % of them had done so after 2015 (Kataki et al., 2021);
- in Lithuania, in 2022, 8.1 % of the population reported they had been diagnosed with a mental disorder at some point in their lives (Grigutytė et al., 2022);
- in Poland, from 2018 to 2020, 7.0 % and 11.3 % of people aged 18–64 years and 65 years and over, respectively, reported having experienced panic-level anxiety attacks, and 7.8 % of all adults reported having experienced some level of anxiety attack; meanwhile, 3.85 % of all adults reported having experienced depression (0.77 % within the last year) (Instytut Psychiatrii i Neurologii, 2021).

National surveys shed light on the proportion of people who report having attempted suicide in their lives, with estimates such as 6.1 % in Latvia (1.6 % more than once), 4.3 % of people aged 15 years and older in Belgium (0.2 % within the past year) and 8.8 % of those aged 9–21 years in Poland in 2023 (Dębski and Flis, 2023). In France, 7 % of people aged 18–75 years have thought about attempting suicide at some point.

## Contextual external shocks and trends

Poor mental health stems from numerous, often interlinked, causes. Contextual factors include financial stress, unemployment, relationship problems, social isolation, discrimination, bereavement, worries about the future and stress related to work, school or informal care provision. The prevalence and characteristics of these causes are affected by external shocks and long-term trends, influencing the prevalence and aspects of poor mental health. For instance, in 2023, 28 % of people in the EU who had had a psychosocial issue in the previous 12 months said that recent world events (the COVID-19 pandemic, the Russian war in Ukraine, the climate crisis, unemployment, rising food and energy costs) had impacted their mental health to a great extent; 50 % reported that events had affected their mental health ‘somewhat’ (analysis of Eurobarometer data, European Commission, 2023b).This section focuses on such contextual developments.

### COVID-19 pandemic

The 2020–2022 pandemic affected people negatively, through both the virus itself (becoming ill from it, being afraid of catching it, knowing people who died or became ill from it) and governments’ non-pharmaceutical measures (social distancing, school closures, bans on leaving the home and on visiting care homes). The resulting grief, loneliness, unemployment, reduced physical movement, unhealthier eating and drinking habits and increased domestic violence were drivers of poor mental health. Among people who were followed by Eurofound’s Living, Working and COVID-19 e-survey and asked about their feelings of depression and tension throughout and after the pandemic, such feelings fluctuated. They peaked in spring 2021 and spring 2022 (with 23–24 % and 27–31 % of respondents, respectively, reporting depression), while in 2023 they returned to around 2020 levels (20–21 %). Such feelings seem to have been responsive to lockdowns, largely bouncing back to pre-lockdown levels once the lockdowns were over. However, this was not the case for individuals already experiencing poor mental health (Jindal and Mascherini, forthcoming). Overall, in addition to short-lasting peaks, there seems to have been a small increase in self-reported poor mental health since the start of the pandemic (RESPOND, 2024). Large-scale, long-term negative impacts on mental health seem absent, except among people whose long-term health was affected by the virus itself or who lost loved ones to it.

National evidence confirms large increases in poor mental health during lockdown periods especially. For instance, 48 % of Poles reported a decrease in mood and self-esteem, with symptoms such as depression, anxiety and neurotic behaviours, or a general decline in mental health (Główny Urząd Statystyczny, 2021). In Austria, in September 2020, around 8 % of adults had suffered from severe depressive symptoms since the pandemic started, up from 1 % in 2014. In Czechia, the prevalence of common mental illnesses rose from about 20 % in 2017 to 30 % during the 2020 lockdowns. People scored positively for depression three times more frequently during the pandemic, anxiety twice as frequently and risk of suicide three times more frequently (Winkler et al., 2020).

In early 2023, depression and anxiety were generally still above 2019 levels (OECD, 2023a; see also ‘National evidence’). In Slovenia, depression rates among adolescents increased from 13 % to 22 % from 2018 to 2022. In Greece, mental disorder rates rose from about 5 % in 2019 to 22.8 % in 2023 (Ministry of Health, 2023).

The mental health of young adults, older people, single people, students, care workers, informal carers, low-income groups and people with a migrant or refugee background has been particularly affected (Eurofound, 2021, 2022a; Benatov et al., 2022; OECD, 2022b; RESPOND, 2024). While people of all ages and genders were affected by the various factors, financial issues were a common driver among young adults; reduced social interaction was a primary factor for older people, young adults and children; and work–life balance problems and exposure to domestic violence

were the most prevalent factors for women. Based on data from EU Labour Force Survey ad hoc modules, workers in the EU reporting exposure to risk factors that can adversely affect mental well-being increased, especially for women (from 28 % in 2013 to 45 % in 2020), but also for men (from 26 % in 2013 to 38.5 % in 2020) (Eurostat [hsw_exp1]).

National in-depth studies give some insight into the types of poor mental health and the factors most frequently at play, and highlight the impacts on groups often not (or not well) captured by population surveys (e.g. children). Illustrations include the following.

- In Austria, depression increased among adults between 2020 and 2022, but anxiety did not, based on PHQ-9 and General Anxiety Disorder (GAD)-7 indexes. Those aged 18–34 years or on low incomes were most affected (Humer et al., 2022). Among people aged 16–69 years, those who had experienced income losses (31 %), single-parent households (32 %) and households hit by unemployment (37 %) reported their mental health had been affected negatively by the pandemic situation more than average (26 %) (BMSGPK, 2023a).
- In Bulgaria, after the first lockdown (2020), suicide increased among both genders, probably due mainly to increased loneliness, domestic violence and alcohol consumption (Zarkov et al., 2022).
- In Cyprus, the mental health of working mothers and university students (faced with a shift from in-person to distance learning) was particularly affected (Demetriou, 2021).
- In Estonia, people whose income decreased due to the pandemic had depressive symptoms more often (41 %) than others (25–26 %). Fewer leisure activities coincided with more depression and anxiety symptoms (Kask et al., 2020).
- In France, a study conducted among people aged 25 years and under showed that use of mental healthcare services had increased, especially post-pandemic (Fond et al., 2025). Living in accommodation without outdoor spaces during the first (most restrictive) lockdown period was a risk factor. Suicidal thoughts were more common among people experiencing loneliness, COVID-19 symptoms, deteriorating health or disability (Santé Publique France, 2024).
- In Greece, in October 2021, the proportions of people who reported suffering from depression and anxiety in the previous 12 months were 12 % and 26 %, respectively, with the highest rates among those aged 17–24 years, low-income groups and people living in more densely populated areas (DiaNEOsis, 2021).
- In Hungary, a deterioration in mental health was reported more than average by women, people who considered their income situation difficult and those whose household included a COVID-19 patient (Sipos, 2022).
- In Latvia, while other mental health diagnoses decreased, anxiety and adjustment disorders surged, especially in 2021. The greatest impact was seen among groups that were already experiencing worse mental health on average (people on a low income, people living alone) and young people (Slimību profilakses un kontroles centrs, 2022).
- In Lithuania, a longitudinal survey among university students aged 18–28 years in late 2020 and late 2021 found an increase in suicidal ideation after the COVID-19 outbreak, with 9 % of students who were already at moderate risk of suicide before the pandemic (reporting high rates of depression) being at higher risk after the outbreak. Loneliness was a risk factor (Gelezelyte et al., 2022). Among children aged 7–14 years, 32 % had clinically relevant emotional and behavioural problems during the second lockdown (April–May 2021) (Jusienė et al., 2021). Among children aged 11–17 years, 82 % showed some anxiety (18 % severe), 31 % loneliness (particularly among those aged 15–17), 81 % tiredness and 24 % severe fatigue. More than half (53 %) reported worsened emotions (anxiety, mood) (Milašiūtė et al., 2023). Both anxiety and depression diagnoses approximately doubled among people under 18.
- In Luxembourg, in April 2020, residents aged 18 years and over in urban areas reported that their mental health had declined during the pandemic (35 % in the southern conurbation, 34 % in Luxembourg City) more often than those in less urban areas (30 % in the east, 28 % in the central region) (STATEC, 2020). Poorer mental health among primary school pupils was mainly due to missing school (68 %) and to relationships with their friends (86 %), teachers (51 %) and family (80 %). For younger people, isolation, reduced social interactions and uncertainty about the future were the main causes. Working adults primarily reported difficulties related to remote work (30 %), fear of losing their job (21 %) and a decrease in income (21 %). For those aged 65 years and over, the deterioration was mainly linked to physical health, worsened finances and isolation.
- In Norway, the prevalence of serious psychological distress among students increased from 20 % in 2010 to 50 % in 2021.
- In Portugal, psychological distress was particularly prevalent among women, people aged 18–29 years, unemployed people, healthcare professionals (especially those treating COVID-19 patients and those needing to move away from family), low-income groups and people who had been in quarantine, hospitalised or infected with COVID-19.

- In Sweden, anxiety and depression increased especially among people already in vulnerable situations, including LGBT+ people, children whose families had issues regarding mental health, addiction or violence, and – due to social distancing and digital exclusion – socially and economically vulnerable older people (FHM, 2020, 2021).

Evidence of longer-term impacts of the pandemic on mental health, beyond early 2023, is scarcer.

- In the Netherlands, among people aged 12–25 years, the proportion reporting stress due to COVID-19 remained stable around 8 % between January 2023 and June 2024.
- In Ireland, in spring 2023, 18 % of adults reported the COVID-19 pandemic as a concern affecting their mental health (Aware, undated). Inpatient admissions due to depressive disorders decreased from 76.6 per 100 000 people in 2022 to 68.8 per 100 000 people in 2023, and those due to anxiety, stress or fear-related disorders decreased from 34.0 to 30.5 per 100 000 people. These were similar to pre-pandemic numbers (HRB, 2024).
- In Norway, while levels of psychological distress were higher during the pandemic, particularly during periods when strict infection control measures were in place, they returned to pre-pandemic levels soon afterwards (Norwegian Institute of Public Health, 2021).

## International conflicts and migration

Refugees from areas experiencing armed conflicts or oppressive regimes face a higher risk of poor mental health (e.g. Ministero della Salute, 2021). In Denmark, one in three adult refugees suffers from post-traumatic stress disorders or depression, and even more report poor mental health (Olsen et al., 2023). In Poland, in surveys conducted in 2022 and 2023, 10.2 % of refugees from Ukraine reported someone in their household to be 'so upset and anxious that it affects the person's daily functioning'. The proportion reporting mental healthcare needs increased from 4.5 % in 2022 to 6.3 % in 2023 (WHO Europe, 2024). In Czechia, 41 % and 23 % of refugees from Ukraine screened positively for (moderate or severe) depression or anxiety, respectively. Self-recognition of poor mental health and help seeking were considered low (Guerrero et al., 2023). In Estonia, in 2022, around 10 % of refugees from Ukraine felt the need for psychological help (Kender, 2023).

International conflicts cause concerns and feelings of insecurity, affecting mental health. In 2022, 76 % of people in the EU expressed high or very high concern about Russia's war on Ukraine (Eurofound's Living, Working and COVID-19 e-survey). In Lithuania, in 2022 and 2023, 39 % of people said their stress or anxiety was caused by international conflicts (Spinter Tyrimai, 2023). Anxiety increased among older adolescents from 2021 to 2022, probably due to Russia's war on Ukraine (Šalčiūnaitė-Nikonovė et al., 2024). In Denmark, in 2023, 24 % people aged 12–30 years were worried about war and destruction. Worry about Russia's war on Ukraine seems to exacerbate the mental health of people already experiencing poor mental health (Østergaard et al., 2022). In Finland, 47 % of people said that they worried about Russia's war on Ukraine and its consequences, and 66 % were worried about its escalation.

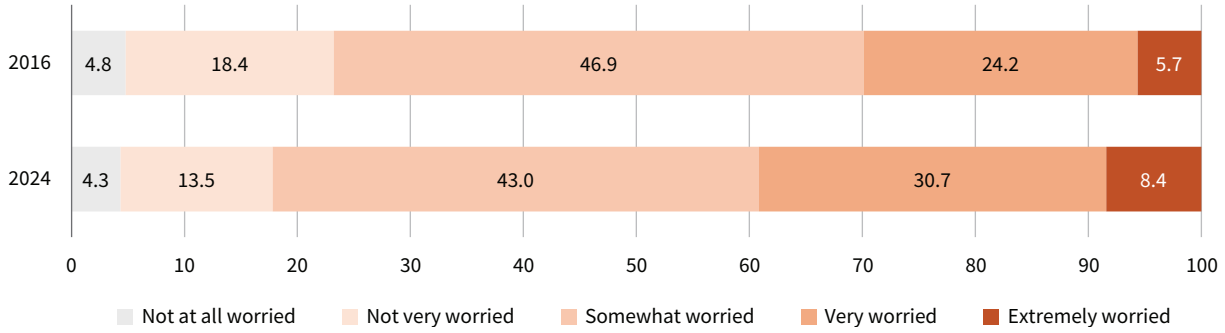
Europe's past conflicts still have an impact today. For instance, the Balkan Wars left a trail of mental health problems (Silobrčić Radić and Švigir, 2023). Decades of wars, occupations and repressive regimes (Nazi, communist) have contributed to high suicide rates in post-communist Member States, although rates have declined rapidly in recent decades (Rimkevičienė et al., 2024).

## Climate change and environmental degradation

Climate change and environmental degradation can negatively impact mental health in multiple ways.

First, worry about climate change and environmental degradation can contribute to poor mental health. Worry about climate change increased between 2016 and 2024 (Figure 7). The number of people reporting extreme worry increased across age groups, though it was less for people aged 15–29 years (from 5.9 % to 8.2 %) than for people aged 30 years and over (from 5.5 % to 8.5 %). However, the peak age range for extreme worry changed from 45–54 years (with 6.3 % of people in this age group extremely worried) in 2016 to 25–34 years (with 10.3 % of this cohort expressing extreme worry) in 2024. Among people aged 16–25 years in Finland, France and Portugal, 33 %, 22 % and 39 %, respectively, reported that climate change made them feel depressed; 49 %, 50 % and 61 %, respectively, reported that it made them feel anxious (Hickmann et al., 2021). In Denmark, in 2023, the 27 % of people aged 12–30 years who worried often or always about climate change were more likely than average to experience anxiety, worry or fear in everyday life (women: 32 % versus 26 %; men: 18 % versus 13 %) (Ahle and Gotfredsen, 2023).

### Figure 7: Levels of climate worry, 2016 and 2024, EU (%)




**Notes:** *Data are weighted. Excluding countries for which there were insufficient data for 2016 and/or 2024 (Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Greece, Latvia, Luxembourg, Malta, Romania and Slovakia). Question: 'How worried are you about climate change?' The percentages for 2024 do not add up to 100 % due to rounding.*
**Source:** *Eurofound analysis of ESS microdata.*

Second, actual climate change and environmental degradation can contribute to poor mental health, for instance through temperature changes, increased frequency of environmental emergencies and pollution. As an example, the 2021 floods in Germany, which caused 180 fatalities and the widespread destruction of buildings and infrastructure, also led to increases in mental and behavioural disorders (Augustin et al., 2024). Farmers' mental health is negatively affected by droughts and the resulting financial insecurity (European Climate and Health Observatory, 2022; OECD, 2023b). Air pollution is associated with depression and anxiety (OECD, 2023b; Lyons et al., 2024).

Third, policies mitigating climate change and environmental degradation can positively impact mental health (e.g. by supporting cleaner air or healthier food). However, they can also negatively impact the mental health of population groups, for instance through job losses or by requiring people to change the way they live or work (Eurofound and EEA, 2023).

## Digitalisation: social media, gaming and digital devices

The digitalisation of working and non-working life has a mental health dimension. For instance, increased telework may, on the one hand, increase loneliness and blur the boundaries between working and non-working time and, on the other hand, facilitate work–life balance and reduce commuting, with different impacts on mental health. However, the focus of this section is primarily on social media use and secondarily on gaming and digital device usage in general, especially among children.

Moderate use of digital technologies tends to benefit mental health. Social media, for instance, helps people to connect with others (62 % in Ireland). Overuse can be a result of poor mental health, but can also cause poor mental health, depending on various factors (OECD, 2024). In particular, social media affects the mental health of about 10–15 % of users negatively and 10–15 % positively (Valkenburg et al., 2022). Social media use leads to poor mental health through addictive use, appearance-based activities, passive use, cyberbullying, sexting and disaster awareness (Prasad et al., 2023).

Problematic social media use (with addiction-like symptoms) among children aged 11, 13 and 15 years increased from 2018 to 2022, especially among girls, who already had higher rates (Figure 8). In 2022, the rates were highest in both genders in Bulgaria, Ireland, Malta and Romania, and lowest in the Netherlands.

### Figure 8: Problematic social media use, 2018 and 2022, EU and Norway (%)


**Notes:** *Problematic use is defined as a score ≥ 6 on the 9-item Social Media Disorder Scale. Percentages are country averages. Excluded are Bulgaria, Cyprus, Denmark, the Netherlands and Slovakia. The score for Belgium is the average of the Flemish and Walloon Regions.*
**Source:** *Eurofound analysis of HBSC (undated).*

In contrast, in 2022, problematic gaming was more common among boys (18 % and 16 % of those aged 13 and 15 years, respectively) than girls (8 % and 5 %, respectively) on average in the 7 Member States for which data are available. It ranges from 5 % in the Netherlands to 19 % in Malta. It is associated with more frequent psychological complaints (WHO Europe, 2024).

National data analysis provides further insights, including on negative impacts on mental health.

- In Austria, in 2022, students aged 14–20 years with higher smartphone usage were more at risk of poor mental health. Higher smartphone usage was also associated with lower physical activity, in turn increasing the risk of poor mental health (Kaltschik et al., 2022).
- In France, in a 2024 survey, 32 % of people aged 18–24 years using social media reported poor mental health, and 65 % had experienced online violence.
- In Germany, an estimated 1 in 16 children aged 10–17 years were addicted to social media or digital games in 2019, over double the 2019 rate. Gender differences were absent in social media addiction, but boys were more often addicted to gaming (DAK-Gesundheit, 2023).
- In Ireland, in 2023, 44 % of adults said social media exacerbates their stress and anxiety. Overall, 38 % said it negatively affected their mood and contributed to their depression; 48 % found that feeling depressed or anxious led to increased screen time (Aware, undated).
- In Lithuania, people aged 11–17 years with problematic social media use were 4.9 times and 1.9 times more likely to experience elevated anxiety in 2021 and 2022, respectively (controlling for other factors).
- In Luxembourg (where the survey used for Figure 8 included a wider age group), in 2022, 9.1 % of children aged 11–18 years showed problematic social media use, up from 5.9 % in 2018. Prevalence was particularly high among girls (11.7 % versus 6.4 % among boys in 2022), as was the increase from 2018 (5.2 percentage points versus 1.6 among boys). This was also the case for groups already at higher risk (low family affluence, living with one parent only, migrant background) (Catunda et al., 2023).
- In Poland, 22.7 % of students and pupils aged under 20 years felt addicted to new technologies (Dębski and Flis, 2023).
- In Slovenia, in 2020, among people aged 14–29 years, time spent with electronic devices was a predictor of higher stress (Lavrič et al., 2021).
- In Sweden, people aged under 19 years with poor mental health use mobile phones, computers and social media for more hours per day than those with fewer mental health problems, including late at night, negatively affecting their sleeping cycle and mental health (FHM, 2024).

## Economic and cost-of-living crises

People on a low income or who are unemployed are at higher risk of poor mental health (see ‘Low socioeconomic status’). An economic crisis means that more people are in such situations, including people who never expected to face unemployment or income reduction and whose self-image is affected. Some people dealing with economic distress may see their situation as less exceptional during a crisis, making them feel less excluded, but, overall, economic crises affect mental health negatively. For instance, the Great Recession that hit the EU from 2008 to 2009 left its mark, especially in the countries most affected.

- In Cyprus, from 2006 to 2012, there was an increase of 17 percentage points in adults reporting they felt anxious at least most of the time (ESS). Risk factors for one-month prevalence of major depression (having experienced major depression in the month before data collection) included being female, being divorced/widowed, being unemployed, having low educational attainment, facing economic distress, having low trust in institutions and having nobody close to them (Economou et al., 2017).
- In Greece, one-month prevalence of major depression among adults rose from 3.3 % in 2008 to 6.8 % in 2009, 8.2 % in 2011 and 12.3 % in 2013. Risk factors included residence in a rural area, low educational attainment, unemployment and economic hardship (Economou et al., 2016).

The importance of the economic environment for mental health is also illustrated by the fact that, while suicide rates rose in Greece, Italy and Spain during the Great Recession, they decreased among migrants from these countries living in Germany (Brennecke et al., 2020).

Reduced purchasing power during the cost-of-living crisis also had a negative impact on mental health.

- In Belgium, in 2023, 41 % of people were very worried about the economy and the increasing cost of living (Sciensano, 2024a).
- In Ireland, in 2023, 32 % and 26 % of adults said the current economic climate and housing climate, respectively, negatively affected their mental health. Most (57 %) said financial worries harmed their mental health; these factors were closely followed by relationships (44 %) and family responsibilities (41 %) (Aware, undated).
- In Lithuania, in 2023, 14 % of people aged 18–75 years said price increases and the economic situation made them feel more anxious, stressed or concerned (Spinter Tyrimai, 2023).
- In the Netherlands, in 2024, over 60 % of people aged 12–25 years worried about the high cost of meeting daily needs and about housing availability and costs, more than any of the other issues asked about. The cost of meeting daily needs was also the most common concern among people aged 26 years and over (RIVM, 2025).

## Population groups

People most at risk of poor mental health (particularly depression and anxiety) include women, those who report being unemployed or 'permanently sick or disabled' as their economic activity status, people with disabilities (defined by being hampered in their daily activities) and single adults (especially parents) (Table 1). In addition to these groups, this section draws attention to other sizeable population groups (not identified in these survey data) who are at higher risk of poor mental health, usually because they face specific barriers in society. Still more groups, not discussed here, who are sometimes at higher risk of poor mental health include migrants, ethnic minorities and foreign workers. For instance, foreign workers in Malta are at higher-than-average risk of suicide. In Germany, Germans were at higher risk of suicide than migrants in

### Table 1: Variation in depression and feelings of anxiety, EU (%)

| | Depressed (past week, 2024) | Feeling anxious (past week, 2012) | Emotional or psychosocial problems, such as feeling depressed or feeling anxious (past year, 2023) |
|---|---|---|---|
| **Gender** | | | |
| Men | 28.4 | 8.6 | 43 |
| Women | 39.5 | 12.6 | 56 |
| **Education level** | | | |
| ISCED level 1 or below | 47.6 | 16.1 | |
| ISCED level 2 | 38.8 | 13.0 | |
| ISCED level 3 | 33.1 | 9.9 | |
| ISCED level 4 | 31.2 | 9.1 | |
| ISCED level 5 | 26.1 | 7.7 | |
| ISCED level 6 | 24.1 | 5.7 | |
| **Activity status** | | | |
| Paid work | 28.6 | 8.3 | 50 |
| Education | 25.4 | 6.8 | 66 |
| Unemployed | 47.1 | 15.9 | 67 |
| Permanently sick/disabled | 70.1 | 27.0 | |
| Retired | 42.7 | 13.7 | 38 |
| Domestic tasks/care | 40.5 | 12.2 | 61 |
| Other | 36.6 | 14.5 | |
| **Hampered in daily activities by illness/disability/infirmity/mental problem** | | | |
| No | 27.7 | 8.1 | |
| Yes, to some extent | 52.0 | 16.0 | |
| Yes, a lot | 72.2 | 27.7 | |
| **Household type** | | | |
| Lives alone | 49.7 | 14.0 | 53 |
| Single parent | 53.9 | 18.8 | 58 |
| Lives with partner (no children) | 31.7 | 9.7 | 43 |
| Lives with partner and children | 29.7 | 9.5 | 48 |
| Other | 30.5 | 8.8 | 56 |
| **Total** | **34.1** | **10.7** | **50** |

**Notes:** *Data on depression are from ESS wave 11 (2024) and weighted. Data covering Bulgaria, Czechia, Denmark, Estonia, Latvia, Luxembourg, Malta and Romania are unavailable. (Depression is calculated as a CES-D-8 score ≥ 7.) Data on feeling anxious are from ESS wave 6 (2012) and weighted. Data covering Austria, Croatia, Greece, Latvia, Luxembourg, Malta and Romania are unavailable. (Question: 'Please tell me how much of the time during the past week you have felt anxious.' The sum of the answers 'Most of the time' and 'All or almost all of the time' are shown here.) Data on emotional or psychosocial problems are from the Eurobarometer, including all 27 Member States. (Question: 'In the last 12 months, have you had any emotional or psychosocial problems (such as feeling depressed or feeling anxious)?')*
**Source:** *Eurofound analysis of ESS and Eurobarometer microdata.*

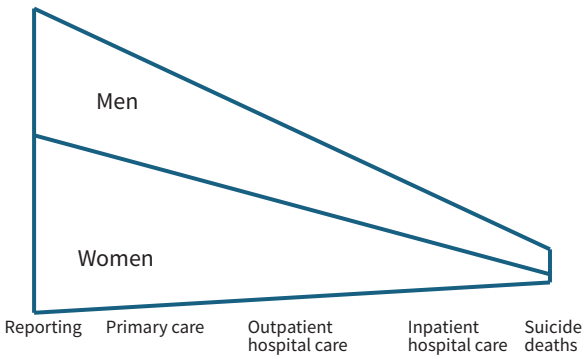
general, but Russian and younger migrants were at relatively high risk (Brennecke et al., 2020). In Denmark, ethnic minority groups face a higher prevalence of anxiety, depression and suicide (Olsen et al., 2023). Other particularly marginalised population groups (e.g. Roma, former detainees) also tend to face a higher risk of poor mental health.

## Women

Overall, women are at higher risk of anxiety and depression than men, judging by self-reporting and primary mental healthcare usage data. Greater exposure to certain risk factors, such as work–life balance tensions, household work burdens, domestic abuse, financial strain and social insecurities, can contribute to this. For instance, more frequent sick leave from paid work due to poor mental health among women in Sweden has been attributed to higher exposure to work-related stress, particularly in care occupations and those that require face-to-face contact with other people, and gender inequality at home, which amplifies the overall workload (Försäkringskassan, 2023).

Women are generally more at risk of poor mental health, but this gender gap tends to narrow – or even reverse – at more severe stages, such as hospitalisations. In the case of alcohol and substance addiction and suicide deaths, the trend reverses and men are at greater risk (Figure 9). This has been attributed to men being less likely to seek support in the early stages of poor mental health.

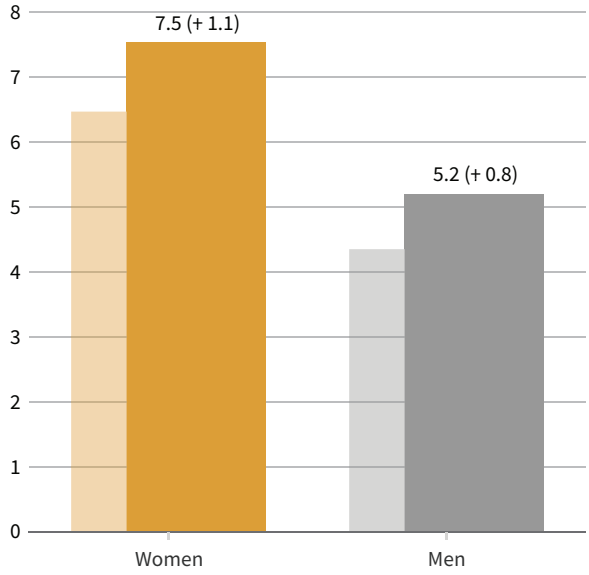
### Figure 9: Schematised gender differences in poor mental health: reporting, care usage and suicide deaths




**Source:** *Authors.*

Between 2014 and 2019, the proportion of people who reported having visited a psychiatrist or psychologist increased in absolute terms more for women than for men, from already higher levels (Figure 10).

### Figure 10: Change in visits to psychiatrists/ psychologists by gender, 2014 and 2019, EU (%)




**Notes:** *Data are weighted. France is excluded. Question: 'In the past 12 months have you visited on your own behalf a psychologist, psychotherapist or psychiatrist?'*
**Source:** *Eurofound analysis of EHIS microdata.*

National service usage and survey data confirm that gender differences vary by type of mental health problem.

- In Austria, in inpatient care, 'mood/affective' and 'other mental and behavioural' disorders are more common among women, and alcohol and substance use disorders among men. Twice as many women as men had depressive symptoms between 2019 and 2022 (Kaltschik et al., 2022).
- In Czechia, in 2022, most of those diagnosed in outpatient care with neurotic, stress and somatoform disorders (72 %) and depression (71 %) were women (ÚZIS, 2022).
- In Estonia, depression (15.5 % versus 8.9 %) and anxiety (12.7 % versus 6.5 %) diagnoses were more common among women than men.
- In Italy, from 2015 to 2018, service usage for schizophrenic and substance abuse disorders was higher in men, and for affective, neurotic and depressive disorders in women. In the case of depression, almost twice as many users were women than men.
- In Norway, anxiety and depressive disorders were the most common reasons for using mental healthcare for both men and women aged 15–64 years. However, for men the next most common reason was alcohol and drug use disorders, and for women it was mental problems due to stressful events (adjustment disorders). Gender differences were less pronounced for schizophrenia and bipolar disorders (Norwegian Institute of Public Health, 2024).

- In Portugal, in 2023, 40.1 % of women and 27.4 % of men aged 16 years and over had anxiety (GAD-2 index ≥ 3), and 13.7 % and 7.9 %, respectively, had severe anxiety (GAD-2 ≥ 3) (INE, 2024).
- In Slovakia, in 2022, among outpatient psychiatric care recipients, affective disorders, neurotic, stress-related and somatoform disorders and organic, including symptomatic, mental disorders were more common among women than men. Mental and behavioural disorders due to substance use and behavioural and emotional disorders with onset usually occurring in childhood and adolescence were more common among men than women.
- In Slovenia, in inpatient care, men are over-represented among those diagnosed with 'mental disorders due to alcohol', and women are over-represented among those (smaller groups) with other diagnoses.
- In Spain, in 2019, depression was three times more common among adult women than adult men; anxiety and phobia were also more common. Meanwhile, schizophrenia and personality disorders were 1.5 times more common among men than women.

Prior experiences with poor mental health also tend to be more common among women; 6.2 % of women and 3.0 % of men reported that they had had chronic anxiety at some point in their lives (3.8 % and 1.7 %, respectively, were diagnosed); and 5.7 % of women and 2.8 % of men reported that they had had chronic depression at some point (3.9 % and 1.7 %, respectively, were diagnosed) (EHIS wave 1; see 'Unmet needs'). In Poland, from 2018 to 2020, 9 % of women and 5 % of men aged 18–64 years said they had experienced panic-level anxiety attacks; the largest gender differences were among students (1.8 % of men versus 8.4 % of women) and retirees (7.6 % of men versus 12.8 % of women). Among women, 4.9 % had experienced depression (1.1 % in the previous year), compared with 2.75 % of men (0.4 % in the previous year) (Instytut Psychiatrii i Neurologii, 2021).

Female users outnumber male users in primary-level mental healthcare in all countries for which data were obtained, and frequently also in secondary and outpatient care, and when all types of care provision are taken together. For instance, in Spain, primary mental healthcare usage among women has been about double that among men over the past decade. In Slovenia, between 2013 and 2022, 61 % of primary care users with mental and behavioural disorders were women.

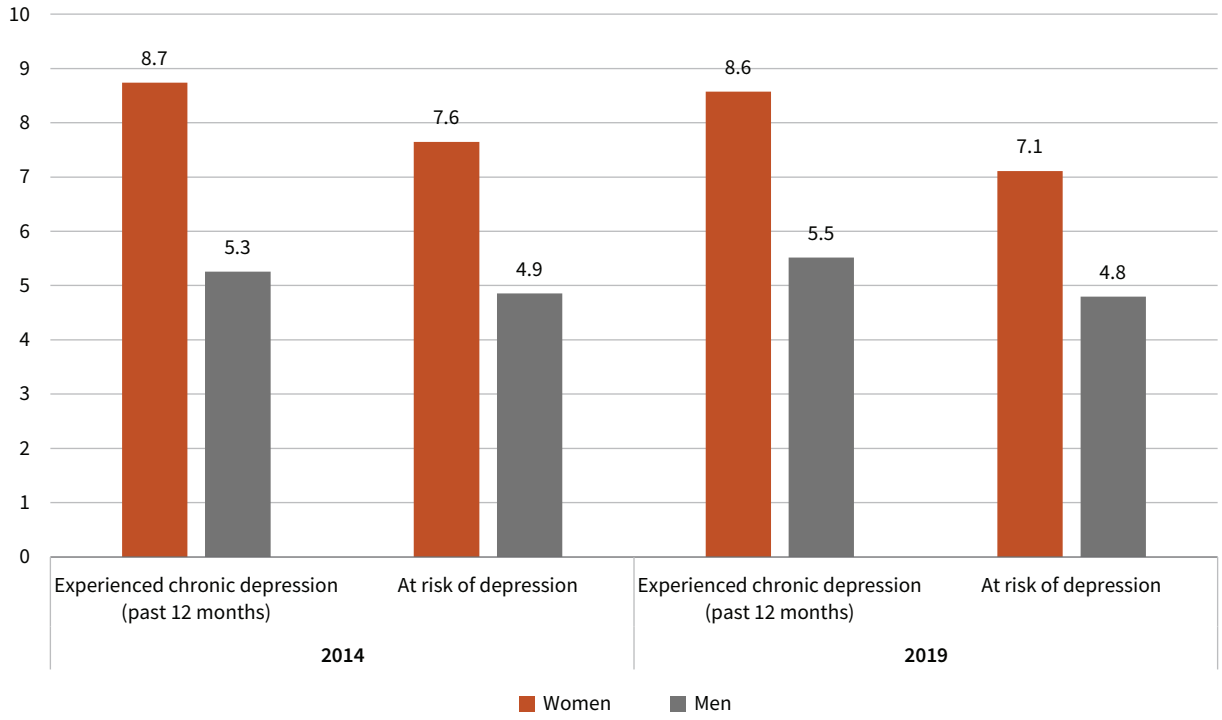
In secondary care, women (56 %) outnumber men (44 %), but by less than in primary care. In outpatient care, women also tend to be over-represented. In Slovakia, in 2022, 59 % of the 417 530 people examined in psychiatric outpatient clinics were women. In Cyprus, most outpatient visits to psychiatric clinics in 2022 were by women (58 % of 150 517). Most patients aged 45 years and over were women, but more patients aged 44 years or under were men. Of 9 743 outpatient paediatric psychiatric visits, 64 % were by boys. In Estonia, from 2016 to 2021, 13.8 % of women (11.6 % of men and 12.8 % of adults overall) used psychiatric, psychologist or psychotherapy services financed by public health insurance.

In inpatient mental healthcare, men tend to be over-represented, or only slightly under-represented.

- In Austria, in 2022, 47 % of the 84 561 patients receiving hospital care for 'mental and behavioural disorders' were men.
- In Croatia, in 2022, mental-health-related hospitalisations were more common among men than women.
- In France, in each of the years from 2019 to 2022, a study on inpatient psychiatric care for people aged 25 years or younger found that around 51 % of patients were men (Fond et al., 2025).
- In Germany, in 2022, 51 % of the 810 978 inpatients were men (general psychiatry: 661 469; child and adolescent psychiatry: 60 711).
- In Ireland, in 2023, 50 % of inpatients were men, at 305.4 people per 100 000, compared with 301.8 for women. This represented a slight shift from previous years when women were over-represented. Of first admissions, 53 % or 120.6 people per 100 000 were men, compared with 106.3 per 100 000 for women (Department of Health, 2022; HRB, 2024).
- In Slovakia, in 2022, 56 % of the 39 944 hospitalisations in psychiatric hospitals/wards were men.
- In Slovenia, in 2022, 55 % of the 6 309 hospitalisations for poor mental health were men.
- In Spain, in 2021, there were 162 hospitalisations per 100 000 inhabitants due to mental and behavioural disorders, 165 in men and 159 in women.

Gender-specific trends can be observed: between 2014 and 2019, the depression gender gap reduced (Figure 11). Among children aged 11, 13 and 15 years, proportions reporting feeling low increased most for girls from 2014 to 2022 (Figure 14).

## Figure 11: Prevalence of depression by gender, 2014 and 2019, EU (%)




**Source:** *Eurofound analysis of EHIS microdata.*

National data reveal more detailed gendered trends:

- in Austria, from 2021 to 2022, clinically relevant symptoms of depression, anxiety, insomnia and suicidal ideation increased, especially among girls;
- in France, from 2016 to 2022, outpatient and inpatient care increased markedly among women aged 25 years and younger (Fond et al., 2025);
- in Germany, from 2012 to 2022, diagnosed poor mental health increased more for men (+ 18.3 %) than for women (+ 10.8 %) (Thom et al., 2024);
- in Latvia, from 2015 to 2021, there was a particularly large increase among women being diagnosed with poor mental health, especially affective and other disorders, which were already over-represented in women (Slimību profilakses un kontroles centrs, 2022);
- in Lithuania, the increase in diagnosed mental disorders was mainly due to more women being diagnosed, from 107 per 1 000 people in 2014 to 147 in 2023; this was particularly the case for anxiety among women, which rose from 11 per 1 000 people in 2014 to 41 in 2023 (from 5 to 19 among men);
- in Sweden, the proportion of people with severe mental stress remained rather stable from 2020 to 2022 but increased for women aged 16–29 years (from 15 % to 21 %).

In the EU, the standardised suicide death rate among men is 3.7 times that among women (2021), down from 4.0 in 2011, but the ratio remained at 4.2 among people aged 65 years and over. In some countries, the overall gender gap has recently grown. For instance, in Austria, suicide deaths per 100 000 people declined by 62 % for women and 36 % for men between 1986 and 2023; from 2022 to 2023, the figure declined by 13 % for women while remaining stable for men (BMSGPK, 2024a).

In the EU, suicide deaths among women aged under 20 years increased from 311 in 2012 to 437 in 2022, while those among men in that age group decreased from 981 to 765 (still 75 % higher than among women). Suicide deaths among people aged 85 years and over increased, mainly driven by an increase among men (by 41 % from 1 875 to 2 640, versus 18 % among women from 740 to 875). In 2022, 3.0 times more men than women in that age group died by suicide, up from 2.5 in 2012.

In most of the countries for which gender-disaggregated data were identified, women are over-represented among recorded suicide attempts. In Belgium, in 2018, women (5.4 %) more often than men (3.1 %) reported having attempted suicide at some point in their lives, or in the previous year (women: 0.3 %; men: 0.2 %). In the Netherlands, in 2023, 68 % of emergency department visits due to self-inflicted harm were made by women, and 32 % were made by men. Visits had increased since

2017, but in 2023 they returned to 2017 levels and are particularly prevalent among 15- to 29-year-old women (Stam, 2024). In Latvia, emergency calls related to suicide decreased more among men than women. In 2021, for the first time, women outnumbered men. In Denmark, in 2023, 65 % of recorded suicide attempts were by women. In Slovakia, in 2022, 59 % of suicide attempts were by women. The number of suicide attempts among girls aged 15–19 years increased from 58 to 115. Men were over-represented among those aged 20–29 years (61 %) and 30–39 years (63 %). In addition, reported suicidal thoughts tend to be more common among women than men. For instance, in Austria, frequent suicidal ideation was reported by 24 % of girls and 12 % of boys aged 14–20 years.

## Low socioeconomic status

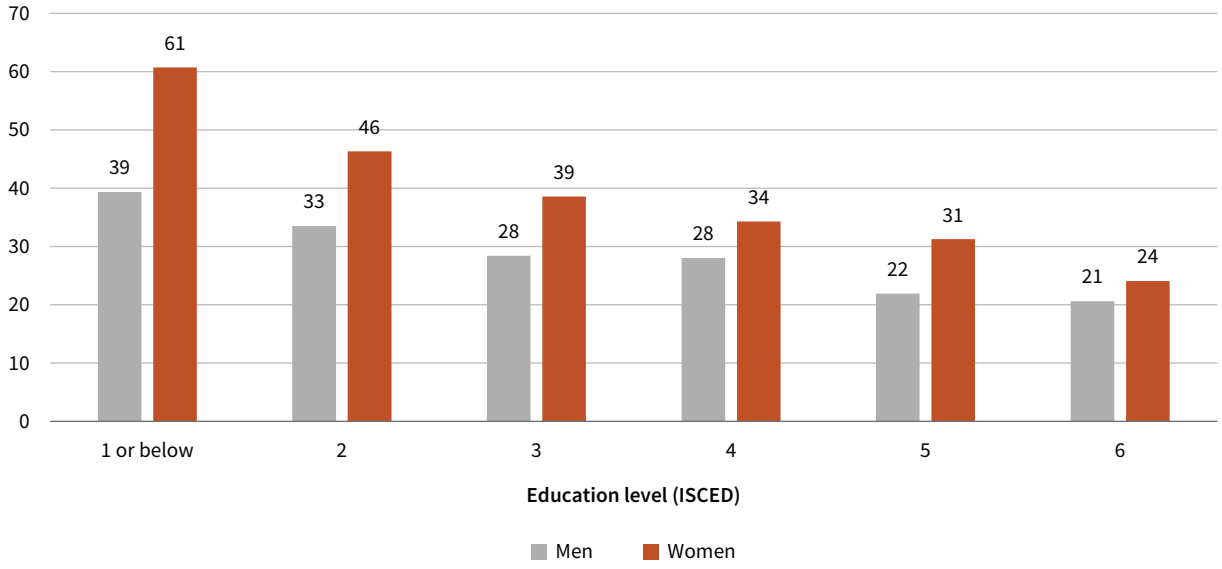
Low socioeconomic status, measured by variables such as low income, low educational attainment or being unemployed, is associated with depression and anxiety.

The likelihood of being at risk of depression is lower for people with higher educational attainment, both for men and women. However, the gender gap reduces from 22 percentage points for people with the lowest educational attainment to 3 percentage points among those with the highest educational attainment (Figure 12). In 2019, 3.4 % of people (men: 2.4 %; women: 4.6 %) in the top (equivalised) household income quintile were at risk of depression (EHIS, PHQ-8 ≥ 10), compared with 10.6 % (men: 9.4 %; women: 11.6 %) in the bottom quintile.

National evidence points to the role played by socioeconomic status in mental health.

- In Bulgaria, among people who died by suicide, people with lower educational attainment did so at an earlier age (Stoychev et al., 2021). People with low levels of education are twice as likely as highly educated people to report suffering from mood disorders and more likely to suffer from depression than those with a university degree (Zarkov et al., 2018).
- In Estonia, the proportion of adults diagnosed with anxiety at any point between 2016 and 2021 was higher among those in the lowest income quartile (14.6 %) than those in the top (7.8 %). People in the lowest income quartile were also more likely to have used publicly financed psychiatric, psychological or psychotherapy services (23.9 %) than people in the highest income quartile (6.8 %) (Konstabel et al., 2022).
- In Ireland, in 2019, 14 % of people aged 15 years and over reported (mild to severe) depression, with higher rates among those in the bottom quintile of a deprivation index (18 %) and those who were unemployed (21 %, versus 9 % of those who were employed). In particular, unemployed people often reported moderate or severe depression (5 %, versus 1 % of those who were employed). Of inpatient admissions in 2023, 36 % were unemployed people. 23 % of adults admitted were diagnosed with depressive disorders, and those aged 20–24 years were the five-year age group most over-represented (472 per 100 000 inhabitants) (HRB, 2024).

### Figure 12: Prevalence of depression by educational attainment and gender, 2024, EU (%)




**Notes:** *Depression is calculated as CES-D-8 ≥ 7. Data are weighted. Excluded are Bulgaria, Czechia, Denmark, Estonia, Latvia, Luxembourg, Malta and Romania. The International Standard Classification of Education (ISCED) 1997 scale is used: up to primary (1), lower secondary (2), upper secondary (3), post-secondary non-tertiary (4), first-stage tertiary (5) and doctoral (6) levels.*
**Source:** *Eurofound analysis of ESS microdata.*

- In Poland, from 2018 to 2020, people whose highest educational attainment was below secondary school were more likely to have suffered from panic-level anxiety at some point (11.5 %) than people with higher education levels (5.6 %).
- In Portugal, in 2023, the proportion of people aged 16 years and over with anxiety symptoms was lower among those with post-secondary education (28 %) or secondary education (29 %) than for those with primary school education (39 %) or no education (49 %). The proportion was also higher for unemployed people (45 %), retirees (37 %) and other economically inactive people (44 %) than for employed people (30 %) (INE, 2024).
- In Slovenia, a less favourable material situation within the household predicts higher stress, according to an analysis of a 2020 survey conducted among those aged 15–29 years (Lavrič et al., 2021).
- In Spain, anxiety and depression are 3.4 times and 2.5 times, respectively, more common in the lowest income quartile than in the highest.
- In Sweden, in 2020, social benefit recipients were five times more likely to die by suicide than those not on social benefits (Swedish National Board of Health and Welfare, 2023).

Within Member States, socioeconomic conditions can explain some of the regional differences in poor mental health, as can be concluded from the analysis of suicide data (but levels of access to mental healthcare also play a role).

- In Latvia, suicide rates are lowest in Riga and Pieriga, which have the highest Territorial Development Index scores in the country (Slimību profilakses un kontroles centrs, 2022).
- In Slovenia, between 2000 and 2009, an increase of 1 percentage point in the regional unemployment rate increased the regional suicide rate by 2.2 percentage points (Korošec Jagodič et al., 2013). In the (less wealthy, less densely populated) eastern parts of the country, suicide rates were up to 40 people per 100 000 compared with under 10 people per 100 000 in the west.

## Children, young adults and older people

The proportion of children aged 11, 13 and 15 years in the EU and Norway with a mental well-being score indicative of depression (WHO-5 Well-being Index ≤ 28) increases with age: 11 %, 20 % and 24 %, respectively, for girls; and 7 %, 9 % and 10 %, respectively, for boys. The gender gap increases with age ([7]). In younger age groups (i.e. below 11), national research suggests that rates may sometimes be higher among younger children. For instance, in Poland, in 2021/2022, 15 % of second graders (mostly 8 years old), 13 % of sixth graders (12 years old) and 13 % of second-year secondary students (17 years old) had low mental well-being (Rzecznik Praw Dziecka, 2023). Among those aged 9–21 years, 29 % suspected they were depressed, 37.5 % felt lonely, 46 % had low self-esteem and nearly one third struggled with self-acceptance, body image issues and regular dieting behaviours (Dębski and Flis, 2023).

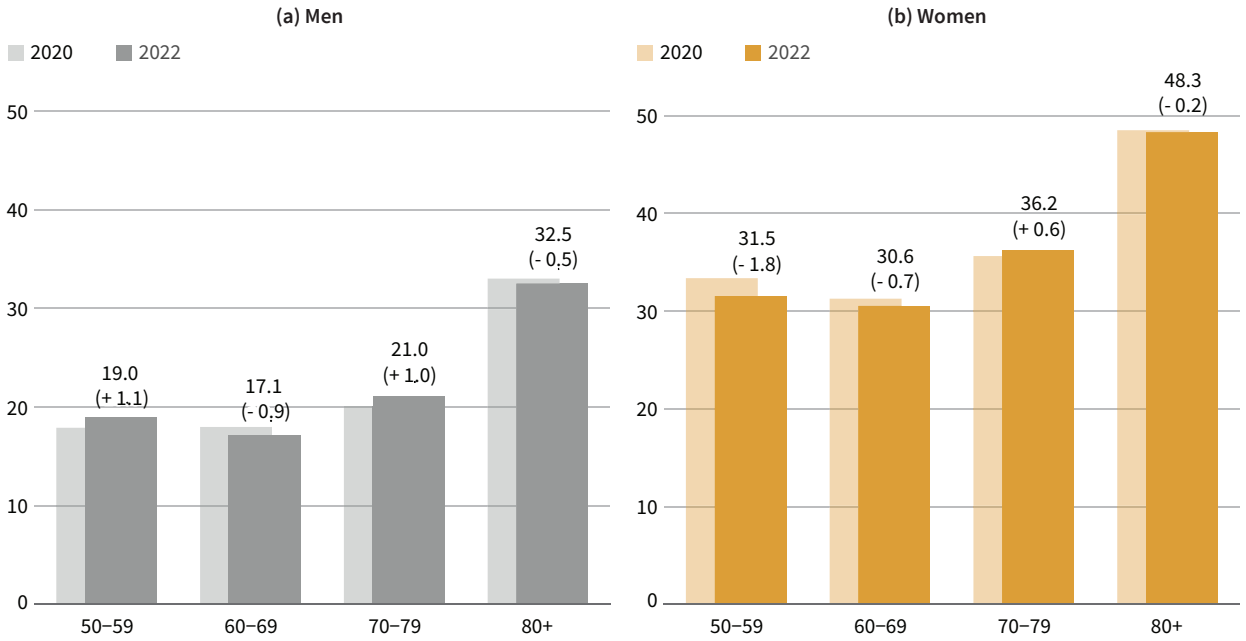
Among people aged 50 years and over, depression is particularly frequent among those aged 80 years and over (Figure 13). Some national evidence confirms high rates of poor mental health among the oldest members of society. In Estonia, the proportion of adults diagnosed with depression at any point between 2016 and 2021 was over 10 % in most age groups (except those aged 25–34 years); it was particularly high among people aged 85 years and over (21.4 %) and people aged 18–24 years (15.7 %). The rate of diagnosed anxiety was particularly high among those aged 18–24 years (12.8 %) but was also over 10 % among those aged 55–64 years and 75–84 years (Konstabel et al., 2022). In Portugal, suicide rates are highest among men aged 65 years and over in the interior and south of the country and in rural areas.

Several trends can be observed. In both 2014 and 2019, 5.3 % of people aged 15–59 years were at risk of depression, while the proportion decreased for people aged 60 years and over (from 8.6 % to 7.4 %). Self-reported chronic depression increased most notably for people aged 15–34 years (from 4.4 % to 5.7 %) and decreased most notably for people aged 65 years and older (from 9.4 % to 8.5 %). Men aged 35–39 and 50–54 years also faced an increase. The proportion of people who reported having visited a psychiatrist or psychologist in the preceding 12 months increased most notably for people aged 15–39 years, by 2.2 percentage points, from 5.4 % in 2014 to 7.6 % in 2019. For people aged 40 years and over, the increase was 0.3 percentage points, from 5.5 % to 5.8 % (EHIS).

Among people aged 50 years and older, from 2020 to 2022, the rate of women at risk of depression decreased (from 35.6 % to 35.0 %), while the rate of men at risk increased (from 20.0 % to 20.3 %). However, there was a

([7]) Country average (excluding Denmark), HBSC data analysis.

## Figure 13: Depression rates among people aged 50 years and over, by age group and gender, 2020 and 2022, EU (%)

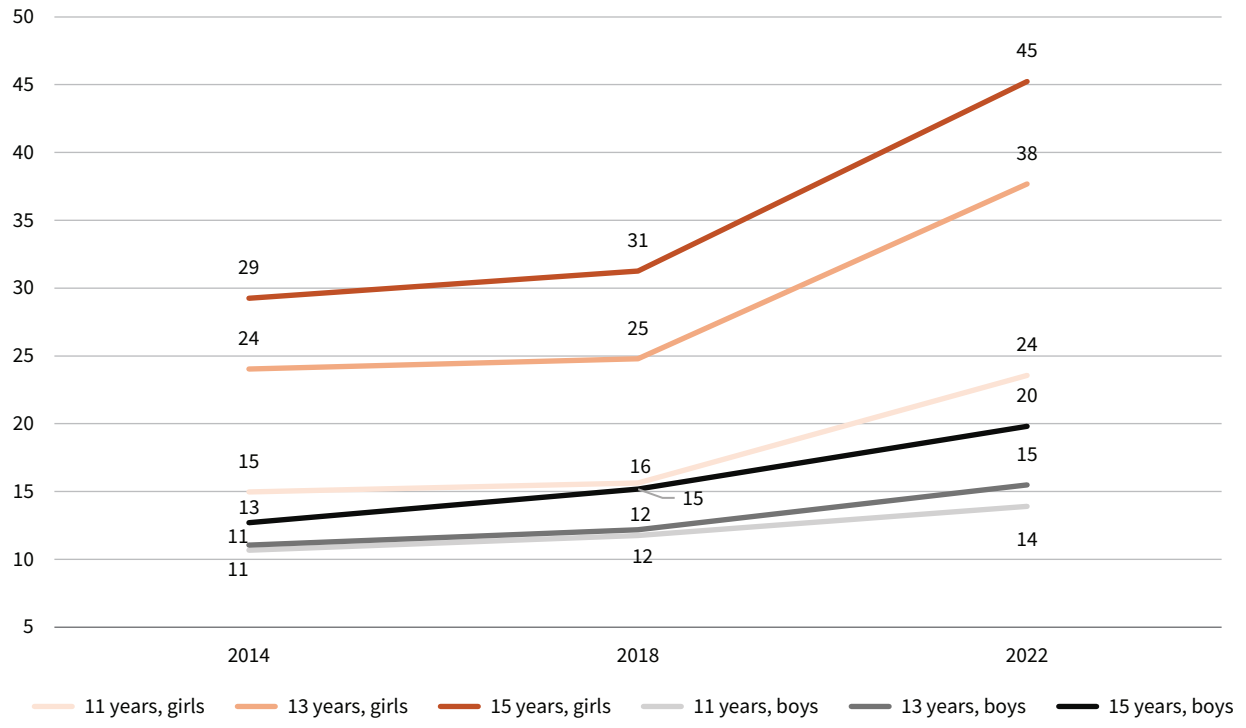



**Notes:** *Depression is calculated as EURO-D ≥ 4 (the EURO-D is a scale used to measure symptoms of depression). Data are weighted. The wave 8 sample is restricted to data that were collected pre-pandemic (March 2020). Ireland is excluded.*
**Source:** *Eurofound analysis of Survey of Health, Ageing and Retirement in Europe data from waves 8 (2019/2020) and 9 (2021/2022).*

marked decline in depression for women aged 50–59 years, while depression rates increased for both men and women aged 70–79 years (from 20.1 % to 21.0 %) and for men aged 50–59 years (Figure 13).

The proportion of both boys and girls aged 11, 13 and 15 years who reported feeling low increased from 2014 to 2018; the increase was particularly marked from 2018 to 2022 (Figure 14).

## Figure 14: Rates of feeling low in children aged 11, 13 and 15 years, 2014, 2018 and 2022, EU and Norway (%)




**Notes:** *Cyprus is excluded; for Belgium, the average of the Flemish and Walloon Regions was taken. Percentages are country averages.*
**Source:** *Eurofound analysis of HBSC (undated).*

National evidence adds to these signs of deteriorating mental health at both ends of the age spectrum, that is, among children and young adults and among older people.

- In Austria, hospitalisation rates for people aged up to 19 years for depression quadrupled between 2002 and 2022, and have particularly increased for girls since 2014 (BMSGPK, 2024b).
- In Germany, from 2012 to 2022, mental health diagnoses increased most for those aged 11–17 years and 60–84 years (by over 15 %).
- In Lithuania, from 2014 to 2023, depression diagnoses increased mainly for people aged under 18 years, from 1.4 to 2.8 per 1 000 people (increasing especially during the pandemic), and for those aged 65 years and over, from 38.6 to 49.4 per 1 000 people (increasing mainly before the pandemic), remaining relatively stable for other age groups. Anxiety diagnoses increased more widely across age groups, but increased most notably (almost five-fold) for those aged 65 years and over, from already higher levels.
- In Norway, poor mental health increased the most among young women.
- In Poland, the number of people being treated for depression in the public system remained rather stable between 2013 and 2018. However, the share of patients aged 18–64 years decreased from 74 % to 68 % (with the most notable drop among those aged 45–64 years), while the shares of those aged under 18 years and those aged 65 years and over increased. The number of minors among primary mental healthcare recipients increased by 52 %, from around 2 900 to 4 400.
- In Slovakia, in 2022, the highest ever number (since 2009, the earliest data available) of newly diagnosed patients aged 15–19 years receiving outpatient psychiatric care was recorded (4 562), following an 18 % increase from 2021, the highest of any age group.
- In Slovenia, while secondary mental healthcare use overall decreased from 2013 to 2022, for those aged 6–19 years, it increased from 23.8 to 33.7 per 1 000 people.
- In Sweden, inpatient care decreased, but child and adolescent psychiatric outpatient visits and inpatient care increased from 123 585 in 2017 to 167 267 in 2023 (SKR, 2023). Anxiety increased the most among women aged 16–29 years, from 9 % in 2006 to 23 % in 2022. It also increased among women aged 30–44 years and men aged 16–29 years, while it remained stable for other age groups. In 2022, severe mental stress was particularly common among people aged 16–29 years (16 %). While remaining stable overall from 2020 to 2022, it increased for women aged 16–29 years, from 15 % to 21 % (Busch, 2023).

An indication of the worsening situation at both ends of the age spectrum is that, while deaths by suicide in the EU decreased between 2011 (51 374) and 2021 (47 346), death by suicide increased for people aged under 15 years and aged 85 years and over by 34 % and 33 %, respectively. More recent national data, and data on suicide attempts, show similar trends.

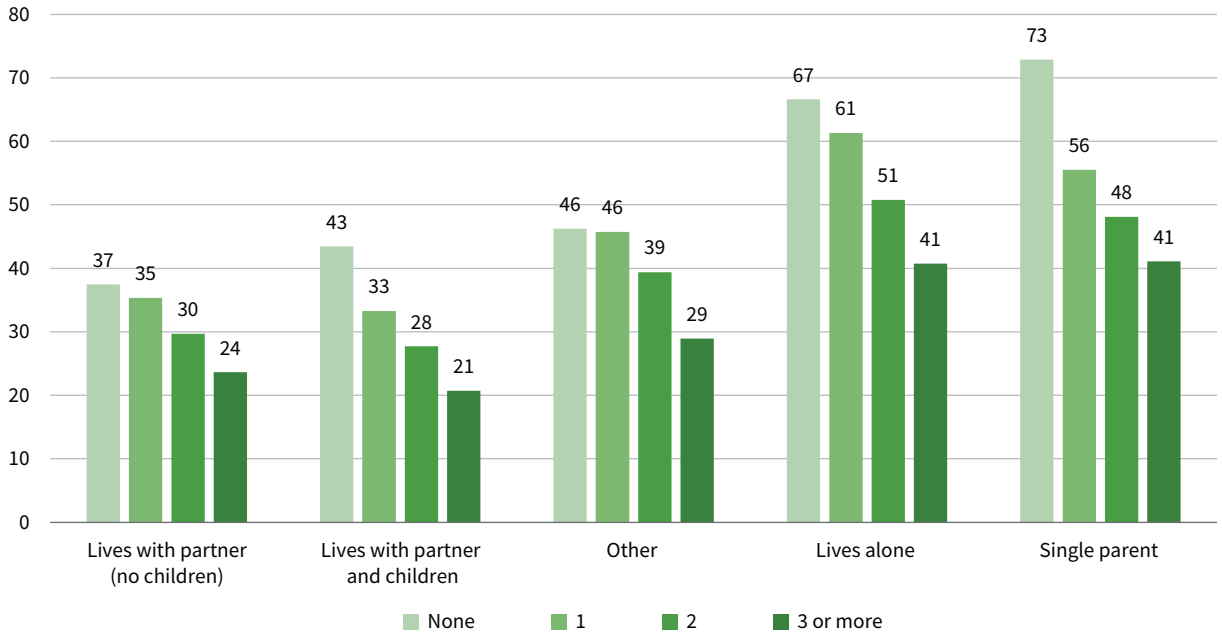
- In Austria, from 2021 to 2023, suicide attempts increased, notably among people aged 80 years and over (especially men in rural areas) and women aged 15–24 years (Gruber et al., 2023).
- In Slovakia, suicide attempts among people aged 15–19 years increased from 68 in 2008 to 96 in 2020, and to 148 in 2022 (78 % girls). Girls represented 74 of the 79 attempts by children aged 0–14 years in 2022, up from 25 girls in 2020.
- In Spain, from 2021 to 2022, suicide increased among people aged 0–19 years, especially boys aged 15–19 years (Fundación Española para la Prevención del Suicidio, 2023).
- In Sweden, from 2000 to 2023, uncertain and certain suicide deaths among people aged 15 years and older increased year on year (from 17.0 to 18.4 per 100 000 people). The sharpest increases were among women aged 15–24 years (from 6.4 to 7.9 per 100 000 people) and men aged 65 years and older (from 26.2 to 30.6 per 100 000 people) (National Centre for Suicide Research and Prevention, 2024).

## Single adults

People living alone do not necessarily feel lonely. However, factors such as lack of access to someone to speak with when needed and lack of a second income to rely upon can make people who live alone more vulnerable to poor mental health. In 2024, in the EU, 7.3 % of people felt lonely most or all of the time and 4.3 % had nobody to speak to about intimate and personal matters (ESS). Rates were higher among people living alone (18.7 % and 8.0 %, respectively) and single parents (13.4 % and 7.0 %, respectively). Depression is particularly common among these two groups (Figure 15). The percentage of people in the EU aged 15 years and over saying they had nobody close to them to count on increased from 1.9 % in 2014 to 2.1 % in 2019, and by 0.5 percentage points or more for people aged 30–39 years and 70 years and over (EHIS, excluding France).

Depression is more common among older people living alone than among young people living alone (42 % among those aged 15–34 years and 50 % among those aged 65 years and older). In contrast, depression decreases with age among people living with a partner and without children in the household (29 % among those aged 15–34 years and 25 % among those aged 65 years and older).

**Figure 15: Prevalence of depression by household type and number of close confidants, 2024, EU (%)**




**Notes:** *Depression is calculated as CES-D-8 ≥ 7. Data are weighted. Data covering Bulgaria, Czechia, Denmark, Estonia, Latvia, Luxembourg, Malta and Romania are unavailable. Question: 'How many people, if any, are there with whom you can discuss intimate ["intimate" implies things like sex or family matters] and personal ["personal" could include work or occupational issues as well] matters?' The household type 'other' includes people with households of more than one person but not containing a partner or children.*
**Source:** *Eurofound analysis of ESS (wave 11, 2024) microdata.*

Overall, depression and anxiety are highest for single parents (Table 1). Being a single parent comes with a set of vulnerabilities, including financial ones. Living alone or being a single parent may have been the result of life events that can exacerbate poor mental health (e.g. partner's death, relationship breakdown).

- In Bulgaria, among people who died by suicide, those who were single/divorced did so at an earlier age (Stoychev et al., 2021).
- In Poland, depression is particularly high among widowed and divorced people (Instytut Psychiatrii i Neurologii, 2021).

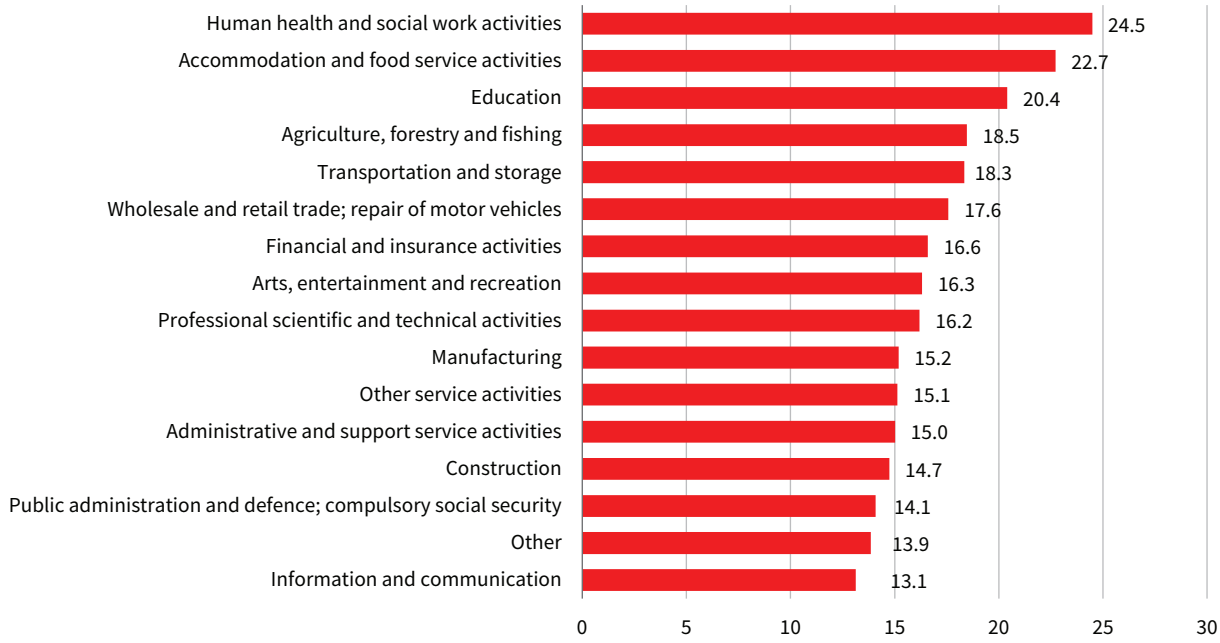
## Profession

Working conditions posing a risk for mental health include excessive workloads, conflicting demands, lack of clarity, lack of involvement in decisions that affect the worker, lack of influence on the way the job is done, poorly managed organisational change, job insecurity, ineffective communication, lack of support from management or colleagues, psychosocial and sexual harassment and third-party violence (EU-OSHA, 2024). The 'social environment', measured by factors such as exposure to adverse behaviour at work, is key for mental health. Two sectors stand out negatively in this regard: health and transport (Eurofound, 2020d).

The 2019 EHIS enables the identification of broad sectors, with the highest risk of depression in 'public administration, defence, education, human health and social work activities' (4.3 %) and 'financial and insurance activities' (4.6 %). These sectors remain at higher risk of depression after controlling for country and household income, suggesting that low income is not the only factor explaining higher mental health risks. After controlling for these variables, two more sectors stand out with higher mental health risks: 'wholesale and retail trades, transport, information and communication, accommodation and food service activities' and 'other services'. After controlling for gender, workers in these sectors remain at higher risk of depression than those in construction, with the lowest mental health risk at 2.1 %.

The 2021 European Working Conditions Telephone Survey largely validates these findings with more detailed sectoral and professional information. Human health and social work, accommodation and food service, and education workers most often report feeling emotionally exhausted by their work (Figure 16). Human health and social work and accommodation and food services both score in the top 3 for emotional exhaustion and (after agriculture, at 50 %) for physical exhaustion (44 % and 46 %, respectively; fourth come education and construction, both at 36 %). In terms of professions, health professionals most often report emotional exhaustion (26 %), followed by health associate professionals (25 %), personal care workers (24 %) and teaching professionals (23 %). Proportions are lowest for information and communications technology technicians (8 %). While this specific

### Figure 16: Feeling emotionally exhausted by work (often or always), by sector, 2021, EU (%)




**Note:** *Data are weighted; sectors with the smallest sample sizes are grouped under 'Other'.*
**Source:** *Eurofound analysis of European Working Conditions Telephone Survey.*

question was not asked in Eurofound's 2015 European Working Conditions Survey, related questions consistently showed relatively high scores for these sectors even before the pandemic. For instance, among the sectors with EU-wide sample sizes of over 1 000 in 2015, 'health and social work' workers had most often experienced anxiety over the previous year (21.2 %), followed by 'hotel and restaurant' workers (18.5 %). 'Education' also scored above the average (16.0 %) at 17.1 % (and in 2010 ranked first).

Within the sectors with the highest mental health risks, workers in direct contact with service users are the most exposed to mental health risk factors. Furthermore, risks seem particularly large in subsectors usually not well covered by survey data. This concerns, for instance, domestic care work where the household is the employer (Eurofound, 2020c).

National evidence points to professions that are at higher risk of poor mental health, and more generally that are exposed to factors that contribute to poor mental health.

- In Greece, in 2022, there were at least 11 suicides of workers in high-risk occupations, such as security, and 3 suicides of military personnel.
- In Ireland, in 2023, 40 % of adults said work negatively affected their mental health (Aware, undated).
- In Lithuania, in 2023, 19 % of people with anxiety said their anxiety was caused by their work, its instability or its workload (Spinter Tyrimai, 2023).

Among healthcare workers, a group considered at particularly high risk of poor mental health, 27 % had clinically relevant depressive symptoms (Rogoža et al., 2021). Hospital physicians often report work characteristics associated with poor mental health: low job decision-making authority (22 %), low job skill discretion (23 %), low supervisor support (26 %), high job demands (36 %) and high job insecurity (36 %) (Zutautiene et al., 2023).

- In Spain, in 2022, 60 % of people with poor mental health reported that professional and educational demands were its main causes.

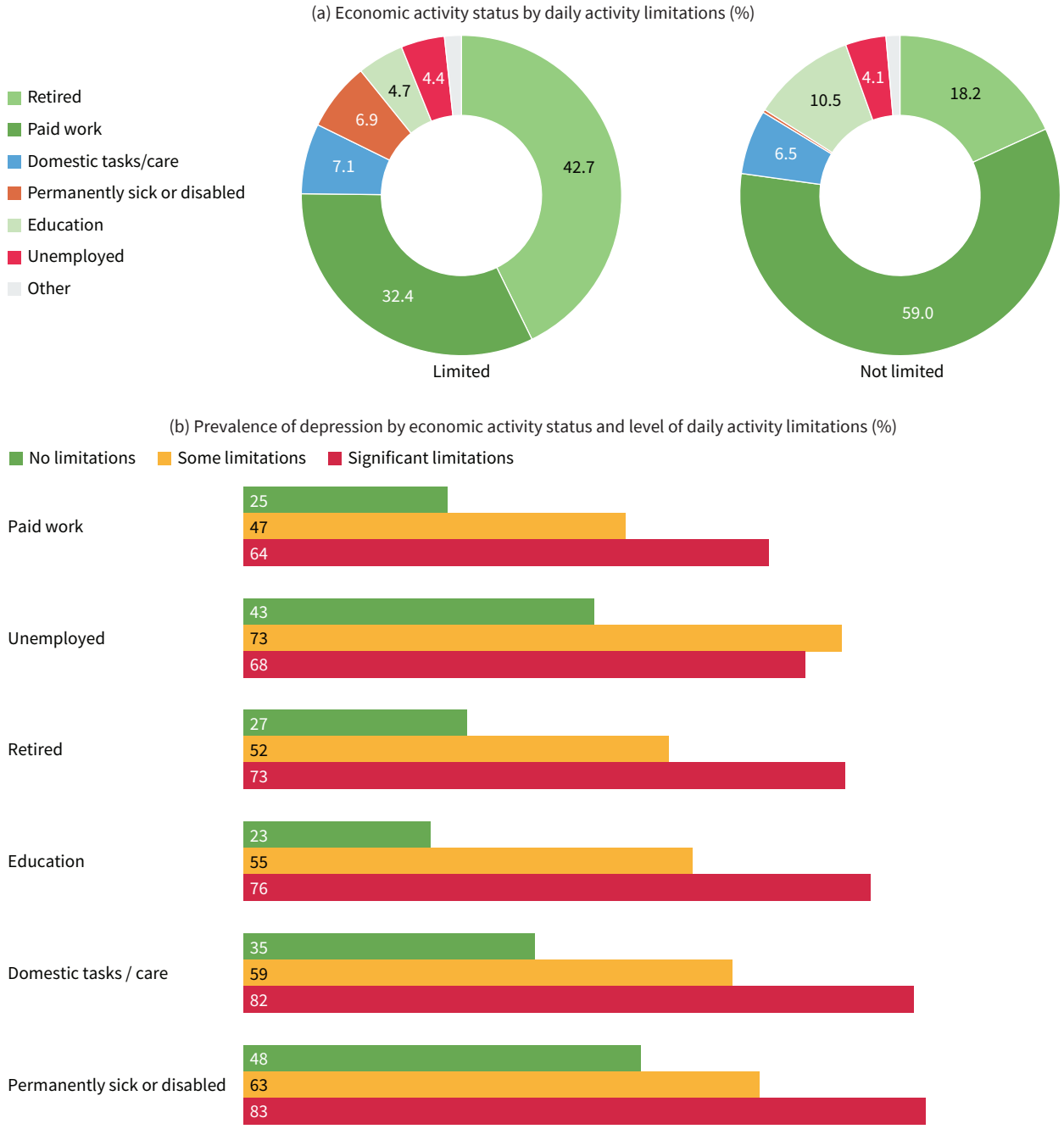
## People with disabilities

People with disabilities face elevated risks of poor mental health, often due to barriers posed by society, for instance in finding employment and gaining social inclusion. Approximately 40 % of children with an intellectual disability have a diagnosable mental health disorder, at least double the rate of children without an intellectual disability (Totsika et al., 2022). Both men and women with disabilities are more often at risk of depression regardless of their economic activity status, and are over-represented among activity statuses with higher risks of poor mental health (Figure 17). Country evidence is scarce.

- In Hungary, self-harm among people with autism is about three times the population average. Women with autism are 5 to 13 times more likely to die by suicide than women without autism (Kakuszi et al., 2023).

- In Poland, disability pension recipients are particularly likely to have experienced depression at some point (7.0 %); 5.6 % of employed individuals have experienced anxiety attacks at some stage, compared with 17.3 % of people with other economic activity statuses (including those reporting to be 'permanently sick or disabled').
- In Spain, people with disabilities were more likely than average to see a psychologist or psychiatrist and take psychotropic drugs (Confederación Salud Mental España, 2023).

## Figure 17: Limitation in daily activities, economic activity status and depression, 2024, EU




**Notes:** *Depression is calculated as CES-D-8 ≥ 7. Economic activity status is determined by the question 'What have you been doing for the last seven days?' Data are weighted. Data covering Bulgaria, Czechia, Denmark, Estonia, Latvia, Luxembourg, Malta and Romania are unavailable.*
**Source:** *Eurofound analysis of ESS (2024) microdata.*

## LGBT+ population

Many in the LGBT+ population face stigma and discrimination within their countries and social environments, contributing to a higher risk of poor mental health in this group (Ventriglio et al., 2022).

- In Czechia, according to a survey conducted in 2022, poor mental health was more common among gay or lesbian (52 %), bisexual (33 %) and 'more sexually diverse' (26 %) people than among heterosexuals (19 %). The same holds true for suicidal thoughts and behaviours, at 25 %, 23 %, 11 % and 6 %, respectively (Pitoňák et al., 2024).
- In Denmark, bisexual women are especially over-represented with regard to depression, anxiety, psychiatric treatment and suicide attempts (Olsen et al., 2023).
- In Spain, the LGBT+ population is more likely to visit a psychologist or psychiatrist and take psychotropic drugs (Confederación Salud Mental España, 2023).
- In the Netherlands, suicide attempts are 4.5 times more common among lesbian, gay and bisexual young people than among heterosexual young people. Over one fifth (21 %) of transgender people have attempted suicide. Risk factors are feeling 'different', being stigmatised and experiencing minority stress and lack of acceptance of their identity (ZonMw, 2023).

## Homelessness

Both homelessness itself and factors contributing to becoming homeless (e.g. relationship breakdown, over-indebtedness) can cause poor mental health. Overall, people experiencing homelessness more often face poorer mental health than others (Onapa et al., 2022). However, data are scarce.

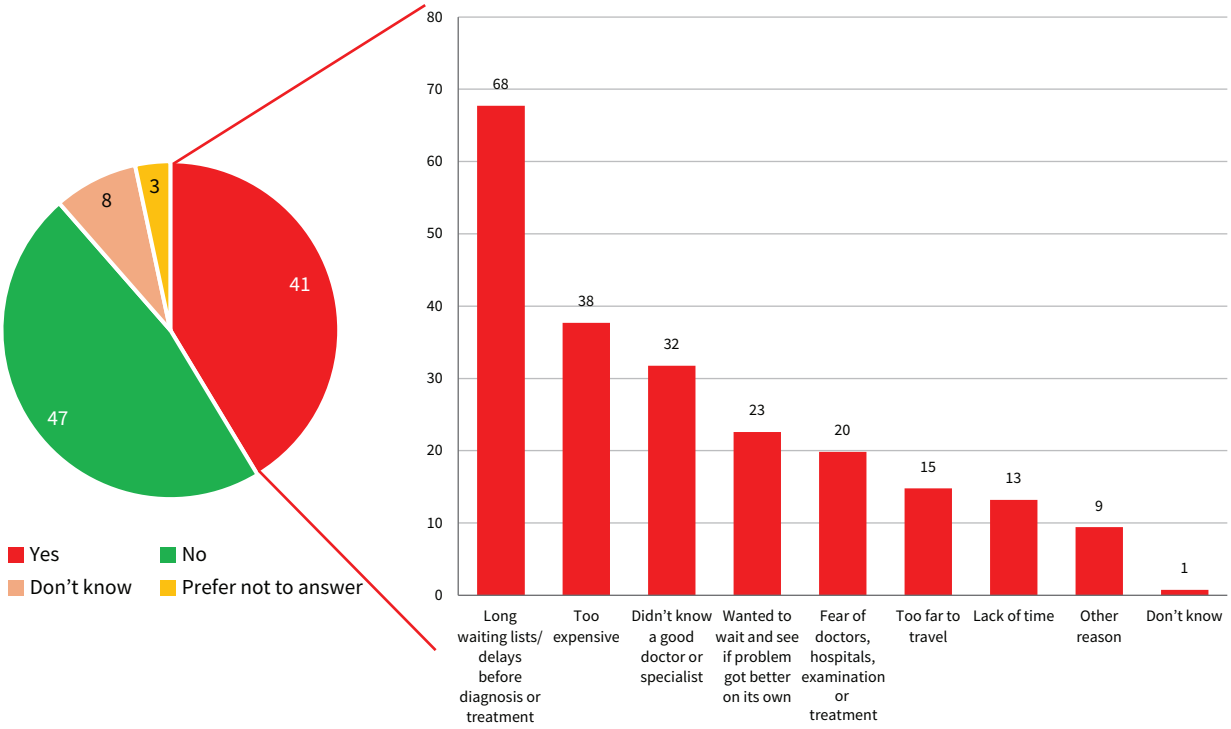
- In France, in 2020, 55 % of people experiencing homelessness surveyed in four cities had symptoms indicating a major depressive disorder (Fond et al., 2020).
- In Hungary, in 2020, 29 % of the surveyed people experiencing homelessness were receiving psychiatric treatment (Bulyáki, 2023).
- In Germany, 23 % of people experiencing homelessness who were surveyed in several cities reported having been diagnosed with poor mental health; 70 % were identified as having poor mental health without a diagnosis (Bertram et al., 2022).

# 2 Mental health support: Access problems

Life can always have low points, and professional help is not always the only or best solution to poor mental health. But access to mental healthcare and other support is needed when prevention (by improving population mental health) and self-help do not suffice. Problems in accessing support can emerge throughout the process, from perceiving support needs to meeting those needs (Eurofound, 2020a). When people receive support, their needs may not be fully met. Inadequate support can even contribute to poor mental health.

Across the EU, 25 % of respondents report that either they or a family member encountered one or more issues accessing mental healthcare. Among people who had themselves experienced an emotional or psychosocial problem (e.g. feeling depressed or anxious) in the 12 months prior to a June 2023 survey, 41 % reported such barriers (Figure 18). Most reported 'long waiting lists/delays before diagnosis or treatment' among the key problems. The second most mentioned barrier was unaffordability, which sometimes also stems from waiting lists (the unaffordability of circumventing waiting lists) and other capacity issues (Eurofound, 2020a).

**Figure 18: Barriers to accessing mental healthcare among people who experienced an emotional or psychosocial problem, by type of barrier, 2023, EU (%)**




**Note:** *Question: 'Which of the following issues(s) did you or they encounter? (Choose a maximum of three answers).' Weight result from target (post-stratification weight) was used.*
**Source:** *Eurofound analysis of Eurobarometer microdata, downloaded from GESIS.*

# Not seeking care

People with poor mental health may not recognise their mental health status or their support needs, if they have any; service providers may not either. If people do recognise their mental health support needs, they may still not seek support due to stigma, discrimination or a lack of clarity about the support available, or because available services do not meet their needs (see 'Low-quality services') or are unavailable (see 'Unavailability').

## Not recognising mental health problems

The social and educational environment may neglect or trivialise mental health, with negative impacts, reducing the likelihood that people with poor mental health will recognise it (LDZ, 2024). Poor mental health in children may not be recognised by their parents, who are often relied upon to seek support for their children (Milašiūtė et al., 2023). Service providers, for instance in primary healthcare, may also not recognise poor mental health among their users (Swedish Gender Equality Agency, 2021).

## Stigma and discrimination

Three quarters of people in the EU think that people with poor mental health get fewer opportunities at work, in finding housing and in social activities (European Commission, 2023c). People who have been diagnosed with poor mental health in the past face legal restrictions on working in certain occupations (e.g. medical doctor, police officer) or on obtaining licences (e.g. for driving). They also face barriers (exclusion, higher fees, administrative hurdles) to obtaining insurance (including life, mortgage protection and supplementary health). Awareness of these consequences can discourage them from seeking support. For instance, in Lithuania, around half of healthcare professionals say that seeking psychiatric care could imperil their occupational licence (Rogoža et al., 2021).

National reports suggest that stigma has reduced in recent years (e.g. in Czechia, Greece, Italy, Lithuania, Spain and Sweden). During crises, when poor mental health increased among groups where it was previously uncommon, it became more accepted and spoken about, such as during the Great Recession and the pandemic. For instance, increased past contact and intended future contact with people with poor mental health from 2019 to 2022 in Czechia seems linked to the pandemic (Winkler et al., 2024). Reduced stigma has contributed to increased demand for mental health services, for instance in Greece (especially psychotherapy) and Sweden (Kataki et al., 2021; Swedish National Board of Health and Welfare, 2023). However, it has also been noted that stigma is increasing in some contexts (e.g. in the 2023–2030 Slovak National Mental Health Programme).

National research confirms that negative attitudes towards people with poor mental health are widespread.

- In Lithuania, one in 10 people report negative attitudes towards people with mental illness. One third report unclear or neutral views, potentially indicating social desirability bias and, therefore, hidden stigma. One in four displays stigmatising views on seeking mental healthcare. Educational and healthcare institutions also exhibit stigma towards people with poor mental health (Grigutytė et al., 2022).
- In Spain, some adults believe that people who suffer, or have suffered, from a mental illness are dangerous (28 %), annoying (26 %) and people they could not live with or work with (22 %). People diagnosed with mental illness experience social rejection (58.5 %) or discrimination (55 %), particularly at work (Confederación Salud Mental España, 2023).
- In Sweden (Stockholm region) in 2019, about half of adults said that people in their social network would react negatively towards them if they sought mental care (Lindh et al., 2023).

National research shows the negative impact stigma and discrimination are having on social inclusion, willingness to discuss mental health and seeking support.

- In Croatia, in 2021, many people said that, at work, mental health was never discussed (55 %), was the subject of jokes (15 %) or was a topic they hesitated to talk about due to fear of labelling and discrimination (25 %) or the expectation that their superiors (40 %) or colleagues (21 %) would be unhelpful (radpomjeri.eu, 2021).
- In Estonia, in 2016, 62 % of the population did not want others to know about their mental health problems.
- In Ireland, in 2023, 39 % of people who had delayed accessing mental health support cited 'shame, embarrassment or fear of judgement' as a barrier; 21 % said they had delayed accessing support because 'people won't understand' (Aware, undated).
- In Portugal, in 2023, 18 % of people with poor mental health who were not seeking care felt uncomfortable talking about it (DECO PROTeste, 2023).
- In Sweden (Stockholm region), in 2019, 18.7 % of people who reported having mental healthcare needs did not seek care because of shame; 5.4 % felt worried they would be recognised by acquaintances when seeking mental healthcare. Rates were higher among men than women. Among care users, 60 % of those who had delayed seeking care had done so due to shame and embarrassment (Lindh et al., 2023).

Men are more likely than women to face stigma as a barrier to seeking care due to masculinity norms (Gough and Novikova, 2020). Men are also less likely to discuss suicidal thoughts with care providers (ZonMw, 2023). Minority groups also face additional stigma, whether from their own or outside communities. For instance, in Greece, research among children from minorities (LGBT+, Roma, Pomak, refugee unaccompanied minors) showed that peer shaming and belittling of poor mental health are key barriers to seeking support (Koumoula et al., 2024). Some refugees from Ukraine in Poland reported that they did not seek support because others might need it more (in addition to logistical challenges like transportation and childcare) (Statistics Poland and WHO, 2023).

### Lack of clarity around available services

Lack of awareness of available services among people with poor mental health, people close to them and care providers (importantly, general practitioners (GPs)), is a barrier to access (CNS, 2019; Malta Chamber of Commerce, Enterprise and Industry, 2023). In Sweden, in 2019, 36 % of people reporting mental healthcare needs did not seek care because they did not know where to go (Lindh et al., 2023). While this could be partly explained by the unavailability of adequate services, lack of awareness can also play a role. In Ireland, 31 % of people who delayed seeking support cited not knowing who could help as a reason. In Austria, in early 2020, 44 % of people reported not knowing whom to turn to in the case of a mental illness (BÖP, 2020). Lack of awareness can be more pronounced among population groups in particularly vulnerable situations, such as Roma people (ERGO Network, 2022).

## Unavailability

Whether support is available to address someone's needs in a timely manner depends on staff numbers, the organisation and its facilities, and how these resources are spread geographically.

### Capacity

#### Care usage and diagnoses

Overall, service usage and diagnoses seem to have increased, mainly due to increased access and decreased stigma, and possibly also because medical professionals are more inclined to offer a diagnosis.

The proportion of adults who reported having visited a psychiatrist/psychologist in the previous 12 months increased from 5.4 % in 2014 to 6.4 % in 2019 (EHIS).

National administrative care usage and diagnosis data are collected in different ways, complicating international comparisons. For instance, Latvia's care use statistics only include patients diagnosed (by psychiatrists) with a mental or behavioural disorder requiring care for at least three months. Comparing these data with data from countries that include patients receiving shorter-term care would underestimate diagnoses in Latvia, where survey analyses suggest around 120 000 people are depressed, around 20 000 receive outpatient treatment for depression and 11 000 are included in the care use statistics (i.e. were diagnosed by a psychiatrist with depression requiring care for at least three months).

However, national data can reveal within-country trends. For most countries for which data were obtained, increases in care usage (and diagnoses) were observed in the past decade, often since well before the pandemic.

- In Czechia, the number of mental healthcare users increased from 1 803 607 in 2012 to 2 134 874 in 2021, and new diagnoses from 438 685 to 548 897. In the case of depression, the number of care users increased (from 109 184 to 119 263), but new diagnoses decreased (from 26 708 to 19 529).
- In Germany, the proportion of statutorily insured people with diagnosed mental disorders rose from 33.4 % in 2012 to 37.9 % in 2022. The proportion of depression diagnoses rose from 12.1 % to 13.9 % and anxiety disorders from 5.1 % to 6.7 %.
- In Norway, both specialist and (especially) primary mental healthcare use increased since 2010, across diagnoses. Contact with specialist mental healthcare increased year on year from 249 601 people in 2018 to 277 229 in 2022 (Norwegian Institute of Public Health, 2024).
- In Poland, the number of psychiatric care and addiction treatment patients increased by 72 % from 2013 (around 3 900 000) to 2018 (6 700 000).
- In Spain, people registered with mental disorders (excluding behavioural disorders) in primary healthcare increased year on year from 11.1 % of the population in 2013 to 17.2 % in 2022 (mainly anxiety (6.7 %), sleep disorders (5.4 %) and depression (4.1 %)); the largest increase was from 2018 to 2019. The number of people with depression and anxiety receiving primary care increased from 105 896 and 1 676 737, respectively, in 2016 to 156 798 and 2 130 910, respectively, in 2022. Psychiatrist consultations in specialised mental healthcare (public and private) increased from 24 008 in 2016 to 26 033 in 2021 (CES, 2024).
- In Sweden, the number of people diagnosed with mental disorders increased by 60 % from 2008 to 2022 (FHM and Swedish National Board of Health and Welfare, 2023).

During the pandemic, reduced or discontinued services, and fear of becoming infected by COVID-19 while seeking care, resulted in reduced access to support. Online support initiatives were launched (Eurofound, 2022a). A meta-analysis of studies of national health records shows new diagnoses and mental healthcare use reduced at the start of the pandemic. New diagnoses declined further during 2020, while care use increased later in 2020 and through 2021 (Ahmed et al., 2023).

Most country data show more diagnoses and care usage after the pandemic than before, often with short decreases (or decreased growth) during the pandemic.

- In Austria, diagnosed acute stress reactions increased from 0.44 % of the population in 2019 to 1.0 % in 2022, anxiety disorders/panic attacks went from 0.81 % to 1.1 %, and depression increased from 6.0 % to 6.2 %.
- In Bulgaria, in the first 10 months of 2021, there were about 23 000 more psychiatrist consultations than in 2019. In the same period in 2020, there were about 15 000 fewer consultations than in the corresponding nine months of 2019 (Zarkov et al., 2022).
- In Czechia, care use and new diagnoses increased year on year from 2012 to 2021, except from 2019 to 2020 (down by 5 % and 10 %, respectively). The number of psychiatric outpatient clinic users increased from 509 949 in 2010 to 662 971 in 2022, only decreasing in 2020 (ÚZIS, 2022).
- In Latvia, in 2021, around 20 000 people diagnosed with depression received outpatient mental healthcare services, up from about 15 000 before the pandemic.
- In Poland, in 2021, 1 874 900 people received outpatient psychiatric care (87.9 % for mental and behavioural disorders, and others for alcohol/drug addictions), 11.9 % more than in 2020 and 9.8 % more than in 2019. About 631 600 received publicly funded treatment for depression in 2018, similar to the preceding five years (91 % of them used psychiatric care, addiction treatment and (most commonly) primary healthcare), although the primary diagnosis of depression fell by 6.8 %, from 542 600 in 2013 to 505 600 in 2018.
- In Portugal, depression or anxiety diagnoses increased from 1 403 543 in 2018 to 1 442 033 in 2019 and 1 478 428 in 2020. Diagnoses of mental disorders increased from 3 317 275 in 2018 to 3 424 624 in 2019 and 3 496 064 in 2020 (ERS, 2023a).
- In Slovakia, in 2022, 417 530 people were examined in psychiatric outpatient clinics, up by 10.7 % (40 330 people) since 2021; the number of people newly diagnosed with a mental disorder increased by 3.4 % (63 083 people) from 2020 to 2021 and 6.4 % (67 147 people) from 2021 to 2022.

Decreasing, or less clearly increasing, trends can also be observed.

- In Denmark, from 2013 to 2017, the number of adult patients receiving psychiatric treatment for 'nervous and stress-related conditions' (including anxiety) increased from around 26 000 to 32 000. From 2017 to 2022, it decreased to under 25 000 patients. Those treated for 'affective disorders' (including depression) remained rather stable at almost 25 000 from 2013 to 2022 (Olsen et al., 2023).
- In Italy, the number of users of psychiatric care services reached a low in 2020 (728 338), and by 2022 (776 829) it had not returned to the 2018 peak (837 027).
- In Romania, mental or behavioural disorder diagnoses in primary care decreased from 234 888 in 2013 to 223 686 in 2018, after which they increased to 237 016 in 2022. The number of outpatients (188 526 in 2022) increased after a 2020 low, but remained below the pre-pandemic level (255 148 in 2019).

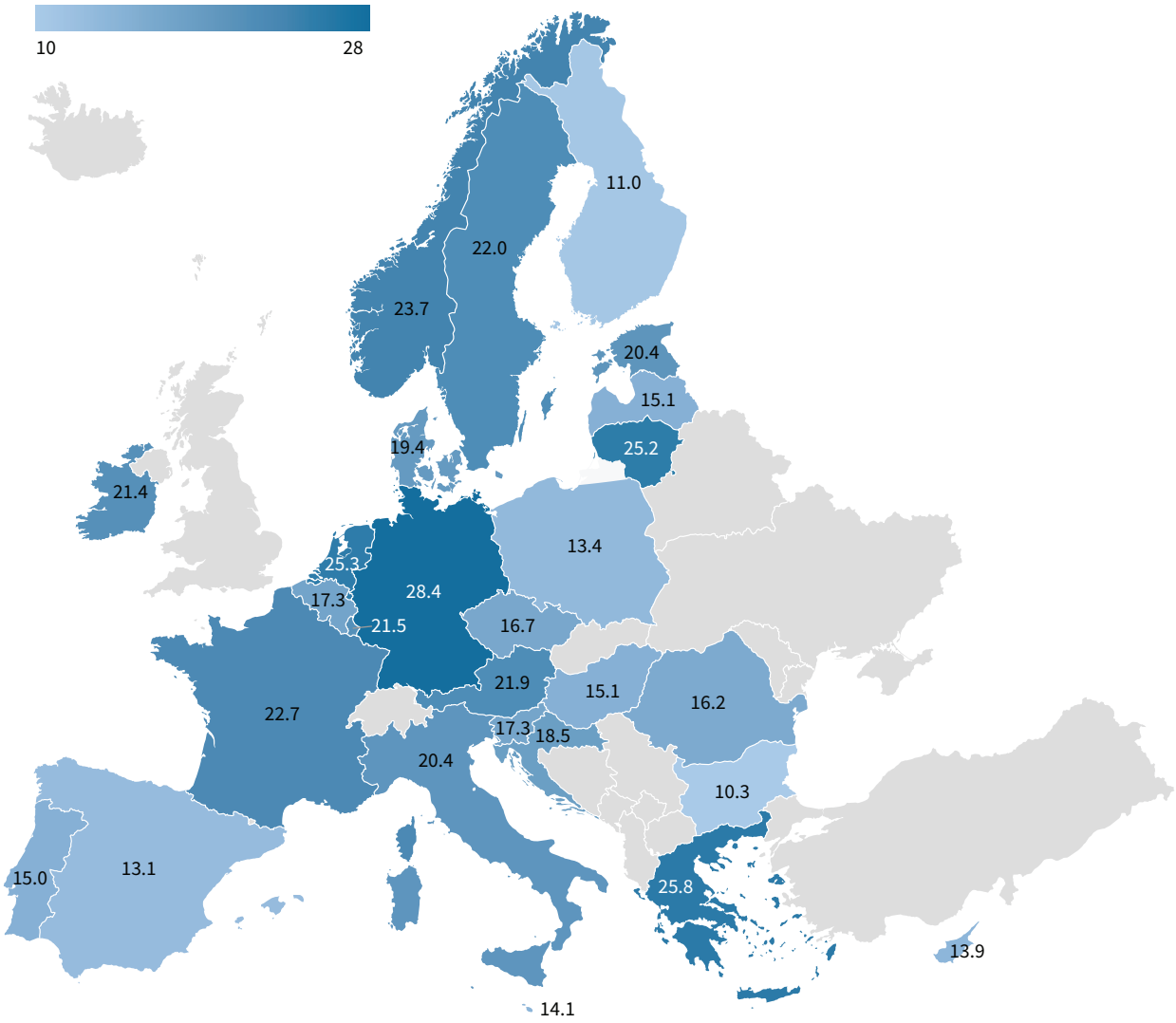
### Psychiatrists, psychologists and mental healthcare nurses

Comparing numbers of psychiatrists (the mental health support profession for which EU-level data are most easily obtainable) is challenging, for instance because the demarcation between specialities differs between countries. Psychiatrists may, for instance, provide services (e.g. psychotherapy) that elsewhere are usually provided by psychologists. The number of psychologists may be particularly low; for instance, Croatia has 8 psychologists per 100 000 inhabitants. Furthermore, full-time equivalent data are unavailable and part-time work may be common.

However, these numbers, along with country-level information (below), suggest a growing mental health workforce. The Member State average number of psychiatrists was 17.7 per 100 000 inhabitants in 2022, up by 1.65 in 5 years ([8]). The number ranges from 10.3 in Bulgaria to 28.4 in Germany (Figure 19).

([8]) Comparing Figure 19 with 2017 data (2019 for Czechia; excluding Luxembourg).

## Figure 19: Number of psychiatrists per 100 000 inhabitants, 2022, EU and Norway




**Note:** *Excluding Slovakia; 2021 data used for Denmark, Finland and Sweden and 2017 data used for Luxembourg.*
**Source:** *Eurofound analysis of Eurostat data [hlth_rs_physcat], extracted 17 February 2025.*

In several Member States, numbers of other mental healthcare workers have also increased.

- In Austria, psychotherapist numbers have increased year on year since 1991. They increased from 6 968 in 2010 to 11 919 in 2023 (Psyonline, 2023).
- In Estonia, the number of clinical psychologists per 100 000 inhabitants almost doubled from 2014 to 2023.
- In Finland, the number of registered psychotherapists increased year on year from 5 845 in 2011 to 8 646 in 2021.
- In Germany, the number of clinical psychologists increased from 23 121 in 2012 to 37 993 in 2022 (Statista, 2024).
- In Ireland, the public healthcare sector employed 11 931 mental health service workers in May 2024, increasing year on year (especially for psychologists) from 9 954 in 2019.
- In Poland, there were about 2 600 psychiatric nursing specialists in 2022, up from around 1 600 in 2018.
- In Portugal, from 2015 to 2022, numbers of mental health workers allocated to public hospitals grew in the three types of professions considered (doctors, psychologists and nurses). The number of nurses per 50 000 inhabitants grew from 4.0 to 7.6 between 2013 and 2022 (ERS, 2023b). Between 2019 and 2020, the number of psychologists and psychiatrists increased in all health regions, after decreasing from 2018 to 2019.

However, shortages in the mental healthcare workforce seem to be a problem in every country, including those where staff increases were observed. For instance, shortages in psychiatry staff were identified in Portugal, especially in primary care; a similar situation applied to psychotherapists qualified to provide long-term therapy in Finland (Rimaila, 2021; ERS, 2023a). In Estonia, a

shortage was noted among mental health nurses, psychiatrists, certified psychologists and other mental health specialists; an estimated additional 30–40 psychiatrists and 130 to 160 clinical psychologists were needed (Riigikontroll, 2022; Ministry of Social Affairs, 2023). In Greece, there is a particularly high number of psychiatrist vacancies in mental health centres. In Malta, the 2018 National Audit Office (NAO) report noted that human resources in physical healthcare had been prioritised, with larger shortages in mental healthcare, particularly among social workers, nurses and multidisciplinary community teams. Human resources improved, but in 2022 were still considered insufficient (NAO, 2022). An ageing workforce, with many about to retire, provides a challenge in addressing workforce shortages. In Bulgaria, 60 % of psychiatrists will have reached retirement age by 2026. In Estonia, half of psychiatrists are at or close to retirement age. In Finland, about one third of psychotherapists are over 65 years old. The EUR 25 000–EUR 60 000 fee that students pay for their psychotherapy education is considered to be a contribution to workforce shortages (Rimaila, 2021). In lower-wage Member States, an additional challenge is that workers move to countries with better pay and working conditions. In Slovakia, 400–500 psychologists graduate annually, but only about 60 of them end up in the country's health sector; the remainder work in companies or abroad.

The number of child and adolescent psychiatrists (hereafter shortened to 'child psychiatrists') per 100 000 people aged 0–14 in 2016 ranged from under 4 (Bulgaria, Czechia, Denmark, Latvia) to over 20 (Estonia, Finland, France, the Netherlands, Sweden) in the countries for which data are available in an international database [9]. More recent data, including from countries for which data were lacking in the database, suggest that, for instance, Croatia, Greece, Hungary, Poland and Slovakia have well below 10 child psychiatrists per 100 000 children. In 2023, Croatia had 49 child psychiatrists (and 18 trainees) despite a target of 120; Hungary had 45, Slovakia 47, and Poland (in 2021) 455. While the numbers for the Netherlands are well above these, capacity issues are still a problem: in 2021, the country had 445 child psychiatrists (330 full-time equivalents, double the 1996 figure). In Slovenia, child psychiatrist, adult psychiatrist and clinical psychologist shortages hinder the development of mental health centres (as planned in the National Mental Health Programme (Mira, 2019)) and the improvement of the general mental health situation (WHO Europe, 2020; NIJZ, 2021; UMAR, 2024).

### Other workers and services providing mental health support

Mental health professionals also work outside the healthcare system context, and other professionals provide mental health support. For instance, in Germany, besides psychiatrists (medical doctors specialised in psychiatry), psychotherapists (five years of university studies and three to five years of specialised therapist training) and medical psychotherapist (medical doctors with five years of additional specialised training), there are other mental health professionals. These work mainly in advisory and counselling centres, schools, universities, kindergartens, the social-psychiatric services of the municipalities, psychiatric departments in hospitals, the child and youth welfare services of the municipalities, day clinics and psychiatric clinics. Psychologists with a university degree, but without the additional therapist training, often work as counsellors in schools and universities, or in advisory centres of independent providers.

In 1979, Greece was the first country to legally establish the profession of psychiatry (and in 1985 psychiatric nursing). While this is now common practice, the extent to which professions (other than psychiatrists) in mental healthcare are legally established differs across Europe. For instance, in Greece, anyone can register as a mental health counsellor, psychotherapist or psychoanalyst. Hungary passed a law in December 2019 limiting the provision of fee-paying medical services or treatments, including psychological services, to people holding medical degrees or healthcare qualifications in clinical psychology. The punishment for violating this law is up to three years in prison. Some media noted negative consequences for the 4 000–6 000 non-clinical psychotherapists who worked in areas such as in school or family counselling, crisis outpatient services, drug prevention, church support services, art therapy and coaching. Luxembourg's 2024–2028 National Mental Health Plan (Direction de la Santé, 2023) includes an investigation of the impact of some services being unregulated (e.g. music or art therapy).

In Germany, social workers and occupational therapists often assist patients with psychological disorders. In Austria, 43 000 social workers and social pedagogues contribute to mental well-being, and their profession became legally protected in 2023 (with unlawful use of the title 'social worker' or 'social pedagogue' incurring a EUR 15 000 fine) (BMSGPK, 2023b).

[9] See https://gateway.euro.who.int/en/indicators/cahb_survey_39-rate-of-practicing-child-psychiatrist-per-100000-population-aged-0-14-years/#id=34022.

In 2022, Romania had 3 138 school counsellors (and 90 school psychologists/school physicians) for 2.9 million students. They provide psycho-pedagogical counselling (supporting the development of children and preventing risk situations), while school psychologists provide psychological counselling. In 2022, Sweden had a total of 3 120 school counsellors (who do not require formal educational qualifications, but most are social workers) and 3 030 school nurses, who also play a role in preventing poor mental health (Akademikerförbundet SSR, undated). In Slovenia, school counselling provided by teams of school psychologists, pedagogues and social workers in kindergartens and primary and secondary schools has been in place since the 1960s. It addresses mental health risk factors, such as school failure, domestic violence, substance abuse and poverty (Gregorčič Mrvar et al., 2020). Estonia, in addition to the national educational counselling system called Rajaleidja (which includes psychologist support), had 300 school psychologists in 2023, 50 of whom did not have the required master's degree (Einmaa, 2023). Poland has 6 105.48 full-time equivalent school psychologists, 1 per 785 students.

Some psychotherapists are outside of the regulated healthcare system, or are not legally defined. For instance, in Czechia, there is no legal educational requirement for private psychotherapists, but health insurers may only contract those with a psychology degree. There are about 1 200 qualified private therapists, mostly self-employed. In Austria, around 4 500 psychotherapists work in a training context under supervision at lower hourly rates (EUR 10 to EUR 40), but users do not qualify for reimbursement from their health insurance for sessions with a trainee psychotherapist.

Non-governmental organisations (NGOs) play a key role in providing mental health support. For instance, in Sweden, such NGOs include Mind, Bris, Friends, Spes and SPIV, and in Estonia an NGO offers mental healthcare to those aged 1–26 years. These services are unregulated and operate outside a formal policy setting. Some receive state funding.

Peer support, usually within some of the organisational structures discussed, also plays a role. In Spain, 4.3 % of people diagnosed with a mental health problem are supported by a person with their own experience with poor mental health. In France, about 220 peer supporters were trained between 2012 and 2023. In Ireland, in 2024, public healthcare employed 26 peer mental health workers.

In Belgium, while certain services legally can only be offered by a psychologist (e.g. care for depression or burnout), around 60 000 to 80 000 coaches (who do not require qualifications) offer services such as help to increase self-esteem.

Social services that do not primarily focus on mental health, such as victim support services (e.g. in Estonia), support lines for older people and debt advisory services, can still provide mental health support, sometimes employing mental health professionals (Eurofound, 2020b, 2022a).

## Waiting times

### Length and trends

Waiting times are a key problem in accessing mental healthcare services, especially through publicly funded systems. While official statistics may be lacking (e.g. in Greece), they often amount to several months and sometimes over half a year (Table 2). That may even be the case for initial appointments, while treatment may start later. People opt for private care to circumvent waiting lists; without this option, waiting lists would be even longer. For instance, in Spain, 46 % and 41 % of people requiring psychological or psychiatric care, respectively, identify the public system's waiting times as their main reason for using private care; rates are higher among people aged 18–24 years (Confederación Salud Mental España, 2023). In Austria, in early March 2020, of the 73 % of people with poor mental health who had sought mental healthcare, 76 % reported it was not immediately available (BÖP, 2020). National information on waiting lists is often lacking or not publicised (e.g. in Austria, Estonia, Latvia, Malta and Spain). While urgent care is usually more accessible than care for mild or moderate needs, there are examples of waiting lists for both types of publicly funded care. In particular, waiting times for initial consultations and registrations have been criticised (e.g. in France and the Netherlands). Waiting times vary within countries (see 'Geographical differences').

Recent and longer-term increases in waiting times have been observed (in Denmark, Estonia, Germany, Lithuania, the Netherlands, Norway, Poland and Sweden). Decreases have also occurred (in Belgium (Flemish Region), France, Hungary and Malta). In Portugal, the average response times for initial adult psychiatry consultations reduced between July–September 2018 and June–August 2019 (CNS, 2019).

Waiting times for child and adolescent services (marked in blue in Table 2) are often highlighted as particularly worrying (e.g. in Belgium, Cyprus, France, Latvia, Slovakia and Slovenia, and in outpatient care and some hospitals in Poland), including when no specific data were identified. For instance, in Latvia, the longest waits are for child psychiatrists, especially for an outpatient consultation with a psychiatrist at its children's university hospital. In Slovakia, waiting times for child psychiatric services and family therapy are considered particularly long, as are those for outpatient clinics for child and adolescent psychiatry in Poland.

Trend data point to recent increases in waiting times for child and adolescent mental healthcare in some countries (e.g. Finland, Ireland and Sweden), and decreases in others (e.g. Malta).

### Limits

Countries set limits on allowed waiting times, whether as a target (e.g. in Ireland) or a legal requirement (e.g. in Sweden). In Denmark, patients must be examined and assessed within 30 days when referred to a hospital. Otherwise, the patient is entitled to free private care. Slovakia covers up to EUR 200 each year for private psychology consultations if the waiting times for public care in the person's area of residence is at least three months. In Estonia, the maximum allowed waiting time is 6 weeks. In Sweden, patients seeking care should be contacted by their local care unit the same day, wait at most 3 days for an assessment and (if referred) receive an initial specialist consultation within 90 days. In Finland, from May 2025, people under the age of 23 are entitled to free psychotherapy or psychosocial treatment within 28 days.

Waiting times can exceed such limits (marked in red in Table 2). For instance, in Portugal, among 57 care units reporting waiting times, 13 exceeded the limit (May–July 2022). In the case of psychiatry for people aged under 19 years, 11 of 35 units exceeded the limit on at least one of the three priority care levels (normal, priority and high priority). In the first half of 2023, 39 % of psychiatric hospital consultations exceeded the limit. In mid-2023, 17 844 patients were waiting, and 57 % of 'high priority', 45 % of 'priority' and 29 % of 'normal' users had exceeded the limit. In 2019, some hospitals had average waiting times above the limits – 95, 90 and 204 days for adult psychiatry and 66, 129 and 240 days for child and adolescent psychiatry for high priority, priority and normal levels (initial consultations), respectively. In the case of public psychotherapy, 58 % of service users had their first session within the time limit (ERS, 2023b; DECO PROTeste, 2024).

**Table 2: Waiting times for various types of mental healthcare services, EU and Norway, 2024**

| Country | Service | Length of wait or number of people waiting | Time trends |
|---|---|---|---|
| **Austria** | Psychotherapy | Usually 1.5 to 9 months | |
| **Belgium** (2022) | Adult care provider (overall) | 46.7 % ≥ 1 month | |
| | Psychiatrist | 60.5 % not accepting new patients<br>43.0 % ≥ 6 months | |
| | Psychologist | 37.7 % not accepting new patients<br>50.9 % ≥ 1 month | |
| | Psychotherapist | 33.3 % not accepting new patients<br>42.0 % ≥ 1 month | |
| | Remedial educationalist | 28.2 % not accepting new patients<br>48.7 % ≥ 1 month | |
| | Child services | 64.2 % ≥ 1 month (15.3 % > 6 months) | |
| | Young people's services | 57.8 % ≥ 1 month | |
| | Community-based mental health centres in the Flemish Region | Average (from enrolment to first face-to-face contact): 41 days (2022) | Down from 57 days peak in 2017; the decline was interrupted during the pandemic, when waiting times were 51–52 weeks |
| **Bulgaria** | Adult mental health facilities | 2 057 (November 2020) | |
| **Croatia** | Psychologist or psychiatrist care | Average: 32 days (major hospitals: 5 days, second-tier hospitals: 30 days, third-tier hospitals: 45 days) | |
| **Cyprus** | Child psychiatry | Nicosia: 1–2 months (most urgent cases get priority) | |
| **Denmark** (1st quarter of 2024) | Psychiatric treatment for adults | Average: 29 days | |
| | Psychiatrist (2023) | Average: 81 weeks | Doubled since 2018 |
| | Psychiatric treatment for children and adolescents | Average: 26 days | |
| **Estonia** | Outpatient specialist care | Less than one third of patients: > 42 days | Increased over past 6 years |
| **Finland** | Care for people aged under 23 years | > 3 months: 613 | Up year on year after a 2015 low, from 50 in 2017, with the largest increase during the pandemic (by 247 from 2020 to 2021) |

| Country | Service | Length of wait or number of people waiting | Time trends |
|---|---|---|---|
| **France** | Adult psychiatric care (2019–2022) | Average: around 3 weeks | Down from 1–4 months in 2018 |
| | Child and adolescent psychiatric care (2018) | Usually 5–12 months | |
| **Germany** | Acute treatment | Average: 14.5 weeks (2019) | |
| | Psychotherapist | 22 weeks (between the initial consultation and the start of psychotherapy) (2019) | Up from 18 weeks in 2015 (before a reform of the psychotherapy system in 2017 to enhance coverage) |
| **Hungary** | Non-emergency psychiatry | Average: 14 (2022) | Down from 17 in 2016 |
| | Child mental healthcare | Can be 6 months | |
| **Ireland** | Free counselling | 4 358 (18 % waiting for 6 months or longer) | |
| | Needs assessment | 8 893 children were waiting (6 963 waiting > 3 months) (4th quarter 2023) | Up from 3 686 (1st quarter of 2019) |
| | Nine community health organisations under Child and Adolescent Mental Health Services | 4 500<br>471 people waiting for psychiatry (June 2024) | |
| **Italy** | Psychologist (public system) | A few weeks to several months | |
| **Latvia** | Psychiatrist | 5–147 days | |
| **Lithuania** (2024) | Psychiatrist | 25.0 % ≥ 15 days | Up from 20.4 % (2022) |
| | Psychologist | 20.2 % ≥ 15 days | Up from 19.5 % (2022) |
| | Mental health nurse | Within 7 days | |
| | Child and adolescent psychiatrist | 20.6 % ≥ 15 days | Up from 18.3 % (2022) |
| **Luxembourg** | Psychologist-clinician and psychologist-psychotherapist | 3–4 months | |
| **Malta** | Community clinics and rehabilitation centres | Average: 3 months (for an initial appointment) (2022) | Down from 5 months (2018) |
| | Psychological services for people assessed as 'low risk' | 32 people (2023) | Down from 2020 peak, dropping to lowest levels on record since 2012 in 2022 and 2023 |
| | Child and Young People's Services | 2–4 weeks for urgent cases, 4.5 months for less urgent cases (2022) | Down from 6 months for urgent and 2 years for less urgent care (2018) |
| **Netherlands** | Mental healthcare (2023) | Waiting: 97 450 (people on waiting lists for multiple providers are counted multiple times)<br>Waiting > 14 weeks: 55 390 (56.8 %) | Up from 87 114 in 2022. Waiting list increased by 25 % from July 2021 to December 2023 for providers who provided data for the entire period |
| | Depression care (December 2023) | Registration: 12 weeks; registration and treatment together: 18 weeks | |
| **Poland** | Psychiatric consultation | Average: 3–4 months | |
| | Outpatient counselling centre (2019) | Average of audited centres: 1 036 people on waiting list (waiting on average 56 days, but in 1 of the 8 audited centres, average waiting time was 120 days) | Up from 564 in 2017 (44 days) |
| | Non-emergency psychiatric hospital care for minors | Average: 1.5 days, 402 waiting (December 2018) | Down from 2 days and 516 waiting in 2017 |
| **Portugal** | Psychiatric consultation | Up to 97 days for high-priority adult care (January 2023)<br>In the 9 hospitals reporting waiting times, end of July 2022: 12 415 waiting for initial adult psychiatry appointment | |
| | Child psychiatric consultation | Up to 79 days for high-priority child mental healthcare<br>In the 9 hospitals reporting waiting times, July 2022: 4 465 waiting for child and adolescent psychiatry | |

| Country | Service | Length of wait or number of people waiting | Time trends |
|---|---|---|---|
| **Slovakia** | Examination by mental health expert | Usually 1–3 months | |
| | Psychotherapeutic care | Average: 7 weeks | |
| | Psychologist | Usually several months | |
| | Psychiatrist | Average: 7.3 weeks, and in some regions even several months | |
| **Slovenia** | Mental health specialist care (2019) | 100 days | Stable compared to 2018 |
| | Child and adolescent care (2019) | > 6 months (can be 1 year for clinical psychology specialist) | Stable compared to 2018 |
| | Newly established mental health centres for adults and mental health centres for children and adolescents (June 2020) | Over 6 months<br>29 % waited 1–3 months for examination, 25 % waited 3–6 months and 10 % waited > 6 months | |
| **Spain** | Psychologist (public system) | Often around 6 months (after referral), usually with about 2 weeks between sessions | |
| **Sweden** (2023) | General psychiatry | 16.8 % did not complete a first visit within 90 days | |
| | Child and adolescent psychiatry | 50.6 % > 30 days (started assessment and/or treatment) | Up from 30.9 % in 2019 |
| | | 7.9 % > 90 days (first visit) | Up from 6.9 % in 2019 |
| **Norway** | Psychotherapy | Average: 4–6 weeks (waiting time following referral) | |
| | Specialist mental healthcare | Median: 46 days (average: 54.1 days)<br>Patients referred to specialist care, waiting for treatment during 2023: 62 559 | Increase from 2022 (after 2013–2022 decrease from average 54 to 40 days and median 44 to 36 days) |

**Notes:** *Due to data unavailability and Eurofound's resource limitations, no trends or older data were obtained for the empty cells in the right-most column. Waiting times for child and adolescent services are marked in blue. Waiting times above the set national limits are marked in red. No waiting list data were identified for Czechia, Greece and Romania. However, in Greece, for example, the media noted waiting lists of over two months for mental health centres (mainly due to psychiatrist vacancies), and over six months in psychosocial rehabilitation and treatment facilities (for mental health issues and addiction problems).*
**Sources:** *Austria: Löffler-Stastka and Hochgerner, 2021; Bulgaria: Institute of Market Economy, 2021; Denmark: Danish eHealth Portal; Estonia: Ministry of Social Affairs, 2020; France: FHF, 2023; Germany: Ärzteblatt, 2023; Ireland: Bowers, 2024; Malta: NAO, 2022; Portugal: DECO PROTeste, 2023; Slovenia: WHO Europe, 2020; NIJZ, 2021; and information from national background reports (see note 2).*

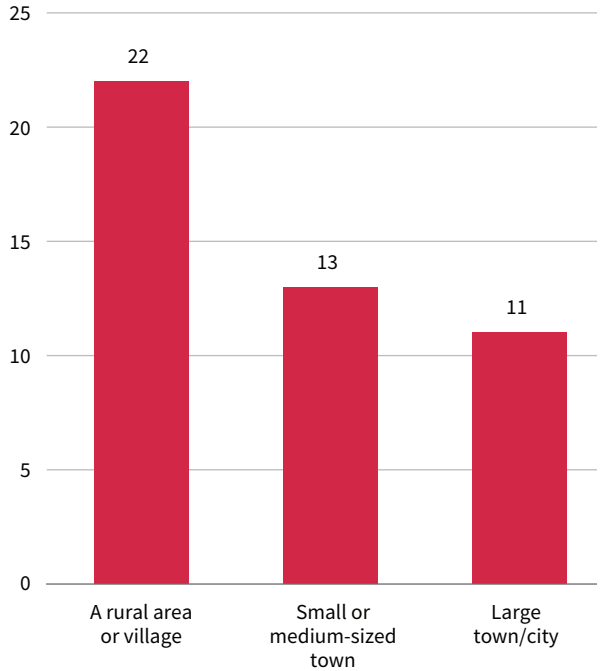
## Geographical differences in access to services

Geographical distribution of mental health services (along with access to transport) impacts reachability of these services. People with psychosocial problems in rural areas are twice more likely to report services being too far than those in cities (Figure 20).

Mental healthcare services, in particular specialised care, tend to be concentrated in densely populated areas.

- In Austria, in 2023, the number of inhabitants per psychotherapist ranged from 412 in Vienna to over 1 200 in the regions of Upper Austria and Burgenland (Psyonline, 2023).
- In Denmark, people with lower education and income levels live further away from psychologists and GP services than people with higher education and income levels, and use these services less, adjusted for needs (SST, 2023).

**Figure 20: Mental healthcare services located too far to travel to, by people who experienced mental health problems, by degree of urbanisation, 2023, EU (%)**




**Source:** *Eurofound analysis of Eurobarometer microdata, downloaded from GESIS.*

- In Estonia, the availability of inpatient psychiatric care is particularly problematic in the counties of Harju (including Tallinn) and Ida-Viru (Ministry of Social Affairs, 2020).
- In Hungary, three of the four state-funded psychotherapy providers are in Budapest.
- In Ireland, in 2023, 17 % of people who had delayed seeking mental healthcare did so because services were lacking in their area (most often a rural area) (Aware, undated).
- In Latvia, child psychiatry is only available in Riga and Daugavpils.
- In Malta, the Northern Harbour district and the Northern and Gozo regions are underserved (Camilleri et al., 2019).
- In Poland, the uneven geographical distribution of medical staff, psychiatric hospital wards and clinics for minors causes access problems in underserved areas (Naczelna Izba Kontroli, 2019). Five districts lacked a day psychiatric ward and one had no 24-hour ward.
- In Romania, in 2018, most of the 80 mental health centres providing free local services were in large cities.
- In Slovenia, some areas lack child and adolescent psychiatry specialists. About 40 % of outpatient psychiatric specialist programmes are offered in psychiatric hospitals providing secondary and tertiary care, where specialists are concentrated, not at the primary care and community levels. In 2020, of 215 psychiatrists, 134 worked in psychiatric hospitals and 44 in health centres; 37 were private specialists whose services were covered by public insurance. Specialists (in psychiatry, clinical psychology and paediatric psychiatry) and mental healthcare programmes are concentrated in Ljubljana and Maribor (NIJZ, 2021). Access problems leave people in rural and remote areas with fewer treatment options or without care (WHO Europe, 2020).

Waiting times can be particularly long for specialised care in cities (see 'Waiting times') but are usually even longer in less urbanised areas.

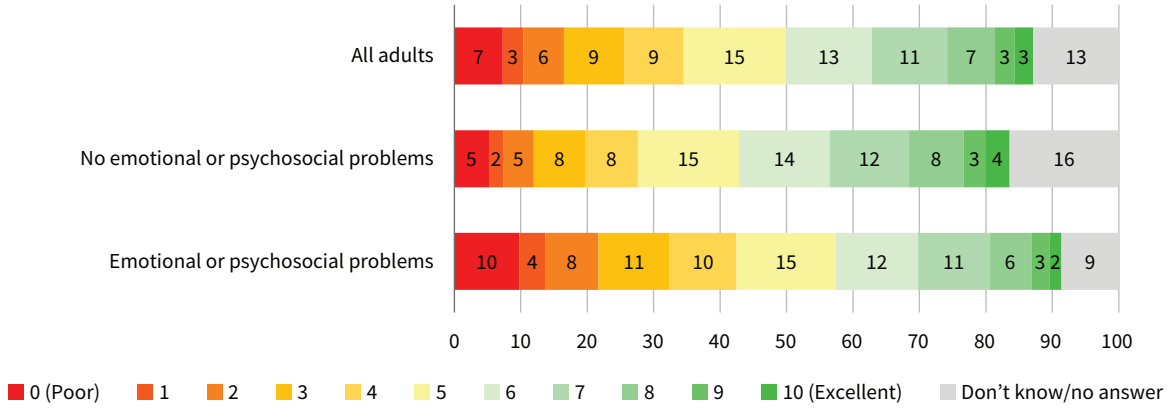
- In Croatia, waiting times in major hospitals are particularly long in Zagreb (26 days for an initial psychological examination and 29 days for a psychotherapy consultation with a psychiatrist) and in smaller hospitals in Pula (65 days for initial treatment). In local hospitals, the longest wait is in Vukovar (156 days).
- In Estonia, waiting times for contracted mental healthcare range from 17 days (in Harju) to 98 days (in Hiiu) for psychiatric support, and from 10 days (in Ida-Viru) to 85 days (in Lääne) for psychological support. In some areas, waiting times for private clinical psychologists are over two months.
- In France, average waiting times for adult psychiatric care in the period 2019–2022 varied from 12 days in Britanny and Île de France to 40 days in Auvergne-Rhône-Alpes.
- In Germany, waiting times for psychotherapy are longer in the countryside than in cities (rbb24, 2022).
- In Lithuania, especially in smaller towns and rural areas, the lack of clinical psychologists results in long waiting times and insufficient mental health centre services (Wijker et al., 2022).
- In Poland, residents of small towns and rural areas face especially long waiting times. In 3 of the 8 hospitals audited in 2019, waiting times were 31, 14 and 11 days. The average waiting time in one outpatient clinic was 120 days. One hospital had an average 13-day waiting time for emergency care (Naczelna Izba Kontroli, 2019).
- In Slovenia, children and adolescents' mental healthcare usage ranged, partly due to variations in paediatric specialist shortages, from 28.3 per 1 000 inhabitants in Primorsko-notranjska to 11.8 in Savinjska (Jeriček Klanšček et al., 2018).

## Low-quality services

Another important aspect of access to mental healthcare is whether the accessible services fit users' needs and are trusted/trustworthy and of good quality (Eurofound, 2020a).

When asked in June 2023 to rate mental healthcare services on a scale from 0 (poor) to 10 (excellent), 40 % of people in the EU scored them below 5, and 57 % below 6 (excluding people who indicated they did not know or people who did not answer; Figure 21). The average rating was 4.9, well below the ratings for other care services (Eurofound, 2020a). In particular, people who in the previous 12 months had experienced emotional or psychosocial problems (e.g. feeling depressed or anxious) and thus were the most likely respondents to have had direct experience with services or to have needed them, often scored them low: 46 % of such respondents gave a rating below 5 and 63 % gave a rating below 6. This is in contrast to other services, for which users tend to give higher ratings than non-users.

**Figure 21: Rating of the quality of mental healthcare services by people who experienced/did not experience poor mental health in the previous year, 2023, EU (%)**




**Note:** *Question: 'How would you rate the quality of mental health services based on your own experience or that of others you know (after the COVID-19 pandemic)?'*
**Source:** *Eurofound analysis of Eurobarometer microdata.*

**Trust/trustworthiness.** 46 % of respondents who had had an emotional or psychosocial problem in 2023 (and 44 % of all respondents) reported not knowing a good care provider, having a fear of providers or treatment, or both, as one of the main barriers to accessing mental healthcare (further analysis of Figure 18 data). Distrust of the healthcare system and mental health specialists (along with discrimination and stigma) discourages care seeking (Doblytė, 2022). Restrictive methods and hospitalisation are feared, especially in countries where care is mainly provided by large psychiatric hospitals, but also elsewhere. People from countries where inpatient psychiatric care has been used to deal with individuals who criticise regimes (e.g. refugees or people from post-communist countries) have an additional historical reason for distrust of care. Distrust among the Roma population exacerbates mental health stigma and diminishes help seeking (ERGO Network, 2022; Guerrero et al., 2024a).

**Services not adjusted to specific needs.** Services may not fit the needs of specific groups. For instance, in Germany, in 2017, around 30 therapists were offering therapy in sign language. Deaf people and those hard of hearing also face shortages of experienced therapists, increased organisational effort (e.g. arrangements with interpreters) and more difficult initial contact processes (Schröder and Vereenooghe, 2021).

**Limited time.** Psychiatrists' time per patient is limited, sometimes leading to ineffective care or overmedication (see 'Reducing over-medicalisation and overmedication'). For instance, in Slovakia, outpatient psychiatrists conduct about 30 consultations daily, at 16 minutes per patient. In Hungary, in 2022, initial sessions with new patients lasted on average 25 minutes, and subsequent sessions 10 minutes.

**Fragmented support.** Mental healthcare services are not always adequately integrated into broader healthcare and social support systems, causing fragmented care and poor coordination among service providers.

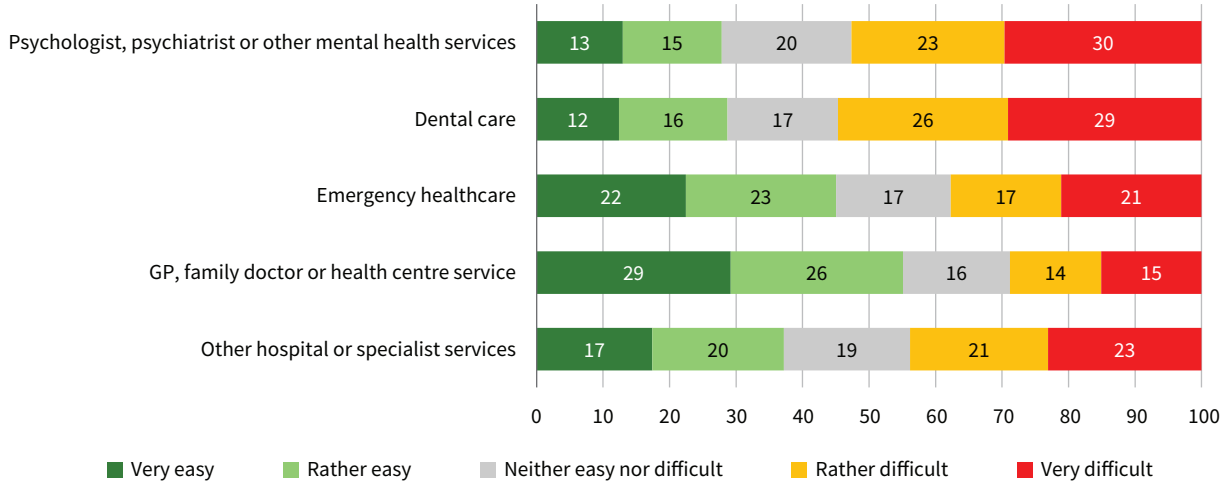
## Unaffordability of timely care

Unaffordability is affected by service costs, low disposable income, travel costs and opportunity costs (especially lost income from missing work to attend care). When people are entitled to subsidies, they may be unable to access them (e.g. because they are unaware of their existence or do not know how to access them). Care itself may sometimes be affordable, but it may not be the type of care that fits a person's needs (Eurofound, 2020a).

In the EU, over one third (36 %) of people surveyed report they would find it difficult or very difficult to afford mental healthcare if they needed it, from 53 % among the bottom income quartile to 23 % among the top (Figure 22; Eurofound, 2018). According to the 2019 EHIS, 4 % of people in the EU who needed mental healthcare (e.g. from a psychologist, psychotherapist or psychiatrist) could not afford it. Others could access it, but faced problems paying for it. Overall, 38 % of people who had experienced an emotional or psychosocial problem found costs a barrier to seeking care (Figure 18).

Postponing or forgoing the care needed can prolong and escalate poor mental health, possibly even worsening the person's income situation, e.g. by leading to loss of employment. Undiagnosed poor mental health can also impede access to benefits. In Slovakia, an estimated 51 % of people who would be eligible for a disability pension due to a mental disorder failed to receive it, as they were undiagnosed (Brazinova et al., 2019). Such negative financial consequences can further contribute to mental healthcare affordability issues.

**Figure 22: Difficulty of affording healthcare services if needed, bottom-quartile income earners, 2016, EU (%)**




**Note:** *Question: 'How easy or difficult would it be for you to cover expenses for each of the following, if you needed to use it tomorrow?'*
**Source:** *Eurofound analysis of European Quality of Life Survey microdata.*

## Basic coverage

Overall, mental healthcare seems largely covered by basic healthcare packages, especially for particularly urgent needs. In Belgium, psychiatric care is generally reimbursed at higher rates than psychological therapies. In Denmark, psychiatric care is free while psychological counselling and other services require co-payments. In Bulgaria, care provided by state psychiatric hospitals is publicly funded, focusing on more urgent needs, including, for instance, an allocated 3 611 outpatient treatment places for complex cases (2023–2025). Psychologists have no contract with the national health insurer, so their care is not publicly covered. However, psychiatric care, for more severe needs, is not always fully covered in the EU. In Estonia, public psychiatric care (beyond psychotherapy) costs EUR 20 per visit (EUR 5 for minors, pregnant women, older people and people with disabilities). In some countries, private inpatient care plays a significant role. In Finland, inpatient psychiatric care has a daily co-payment of EUR 25.10 (capped at 7 days for people aged under 18 years). Mental healthcare at primary local health centres is free. Long-term outpatient psychiatric care costs vary across Finland and may depend on income (e.g. in Helsinki). In France, 25 % of psychiatric hospital beds are in private for-profit establishments; in Greece, private clinics have 4 700 beds.

In the EU, psychotherapy sessions accessed through the public system are usually free (in 15 Member States). Some require a co-payment (in Croatia, Cyprus, Estonia and Sweden), while others must be fully paid upfront but are partially reimbursed (in Belgium, Denmark, Finland and France) or fully if the user's total annual healthcare costs are above a certain cap (in the Netherlands and Norway) (Table 3). However, capacity problems are significant (e.g. waiting lists, unavailability, little time per session or few allocated sessions). In countries with social health insurance systems, fully covered services are usually restricted to therapists who have been contracted by insurers (Austria, Czechia, Slovakia and – usually – the Netherlands). In Ireland and Italy, sessions are only free through the public organisation responsible for mental healthcare provision. In Latvia, where psychiatrist consultations are publicly covered, people diagnosed with poor mental health are exempted from co-payment. In Austria, while public psychiatric and psychological care (contracted by insurers) is free, there are limited psychotherapy places available (70 000). In Hungary, in 2023, health insurance financed more psychiatric care (1 089 551 cases, 3 874 207 interventions) than psychotherapy care (9 406 cases, 45 149 interventions).

Basic coverage in six Member States (Austria, Belgium, Denmark, the Netherlands (only some insurers), Romania and Slovakia) includes partial or full reimbursement; Germany, for example, provides free private sessions. In Denmark, 60 % of the cost is reimbursed for 12 sessions. Romania reimburses psychologist care contracted by referring medical specialists (not necessarily by the insurer). In some countries, private care is partially or fully covered only if waiting times for public care exceed a certain limit (see 'Waiting times'). In countries with multiple insurers providing basic insurance, reimbursement usually differs between insurers. In Austria, for instance, the largest health insurance provider and the insurer for self-employed people reimburse EUR 33.70 (unchanged since 2018) and EUR 40, respectively. Belgium's largest insurer covers the first session with a psychologist in full, while own contributions for subsequent sessions are EUR 11.

In the Netherlands, psychotherapists not contracted by the insurer are usually not fully reimbursed, in contrast to those contracted.

Private provision of mental healthcare can be attractive for mental healthcare professionals. Under half of Slovakia's 360 psychotherapists have contracts with basic health insurers. In Latvia, psychologists receive EUR 25.33 per publicly funded session (while more highly educated psychotherapists and medical psychotherapists receive EUR 28.52), well below the amount for private sessions. In Hungary, psychotherapists earn three to four times more for privately provided services than for publicly funded ones.

In six Member States, low-income groups and other groups in vulnerable situations may qualify for extra public support to pay for psychological services (Belgium, Ireland, Italy and Luxembourg) or for supplementary insurances covering co-payments (Croatia, France). In Luxembourg, co-payments are limited to 2.5 % of people's income. In Ireland, up to eight psychotherapy sessions are free through the public provider for people with a 'medical card'. In 2023, 30.5 % of people in Ireland qualified for such a card, as their income was below a threshold dependent on household composition, housing costs and commute. In Croatia and France, low-income (and other) groups qualify for free supplementary insurance, covering co-payments. 15 % of Croatia's population and 20 % of France's have such state-funded insurance. In Belgium, people with an annual income below EUR 27 550.86 (plus EUR 5 100.42 for each additional household member) qualify for extra reimbursement (i.e. Belgium's largest insurer reduces their user costs to EUR 4 per session). In Italy, people with below-threshold household incomes qualify for a reimbursement of up to EUR 1 500. However, only 14 % (54 859) of the 400 505 applicants have received it, mainly because of a limited budget (EUR 10 million in 2024). In Austria, psychotherapists in the public system usually give priority to people on a low income or those in other disadvantaged situations.

Some Member States cover sessions for young people specifically. In Denmark, co-payments for sessions for depression or anxiety are waived for people aged 18–24 years. In France, students qualify for 12 additional free sessions. Since 2024, Belgium's largest insurer has fully covered sessions by psychologists for people aged under 24 years.

The limited capacity of the publicly covered services implies that timely access to non-emergency mental healthcare comes with user costs (or the need for supplementary insurance) to circumvent waiting lists and availability problems by accessing these services on the private market. This is especially the case for services such as psychotherapy sessions. For instance, in Spain, 36.1 % and 33.5 % of those who seek psychological and psychiatric consultations, respectively, opt for private mental healthcare, and 8.7 % and 10.4 %, respectively, combine public and private care (self-paid or through supplementary insurance). The public health system focuses on the most severe cases (Confederación Salud Mental España, 2023). In Austria, in 2019, among people receiving psychotherapy, an estimated 52 % received a subsidy, 27 % received free services and 21 % were self-paying (Löffler-Stastka et al., 2023).

Usually, certain therapies are excluded from basic coverage (e.g. therapies to address relationship problems or burnout in the Netherlands). More non-conventional and preventative services are also usually excluded.

A GP referral is not always needed to visit psychiatrists or mental health nurses, especially for care deemed urgent; these providers may then provide or prescribe psychotherapy (e.g. in Estonia, Germany, Greece, Poland and Slovakia). For instance, in Slovakia, psychiatrists can provide psychotherapy without a referral, but a GP referral is needed for publicly covered psychotherapy by psychologists. Usually, however, a referral is needed for non-emergency mental healthcare (e.g. in Croatia, Estonia, Greece, Ireland, Luxembourg, Norway, Portugal, Romania and Spain). In Romania, since July 2023, all doctors can make referrals. In Cyprus, outpatient visits without a referral cost EUR 25 and with a referral EUR 6. Referrals are valid for three outpatient specialist visits within six months. Long-term referrals (12 visits annually) can be applied for. In Finland, people need to receive three months of primary care treatment before qualifying for either free or subsidised psychotherapy. GP referrals can entail costs (e.g. in Ireland for people without a medical card or GP visit card).

There may be no maximum to the number of sessions covered (e.g. in Lithuania and the Netherlands). Usually, however, the maximum yearly number of sessions covered is limited, regardless of needs (Italy: 8; Latvia: 10; Denmark and France: 12; Cyprus: 18 for adults, 24 for children; Germany: 24; Slovakia: 25; Finland: 80). The maximum often depends on the diagnosis and type of therapy (e.g. in Estonia, Finland, Greece). For instance, in Poland, 12 sessions over 6 months are covered for family therapy, and 110 sessions over 1 year for long-term group psychotherapy. Sometimes longer therapy durations can be granted, but they need to be applied for (in Austria after 50 sessions), usually require medical and insurance approval (in Germany and Slovakia), and are sometimes subject to upper limits (in Denmark, 24 sessions for depression and anxiety). In Finland, for instance, the number of sessions covered varies from 20 to 80 and can be extended to 200 over 3 years.

Table 3 gives a rough indication of psychotherapy costs. Outside the public system, the cost of 10 of the cheapest type of sessions is rarely less than 50 % of the net minimum monthly wage, and 10 average-priced sessions cost more than a monthly wage in about one third of Member States. Costs often vary within countries by level of urbanisation, psychotherapists' experience and qualifications, and whether the sessions are online or in person. For instance, in Portugal, in early 2023, an initial adult psychiatric consultation cost on average EUR 79, ranging from EUR 107 in Beja to EUR 55 in Azores. Child and adolescent psychiatric consultations cost around EUR 83 on average (usually EUR 90). Psychological consultations for children and adults usually cost EUR 50 and EUR 60, respectively. Usually, the initial consultation was more expensive than subsequent ones by EUR 5 to EUR 20, whatever the speciality (DECO PROTeste, 2023). Some countries have set prices or price caps (Germany, Luxembourg and the Netherlands).

**Table 3: Psychotherapy sessions: basic coverage, user costs, support for low-income earners and supplementary insurance by country, 2024**

| Country | Coverage through public system (per session, non-means tested) | Means-tested additional coverage | Cost of private session (approximate) | Cost of 10 private sessions as proportion of net monthly minimum wage | Supplementary insurance: significant role in covering psychotherapy outside the public system? | Supplementary insurance: population covered |
|---|---|---|---|---|---|---|
| **Austria** | Free (private: EUR 30–50 subsidy, differing between social health insurance providers) | | EUR 60–160 | 48–128 % | Yes; reimbursement (session numbers, cost levels) differs between insurers | 38.4 % |
| **Belgium** | Reimbursement, varying by insurance fund | Extra reimbursement | Around EUR 70 | Around 49 % | Yes; mainly covers inpatient co-payments | About 90 % |
| **Bulgaria** | None | | BGN 30–120 (EUR 15–62) (as at 27 June 2025) | 41–166 % | No | < 5 % |
| **Croatia** | Co-payment | Supplementary insurance | EUR 40–70 | 53–93 % | Yes; covers co-payment | Almost 60 % |
| **Cyprus** | Co-payment (EUR 10) | | EUR 50–100 | 56–113 % | Yes | 255 000 people |
| **Czechia** | Free | | Around CZK 1 000 (EUR 40) | Around 61 % | Yes; reimbursement provided by 2 of the 7 health insurers for 10 private sessions, up to CZK 4 000 (EUR 162) and CZK 5 000 (EUR 202), respectively | |
| **Denmark** | Co-payment (40 %) | | DKK 800–1 400 (EUR 107–188) (usually DKK 900–1 100 (EUR 121–147)) | 100–175 % | Yes; differs between insurers | 2.7 million people |
| **Estonia** | Co-payment (EUR 20) | | EUR 80–120 | 98–148 % | Yes | Unknown, but 48 400 employees (2022) |
| **Finland** | Subsidised (≤ EUR 57.60 per session) only for people aged 16–67 years for therapy to integrate them into employment/education; for others, counties may subsidise therapy to different extents (using vouchers) | | EUR 80–140 | 47–82 % | Yes; usually covers some of the costs for a limited number of sessions | 1.3 million people by private insurance and 0.7 million people by other occupational health insurance |
| **France** | Co-payment (EUR 30) (60 % reimbursement of costs of up to EUR 50) | Supplementary insurance | EUR 50–80 | 36–58 % | Yes; covers co-payment (97 %) | |
| **Germany** | Free | | EUR 100–150 | 66–99 % | No (usually used instead of basic insurance and does not cover more psychotherapy) | |

| Country | Coverage through public system (per session, non-means tested) | Means-tested additional coverage | Cost of private session (approximate) | Cost of 10 private sessions as proportion of net monthly minimum wage | Supplementary insurance: significant role in covering psychotherapy outside the public system? | Supplementary insurance: population covered |
|---|---|---|---|---|---|---|
| **Greece** | Free | | EUR 40–140 | 49–170 % | Yes, for some insurers (e.g. EUR 50/session, up to EUR 500) | |
| **Hungary** | Free | | HUF 7 000–25 000 (EUR 17–62) (usually HUF 10 000–14 000 (EUR 25–35)) | 39–141 % | No | < 5 % |
| **Ireland** | Free | Up to 8 free sessions (public) | EUR 60–90 | 32–48 % | Yes; differs between insurers | 45 % |
| **Italy** | Free | Reimbursement | EUR 35–114 | 39–127 % | Yes; reimbursement for number of sessions and costs differs between insurers | 40 % |
| **Latvia** | Free | | EUR 45–100 | 72–161 % | No; insurance rarely provides additional psychotherapy coverage | 24 % (2022) |
| **Lithuania** | Free | | EUR 30–90 | 42–127 % | Yes; usually up to around EUR 200/year covered, for clinic-based providers (growing, but small) | |
| **Luxembourg** | Co-payment (EUR 45.39) | Extra reimbursement | EUR 155.07 | Around 72 % | Yes; additional reimbursement | Two thirds |
| **Malta** | Free | | EUR 45–60 | 57–76 % | Yes (e.g. largest insurer: EUR 50 for psychologist; EUR 85 for specialist) | |
| **Netherlands** | Fully reimbursed, if above healthcare costs cap (EUR 380/year) | | EUR 140–160 | 74–85 % | Yes; lower annual cap and some cover more sessions | 85 % |
| **Poland** | Free | | PLN 150–300 (EUR 35–70) | 46–92 % | No; insurance rarely provides additional psychotherapy coverage | 5 million people |
| **Portugal** | Free | | EUR 50–90 | 71–128 % | Yes | 38 % |
| **Romania** | Free | | RON 200–500 (EUR 39–99) | 100–250 % | No | < 5 % |
| **Slovakia** | Free | | EUR 30–70 | 50–116 % | No | < 5 % |
| **Slovenia** | Free | | EUR 50–60 | 55–67 % | No | |
| **Spain** | Free | | EUR 40–70 | 39–68 % | Yes; usually 15–20 sessions covered, with different reimbursement levels | 26 % (2023) |
| **Sweden** | Co-payment (SEK 100–400 (EUR 9–36) for primary care, SEK 260–450 (EUR 23–41) for specialist care); healthcare costs capped (SEK 1 400/year (EUR 126)) | | SEK 800–1 500 (EUR 72–135) | 71–134 % | Yes | Unknown, but 780 000 employees |
| **Norway** | Healthcare costs capped (NOK 3 165/year (EUR 268)) | | NOK 800–1 200 (EUR 68–102) | 40–60 % | Yes | 750 000 people |

**Notes:** *Based on rough indications of the cost of a 45–60-minute session. Austria, Finland, Italy, Norway and Sweden have no national minimum wage, but EUR 1 250, EUR 1 700, EUR 900, NOK 20 000 (EUR 1 694) and SEK 11 200 (EUR 1 010), respectively, were taken as rough net monthly bottom full-time wages.*
**Source:** *Eurofound, based on input from the Network of Eurofound Correspondents, desk research and (for minimum wage) Eurostat [earn_mw_cur], second half of 2024.*

People who are entitled to publicly funded mental healthcare may still face unaffordability issues if they look beyond the public system due to its capacity limitations. For instance, in Spain, most people with poor mental health (57 %) consider visiting a mental health professional to be financially inaccessible, especially people from lower-middle-income and lower-income classes (63 %) (Confederación Salud Mental España, 2023). In Austria, between 2017 and 2020, among people receiving outpatient psychotherapy funded by health insurance who had also had at least one inpatient treatment, 70 % had had poor mental health for over two years and had previously received inpatient (46 %) or outpatient (82 %) psychotherapeutic treatment; of those who had received prior outpatient psychotherapy, 45 % had received it publicly while 55 % had paid for it. Of those using self-funded psychotherapy, 70 % had been unable to work before the inpatient treatment and 39 % earned under EUR 1 000/month.

## Supplementary coverage

In some countries, people tend to pay out of pocket for private healthcare, rather than through supplementary insurance (e.g. Hungary, Malta and Slovakia). Certain insurers and private hospitals offer types of supplementary insurance, but these are not widespread and may not cover mental healthcare.

However, in several countries, supplementary insurance plays a larger role, which has recently increased (e.g. Austria, Denmark, Ireland, Italy, Norway, Portugal, Spain and Sweden). In Denmark, the number of people with supplementary insurance increased from 196 794 in 2010 to 2 889 254 in 2023, in Spain from 8.7 million in 2011 to 12.4 million in 2023, and in Sweden from around 588 000 in 2015 to 808 000 in 2024. In Cyprus, the proportion of people with private insurance has been increasing since 2022 (by about 5 % annually) after two years of decreases. Often such insurance is provided by employers (e.g. 99.6 % of supplementary insurance in Latvia and 89 % in Norway). In Estonia, the number of employees covered by private health insurance increased by 72 % from 2021 to 2022. In Sweden, 6 out of 10 employees receive it from their employer. Supplementary insurance offered by trade unions has increased in recent years (Svensk Försäkring, 2025). Employers also provide additional access to care in other ways. For instance, in Ireland, the Employee Assistance Programme provides free counselling/therapy services to employees, including for anxiety or depression. People with supplementary insurance are often those financially better off, who can afford it or whose employers provide it. For instance, in Portugal, supplementary insurance is relatively common among people aged under 55 years, with higher levels of education, in employment and with higher incomes (Portal dos Seguros de Saúde, 2024).

Usually, supplementary insurance helps circumvent waiting lists by covering (some of the) costs for private psychotherapy or psychiatry (e.g. in Austria, Estonia and Norway). In Portugal, the three reasons for acquiring private insurance most often reported are poor access to the public system (30 %), reduced waiting times (13 %) and the opportunity to be followed up with by a specialist (10 %) (Portal dos Seguros de Saúde, 2024). Supplementary insurance may also provide better coverage of prescription drugs (e.g. in Estonia), outpatient care (e.g. in Estonia) or hospital care (e.g. in Belgium and Greece), or may cover co-payments for publicly funded care (e.g. in Croatia and France). Supplementary insurance also offers services beyond basic coverage (e.g. online therapies, non-medical/preventative services). For instance, in Austria, private health insurers have recently started covering online therapy services, including non-medical online services (e.g. sleep or stress coaching). In the Netherlands, they also cover alternative therapies. Exceptionally, in Germany, private insurance mainly covers people without basic insurance (10 % of the population, mainly self-employed people), rather than supplementing basic entitlements. It covers psychotherapy less than basic insurance, but may cover non-accredited therapists' care and therapies. In Sweden, employers may offer a (nationally standardised) healthcare allowance for sports and welfare activities.

Coverage often differs between insurers and packages (Table 3). Exceptional systematic research on these differences has been conducted in Portugal. Since the pandemic, supplementary insurance has increasingly covered mental healthcare in Portugal. Some types offer free online consultations. Three insurers cover an unlimited number of psychiatric consultations and six psychiatric hospitalisations (usually up to 15 days annually). Most policies restrict usage to contracted psychologists/psychiatrists, concentrated in urban areas. Some insurers specify psychiatric and/or psychological assistance for cancer patients (DECO PROTeste, 2023). In Cyprus, for instance, one large insurer covers, depending on the package, no, limited (five visits, covering EUR 40 per visit) or unlimited outpatient psychiatric treatment. In Finland, a large insurer covers three sessions with contracted psychiatrists, and with others only shorter remote sessions; most only reimburse short-term psychotherapy.

## Procedural/administrative barriers

People also face difficulties accessing affordable care because of the complex administrative procedures involved in accessing publicly funded care. Administrative hurdles can be particularly challenging, for instance, for non-nationals, refugees and marginalised groups (Depaigne-Loth and Ligier, 2021; Ministero della Salute, 2021; PTK NRW, undated).

In systems based on care being reimbursed by health insurers, complex reimbursement systems and rules varying by insurance provider can form barriers (e.g. in Belgium and the Netherlands). Other barriers include the following.

- In Finland, to qualify for a psychotherapy subsidy, the person with care needs must be diagnosed by a psychiatrist (with long waiting times, if they use the public system), go through the application process and (amid a shortage and varying approaches) identify an appropriate psychotherapist.
- In Portugal, the complexity of booking psychiatric consultations, and consultations for children and adolescents, was considered a barrier (DECO PROTeste, 2023).
- In Slovakia, the requirement to demonstrate that waiting times for contracted providers in the applicant's area are at least three months (required for public funding of private care) can form barriers.

Entitlements to additional support, such as the medical card in Ireland (determined by an income calculation) and additional reimbursement in Belgium and Italy, can be hard to establish, causing lack of take-up (Eurofound, 2024b; Griffin, 2024).

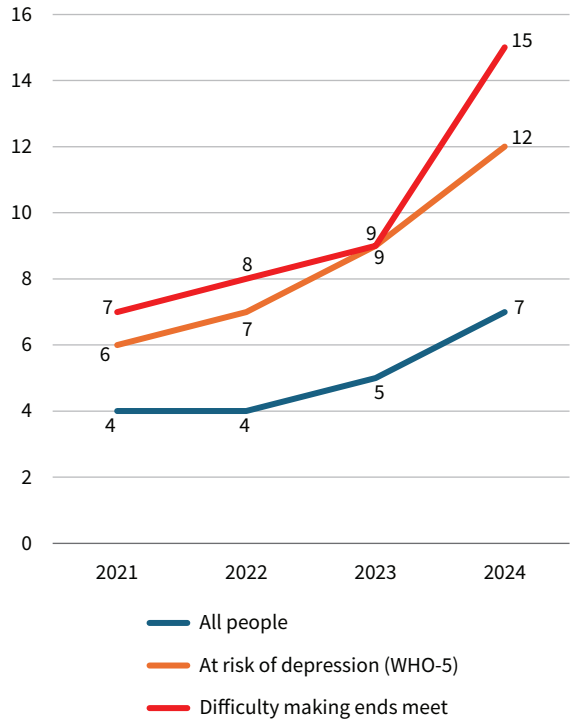
## Unmet needs

Not everybody with poor mental health needs to be diagnosed or receive care through the formal system. However, a certain proportion of people with poor mental health who are not diagnosed or do not receive care do show indications of being left without the support they need. The proportion of people in the EU reporting unmet mental healthcare needs increased from 4 % in 2021 to 7 % in 2024, probably due in part to reduced stigma around reporting such needs. The proportion and increase are particularly high among people with difficulty making ends meet, suggesting unaffordability plays a role (Figure 23).

In the 13 Member States included in the 2009 EHIS, among people who reported having experienced chronic anxiety or depression at some point in their lives, 16.5 % and 13.2 %, respectively, had not been diagnosed. Estimates based on national data sources suggest that the proportions of people with poor mental health who do not receive any care (whether they are diagnosed or not) lie well above this.

- In Bulgaria, in 2022, there were reports that 70 % of people with poor mental health received no care (and those who receive state hospital care cannot be directed to post-treatment care in the community) (ESC, 2023).

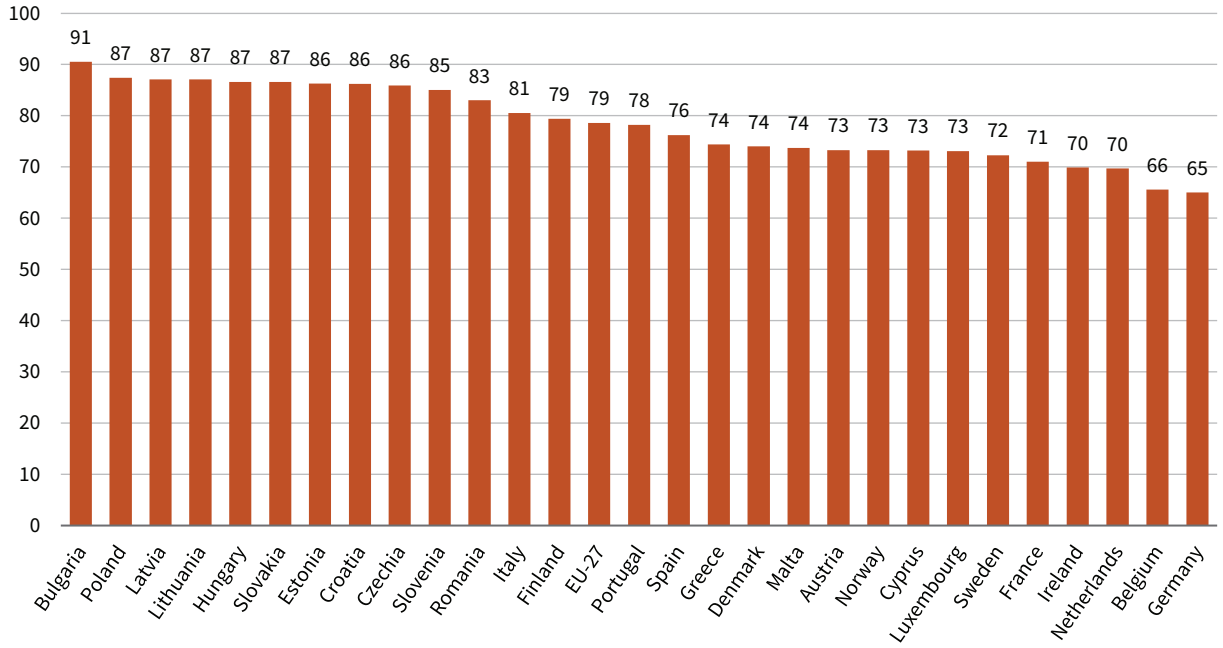
**Figure 23: Reported unmet mental healthcare needs, EU (%)**




**Note:** *WHO-5, WHO-5 Well-being Index.*
**Source:** *Eurofound analysis of Living, Working and COVID-19 e-survey microdata.*

- In Latvia, most cases of depression go unrecognised, undiagnosed and untreated. In 2021, the number of patients registered (around 11 000) and treated (around 20 000) was lower than the estimated number of people with depression (around 120 000 in 2022, 7.9 % of the population, based on 2011–2012 survey data) (Slimību profilakses un kontroles centrs, 2022).
- In Lithuania, in 2020, 21 % of people experiencing poor mental health used mental healthcare services and 20 % said mental healthcare was unavailable (others felt no need for it) (Grigutytė et al., 2021).
- In the Netherlands, in 2024, among young people with suicidal thoughts, 41.8 % received help, 3.7 % wanted to seek help and 21.6 % did not know where to go. Most of the other 32.8 % not receiving or seeking help considered it unnecessary (or no longer necessary) (RIVM, 2025).
- In Portugal, in 2023, 57 % of people who reported having had a psychological problem in the last three years had received no treatment.
- In Slovakia, in 2015, two thirds of people with depressive disorders and 80 % of people with anxiety disorders received no care (Horák, 2017).
- In Spain, in 2022, 65 % of people diagnosed said they had received no services (Confederación Salud Mental España, 2023).

## Figure 24: People with major depression not receiving adequate treatment, 2021, EU and Norway (%)




**Notes:** *Adequate treatment was defined as either pharmacotherapy (one month of medication, plus four visits to any medical doctor) or psychotherapy (eight visits to any professional). Data mainly come from population surveys from varying years.*
**Source:** *Eurofound compilation of data from Santomauro et al., 2024.*

An estimated Member State average of people with major depression not receiving adequate treatment is 78.6 % (Figure 24).

For some population groups, unmet needs are higher. Having experienced anxiety and especially depression at some point, but never having been diagnosed with it, is more common among men (17.4 % and 16.8 %, respectively) than women (16.2 % and 11.6 %, respectively) (2009 EHIS data). In Belgium, people with lower incomes and levels of education and those facing economic difficulties have greater challenges accessing mental healthcare services (Sciensano, 2024b).
In Germany, in a 2021 survey of people experiencing homelessness in four cities, 70 % of those identified as having poor mental health did not receive care for it (Bertram et al., 2022). In Denmark, poor mental health is less likely to be diagnosed in people from ethnic minority groups (Olsen et al., 2023).

Refugees from Ukraine also face unmet mental healthcare needs. In Ireland, in 2023, 5.5 % of the refugees surveyed about their need for psychological support said that they were speaking with a therapist, 2.3 % were attending a support group, 16.5 % were looking for support, 24.0 % did not know if they needed support and 52.0 % felt they did not need support.

In Estonia, in 2022, less than one tenth of the refugees from Ukraine who reported having psychological support needs had used helplines (Kender, 2023). In the Netherlands, unmet mental healthcare needs were particularly large for children from Ukraine (NOS, 2024) (see 'International conflicts and migration').

In general, information is scarce about whether the care received meets users' needs, including because little or no care is received among people diagnosed with depression or anxiety.

- In Spain, half of the people diagnosed with a mental health disorder attend public or private psychiatric or psychological consultations. One in five (19.8 %) has been admitted to a psychiatric hospital or a general hospital's psychiatric ward (Confederación Salud Mental España, 2023).

Considerable shares of people who die by suicide have not received care, and little is known about the care received by those who had. For instance, in Malta, of the suicide deaths between 2015 and 2021 that were investigated, fewer than 50 % of the deceased had been in contact with the public health system (Cachia, 2022). In Bulgaria, 60 % of people who died by suicide between 2009 and 2018 in one of the major administrative regions in Bulgaria had seen a psychiatrist in the previous 12 months, and 27 % had seen one in the previous month (Stoychev et al., 2021).

# 3 Policies

## Strategies

National mental health strategies/plans are prevalent in the EU and Norway. Various Member States adopted national mental health strategies after the COVID-19 pandemic, signalling increased attention to mental health (Table 4). Strategies differ with regard to comprehensiveness and allocated funding. For instance, Latvia's 2023–2025 plan focuses specifically on improving the organisation of mental healthcare. A study investigating the plans in place in 2020 noted that there is no national and/or regional evaluation envisaged for about half of them (Guerrero et al., 2024b).

**Table 4: Examples of mental health strategies adopted after and before the COVID-19 pandemic**

| Member State | Years covered |
|---|---|
| **Bulgaria** | 2021–2030 |
| **Croatia** | 2022–2030 |
| **Denmark** | 2022–2032 (agreed in 2019) |
| **Greece** | 2021–2030 |
| **Latvia** | 2023–2025 |
| **Netherlands** | 2022–2025 |
| **Slovakia** | 2024–2030 |
| **Spain** | 2022–2026 |
| **Pre-pandemic** | |
| **France** | 2018 |
| **Lithuania** | 2007 |
| **Malta** | 2020–2030 |
| **Poland** | 2017–2022 (continuation 2023–2030) |
| **Portugal** | 2017–2020 |
| **Slovenia** | 2018–2028 |

**Source:** *Eurofound, based on input from the Network of Eurofound Correspondents and desk research.*

## Addressing discrimination and stigma

### Discrimination and barriers

Being diagnosed with poor mental health can impede access to certain occupations (e.g. medical doctor), licences (e.g. driving) and insurance (e.g. life, mortgage protection, supplementary health). This prospect can contribute to unwillingness to seek care, misclassification of poor mental health (with healthcare workers protecting their patients from being excluded from work) and further stigma and discrimination in society. These barriers can also negatively affect the current mental health of those who have had poor mental health in the past.

### Anti-stigma campaigns

Large-scale anti-stigma campaigns, including those that actively involve people with lived experience of poor mental health, seem effective in reducing stigma. However, it is still a challenge to reduce certain types of stigma against people with mental health problems and to reach certain sections of the population.

**Assessments of large-scale campaigns.** In Catalonia in Spain, a mass media anti-stigma campaign improved attitudes and intended behaviour towards people with poor mental health. The impact on stigma was limited to attitudes related to benevolence. A wider range of anti-stigma messages could produce a stronger impact on attitudes and intended behaviour (Rubio-Valera et al., 2016). Czechia's mental healthcare reform and its nationwide anti-stigma project seem to have positively affected attitudes among the population, but not people's desired future contact with individuals who have poor mental health (Winkler et al., 2021).
An assessment of a national 2010–2014 anti-stigma campaign in Sweden suggests that campaigns primarily based on face-to-face contact with people who have experienced poor mental health themselves positively affect knowledge about, attitudes towards and intentional behaviour with regard to social contact with people with poor mental health (Hansson et al., 2016). An underlying idea is that people who know someone who has experienced poor mental health tend to have less prejudice against it (Grigutytė et al., 2022).
There are other examples of initiatives that follow this approach. In Lithuania, a 2022–2028 project is under way involving mental health ambassadors (who themselves have experienced poor mental health or whose loved ones have) who share their experiences at events and in the media to reduce stigma. In 2023, there were 130 ambassadors. In Denmark, the national 'One of us' campaign involves ambassadors sharing their own experiences with poor mental health. In an

example of the kinds of challenges faced by such campaigns, a project in Slovenia aimed at improving knowledge about mental health through workshops and a website had difficulty reaching men, who made up only 9 % of participants.

## Targeted focus on prevention

Preventative policies may be particularly effective when they range well outside the area of mental health (see Chapter 4). When they concern mental health, however, they sometimes target society as a whole. For instance, Ireland had a media campaign urging people to look after their mental health and that of those close to them. Other initiatives focus on targeting specific risk factors for poor mental health.

- **Giving birth.** In 2023, Lithuania approved an action plan to improve postpartum depression recognition and care, including requiring healthcare staff to ask about depression symptoms.
- **Having local specificities.** In Hungary, between May 2016 and May 2017, mental health promotion centres were established after assessing specific local needs, aiming for an evidence-based response that builds on good practices. In the Győr district, for instance, services include the promotion of healthy nutrition and sport, smoking prevention, early recognition of excessive alcohol consumption, and parenting improvement. Six centres were established in six regions, 24 fewer than planned because the financing organisation pulled out.
- **Being in education.** In Denmark, the Mindhelp website for those aged 10–25 years was rolled out for all regions in 2018. It provides advice on dealing with anxiety, stress and bullying. Educational material for schools was released in 2020. A 2022 evaluation of the online programme suggests that participants' anxiety and depression symptoms decreased on average by 13 % and 9 %, respectively. Involving young people in the development of this initiative may have been a factor in its success.
- **Experiencing domestic violence.** In Bulgaria, Zona ZaKrila multidisciplinary teams provide free services for children and their non-violent parent (first financed by the United Nations Children's Fund, but state-funded since 2023).
- **Experiencing vulnerabilities in childhood.** In Luxembourg, in 2008, a hospital in the capital established a service for children aged 4–18 years, with outpatient consultations offering adolescents and young adults individualised medical, psychotherapeutic and/or educational interventions. The aim was to intervene early in vulnerabilities to increase chances of educational, professional and social success. In 2023, 822 children participated, up from 592 in 2021. Other organisations replicated the principle.
- **Recently being treated for poor mental health.** In Czechia, an NGO's three training cafés (established in 1997, 1999 and 2010) help people leaving mental healthcare develop their social and work skills to integrate into employment.

## Suicide prevention

Suicide prevention is usually part of more general mental health strategies (e.g. Spain's strategy includes 'early detection [of] and attention to suicidal behaviour'). Nine Member States and Norway have specific national or regional government suicide prevention plans (Table 5). Bulgaria had a suicide prevention plan running from 2013 to 2018, but it has not been updated.

### Table 5: Suicide prevention plans, selected countries

| Country | Year adopted or years of coverage |
|---|---|
| **Austria** | 2012 (Suicide Prevention Austria (SUPRA))<br>2025–2030 (SUPRA action plan) |
| **Czechia** | 2020–2030 |
| **Estonia** | 2024 (part of EU Joint Action ImpleMENTAL) |
| **France** | 2024 |
| **Germany** | 2024 (but a national suicide prevention programme had already been established in 2001 in partnership with the WHO) |
| **Lithuania** | 2020–2024 and 2023–2026 |
| **Luxembourg** | 2019 |
| **Spain** | 2025–2027 (previously only regional plans – e.g. in Castile and Leon 2021–2025, the Basque Country 2019 – and specifically in educational establishments in 2022) |
| **Sweden** | 2008 (a 2024–2027 study is developing the next 10-year plan) |
| **Norway** | 2020–2025 |

**Source:** *Eurofound, based on input from the Network of Eurofound Correspondents and desk research.*

Areas of action include learning from suicide data, providing follow-up care after a suicide attempt, providing preventative care, informing society and training care professionals. Examples from suicide prevention strategies and other initiatives are presented in the following sections.

### Learning from the data

Data collection is important to inform policies. However, only a few countries record reported suicide attempts (reported by medical services, emergency numbers, police) and even fewer record detailed characteristics of people who attempt or die by suicide and the reasons for it (e.g. Poland, Slovakia, Slovenia and Sweden). In Sweden, healthcare personnel are, in

some cases, legally obliged to conduct an event analysis of individual suicides. In Luxembourg, a 'psychological autopsy study' documents the characteristics of people who die by suicide. These include sociodemographic and economic characteristics, the presence of mental disorders and general life trajectories, as well as relationships with services, early services and early interventions that may have prevented suicide.

NGOs play a key role in data collection, including in countries that lack a national strategy (e.g. Greece), or have long lacked a national strategy (e.g. Spain). In Greece, the NGO Klimaka's Suicide Observatory records suicide trends from the press, calls to its 24-hour suicide intervention line and psychological analyses of individuals who have survived a suicide attempt. It collects data relating to the services provided by the Centre for Suicide Prevention, a network of health and mental health professionals and citizen volunteers, and collaborates with health units, forensic services, funeral homes and detention facilities.

### Preventative and follow-up care

Primary care services, often contacted by people in the period before dying by suicide, can play a key role in suicide prevention strategies and interventions (Stene-Larsen and Reneflot, 2019).

Furthermore, quality of care can be enhanced specifically for patients identified as suicidal. For instance, Estonia's strategy includes suicide risk assessment tools and a management model for suicidal patients. The German strategy includes informing people at risk of suicide, their relatives and specialists about the topic through a nationwide website that offers information on help and suicide prevention. It also involves developing training courses for health and care personnel on awareness raising and dealing with people at risk.

Another approach involves proactively approaching groups at higher risk of suicide. For instance, in Sweden, a 2020–2022 project called 'We talk about life' focused on men aged 70 years and over to prevent suicide.

Since 2014, Lithuania has been piloting and developing 'local algorithms', with various services discussing and agreeing how to better react to, and prevent, suicide. Challenges have included service providers not believing they have a role to play in suicide prevention. Since 2024, there have been municipal 'suicide prevention coordinators', who organise municipal suicide prevention programmes and are involved in initiating, implementing, monitoring and improving the algorithm for responding to suicide threats.

Since 2008, people in the Netherlands receiving emergency hospital care after a suicide attempt are asked whether a service can contact them; roughly 90 % accept. The person is contacted within five days, and for six months there are weekly or monthly conversations, depending on the person's needs. Psychological and other support needs (e.g. housing or debt assistance) are discussed. There is also a regional project that entails a monitoring system for people with suicidal thoughts. Professionals (e.g. healthcare providers, school counsellors, railway employees, bailiffs and police officers) can register people with suicidal thoughts who have given their permission to be monitored. These professionals are then guided to provide support. Since 2023, a merger of these two approaches has been piloted, ensuring care continues when users do not attend appointments. In Norway, municipalities are responsible for preventing, disclosing, averting threats of and following up on self-harm and suicide attempts in accordance with national guidelines. Specialist healthcare services are responsible for investigating, treating and following up with people at risk of suicide or who have attempted suicide.

## Helplines

Helplines can provide accessible, rapid, anonymised and free support, reducing barriers such as stigma, low reachability and costs. For instance, the Netherlands has a telephone number (113) that people can call when they need mental health support. When media discuss mental health issues, this number is mentioned for readers or viewers. Since 2022, Malta and Spain have had free 24/7 helplines; the Maltese helpline provides mental health support and advice by psychologists, while the Spanish helpline focuses specifically on suicide prevention support. A 2023 assessment of Austria's suicide prevention programme led to the development (ongoing) of a national helpline. The German suicide prevention strategy envisages working with the German regions to establish one.

In some countries, 24/7 mental health helplines are absent. In others, for example, the focus is mainly on victims of violence (e.g. Estonia). However, several of these countries do have mental health helplines with more limited hours (e.g. in Cyprus, Estonia, Hungary, Italy and Slovenia), or for mild or moderate support needs (e.g. in Finland and Lithuania). Some helplines are run by NGOs (e.g. in Cyprus, France, Ireland, Italy, Latvia, Norway and Slovakia), and occasionally are religiously affiliated (e.g. in Germany). Usually, helplines are free of charge, but not always (e.g. in France). Different helplines may target specific population groups, such as children and adolescents (e.g. in Lithuania and Poland), people who are deaf or hard of hearing (e.g. in Croatia) and regional populations (e.g. in Austria).

To illustrate the usage of helplines:

- in Denmark, in 2022, about one in three national helpline callers expressed feelings of loneliness;

- Portugal's 24/7 helpline (established in April 2020) was called by 65 760 users and 4 181 health professionals in 2021;
- Lithuania's Youth Line held 34 978 online or telephone conversations in 2023, mainly about mental health problems (31 %), self-harm/suicide risk (21 %), loneliness (19 %) and romantic relationships (19 %).

# Measures for pupils, workers and carers

## Pupils

While this section focuses on the larger group of primary and secondary school pupils, there are also measures targeting university students, such as university counselling services (Nastro et al., 2024). School-level measures are key in reaching children at risk of poor mental health. They can also be particularly effective in reducing stigma against people with poor mental health (BMASKG, 2018). In several Member States, there is an important role for school counsellors and nurses in preventing, identifying and providing basic support to address poor mental health (see 'Capacity'). This is not the case in all Member States. School nurses' activities may be confined to physical health. This was the case in Cyprus, which from 2023 to 2024 ran a pilot programme providing school nursing services that include mental health support. It started in three secondary schools in rural areas. Following an ongoing evaluation, the service may be extended. In several Member States, schools received funding after the pandemic, primarily to address learning gaps due to school closures, but sometimes also to enhance pupils' mental well-being more broadly (Eurofound, 2022b).

Specific initiatives include the following.

- In Bulgaria, the EU-funded 2022–2024 'Презареди сега' ('Reboot now') programme provides mobile psychological counselling rooms in schools to support young people and families to recover from difficulties due to pandemic measures. It includes an online platform with information and training materials for adults (school staff and families) and children. It also offers workshops to inform, raise awareness among and empower pupils aged 10–14 years in schools, with older peers (aged 15–18 years) acting as co-teachers.
- In Croatia, since 2000, pupils have filled out a questionnaire to identify those at risk of poor mental health, qualifying them for a clinical assessment by the school doctor. Around 70 000 students (14 000 with poor mental health) had participated by 2024. Mental health training for educational workers is also provided (2 350 have completed basic and 478 advanced-level training).
- In Hungary, the 2019 'Az élet iskolája' ('The school of life') pilot programme targeted pupils aged 14–16 years in secondary schools, with actors and drama pedagogists stimulating pupils to open up about their problems.
- In Italy, the one-year 2022 '#With you – Wellness training for health – La psicologia con te' ('Psychology with you') project in secondary schools focused on assessing poor mental health and integrating mental care services, with focus groups and prevention activities on mental health and psychosocial well-being.
- In Malta, the mental health strategy aims to train educational professionals to support children within schools, recognise behavioural changes and refer children for support.
- In Poland, in 2024, 'Punkt Zwrotny' ('Turning point'), organised and funded by NGOs, disseminated educational material that could be used during classes and ran educational workshops, early intervention programmes with mental health screenings, peer support networks and helplines.
- In Slovenia, online counselling and prevention work in schools includes 'To sem jaz' ('It is me', a programme for parents, children and teachers) and 'Neverjetna leta' ('The incredible years', a web page).

Some programmes have a particularly strong focus on addressing specific causes of poor mental health, rather than on recognising and addressing problems after they emerge.

- In Slovakia, courses were provided to school staff on the prevention and elimination of abuse and bullying among pupils at schools and school facilities. In an evaluation, participants called for more interactive methods, practical experience and advice from professionals (Makišová et al., 2022).
- In the United Kingdom (a former Member State), guidance for mental health services was developed, informed by assessments. It recommended a whole-school approach and universal curriculum content, identifying pupils at risk of poor well-being, providing targeted support and assisting pupils with school-related transitions and other life changes. It is key for groups in specific vulnerable situations to be included in developing such an evidence base (Totsika et al., 2022).

### Workers

Examples of initiatives addressing mental health issues in two of the sectors with the highest risk of poor mental health (education and care) are presented below.

- **Education.** Since the 2023/2024 school year, Slovakia has provided a 50-hour module aimed at strengthening educational professionals' mental health. Evaluations of earlier courses on other topics revealed that school employees wanted more attention dedicated to the bullying of school staff (including cyberbullying) and more interactive methods to practise dealing with stressful situations and conflicts (Makišová et al., 2022).
- **Care.** Since 2021, Belgium has had a 'care screener', a questionnaire assessing psychological support needs and identifying signs of overburden. Respondents are then offered the option of being contacted by a fellow care provider within three working days, and information is provided on how to access care.

Many other types of measures are possible, in all sectors (EU-OSHA, 2024). In Greece, in 2022, among actions workers would like to see from their companies, the most often mentioned were training for managers in caring for employees' mental well-being (55 %), fostering a culture of respecting time through new ways of working (54 %) and training all employees in stress management and self-care (53 %). Measures to protect remote workers' well-being (e.g. 50-minute online meetings, one day a week without online meetings) (32 %), remote working policies (31 %) and telephone or online psychological support (both 24 %) were also frequently mentioned. The European Commission's best-practices database includes the 2020–2023 Horizon Europe H-WORK project aimed at enhancing mental health in public organisations and small and medium-sized enterprises through targeted interventions. Among the 1 178 participants, it moderately boosted attributes that are positive for mental health, like leadership knowledge and employee engagement.

### Carers

Support for informal carers can include access to respite care (facilitating care breaks), information, consultations and mutual support groups. To make sure the support matches the needs of carers and people cared for, they should be consulted in its development (Eurofound, 2020a, 2022a).

## Mental healthcare: increased coverage, capacity and quality

Here the focus is on instances of increased coverage and capacity, as examples of how policies can enhance access to mental health support. However, capacity has also reduced. For instance, in Greece, two of the three specialised psychiatric hospitals were closed in 2024, and prevention centres are expected to close. In Poland, the number of facilities offering outpatient psychiatric services to minors has decreased. Coverage has also been reduced in several countries. For instance, Ireland tightened income requirements for its medical card scheme, entitling fewer people to free sessions with psychologists. From April 2025, Estonia increased specialist (including psychiatric) care co-payments from EUR 5 to EUR 20 per visit. Furthermore, some of the increased coverage is a result of projects that were initiated in response to the COVID-19 pandemic, and they may be discontinued.

Policies to improve the quality of care are also presented. They focus on two aspects: reducing medicalisation and institutionalisation.

### Coverage

Several countries have increased mental healthcare entitlements (for a description of the current situation, see 'Basic coverage'). Examples are detailed below.

- In 2018, Austria increased the health insurance subsidy and funded psychotherapy hours. Funding for mental health increased in the aftermath of the pandemic, and 20 000 free psychotherapy places were added between 2020 and 2023 (making a total of 100 000 places). This was the first increase since 2017, and the measure included quotas for groups in particularly vulnerable situations. Since 2021, people under the age of 21 qualify for 15 free clinical psychological, health psychological, psychotherapeutic or music therapeutic consultations, and 10 000 therapy places were funded in 2024. Since 2024, social health insurance subsidises private psychotherapy sessions.
- In September 2021, Belgium's basic insurance started covering psychological/psychiatric therapy sessions (the number of sessions depends on the insurance fund), subject to a EUR 11 co-payment per session. The initial consultation is free.
- In June 2019, Cyprus reformed its healthcare system; in addition to facilitating GP access, people have been entitled to free specialist mental healthcare since 2020.
- In April 2022, France began reimbursing up to eight sessions annually by psychologists contracted by the public health insurance system. In June 2024, the requirement for a referral was removed, and the number of sessions covered increased from 8 to 12; students became entitled to 12 additional sessions.

- Ireland has had a free adult mental health counselling service since 2013.
- In 2021, Italy introduced income-tested reimbursement of psychological treatment.
- Latvia now provides state-funded psychological and psychotherapeutic support, including for depression. Before May 2021, only GP and psychiatric care was state funded.
- In the past 5 to 10 years, Lithuania has phased out mental health centres' practice of limiting the number of free psychotherapy sessions (usually to 10), due to increased resources and the Ministry of Health's opposition to it.
- In 2024, the Netherlands abolished co-payments for psychological care.
- In 2014, Romania made several psychological services reimbursable.
- Slovakia abolished co-payments in 2024.

## Capacity

Mental healthcare staff numbers have increased in some countries (e.g. in Austria, Estonia, Finland, Germany, Ireland, Poland and Portugal; see 'Unavailability'). Other examples of increased capacity include the following.

- Since 2021, local governments in Estonia can apply for mental healthcare support, at EUR 2 414.46 monthly per 7 000 residents; the number of municipalities receiving this increased from 21 in 2021 to 48 in 2023. In 2024, municipalities received EUR 1.5 million in support.
- In Slovenia, the 2018–2028 National Mental Health Programme initiated a network of regional mental health centres offering psychiatric outpatient services, triage, medical advice and interdisciplinary treatment combining care with local social support. It aims to establish 25 adult centres (annually serving 50 000 to 70 000 adults aged 20 years and older) and 25 child and adolescent centres (annually serving 12 000 to 16 000 users). In 2024, there were 17 adult and 20 child and adolescent centres. About 50 % of users had not received treatment previously. Most came from areas without mental healthcare services. Slovenia seeks to address labour shortages, for instance through grants for clinical psychology specialisation (NIJZ, 2021).

The EU's recovery and resilience plans envisage strengthening mental healthcare in various countries:

- Greece envisages creating 13 mobile support units for children and adolescents, offering psychological and psychiatric support;
- Portugal aims to complete the national coverage of local mental health services in inpatient, outpatient and community intervention and to expand places for mental health patients in the National Network for Integrated Continuing Care.

### Serving underserved areas

Initiatives to improve mental healthcare's geographical coverage include the following.

- Croatia aimed to add 130 psychological teams by the end of 2024 to improve access, especially in rural areas.
- Since 2019, Slovenia has prioritised setting up mental health centres in the eastern regions, which tend to have worse mental health and access to care (NIJZ, 2021).
- Since 1999 (following a pilot), Greece has had mobile mental health units, especially in remote areas. They consist of multidisciplinary teams (adult, child and adolescent psychiatrists, psychologists, nurses, social workers, therapists), using primary healthcare infrastructure. Since 2015, they have been strengthened to respond to migrants' needs. Since 2018, teams have been added to support people with more severe needs (Peritogiannis et al., 2022).
- Latvia's 2023–2025 plan to improve mental healthcare organisation includes improving access in underserved regions.

### Digital sessions

Digital mental healthcare sessions have taken off since the pandemic. In Estonia, in-person consultations by psychiatrists per 1 000 inhabitants (aged 15 years and over) decreased from 208.0 in 2014 to 153.1 in 2022. However, remote consultations increased from 0 in 2014 to 44.1 per 1 000 inhabitants in 2022. In Lithuania, diagnosed mental and behavioural disorders increased year on year from 92.7 per 1 000 inhabitants in 2014 to 121.1 per 1 000 in 2023 (the increase was particularly stark between 2016 and 2018). Psychiatric consultations (primary and secondary care) doubled from 18 per 100 inhabitants in 2001 to 36 per 100 inhabitants in 2019. Face-to-face consultations dropped during the pandemic, to 21 per 100 inhabitants in 2020 and 2021, before increasing again to 34.5 per 100 inhabitants in 2023. However, if online/telephone consultations (which took off in 2020) are included, only in 2020 were the total number of consultations below pre-pandemic numbers (33 per 100 inhabitants), and they increased to 40 per 100 inhabitants in 2023.

Besides mainstream e-consultations, chat and email services play a role. Finland established the 'Sekasin-chat' for people aged 12–29 years in 2019. By 2023, 160 000 people had used the platform (37 028 conversations took place in 2023 alone). Most users (81 %) said they would have been left unsupported

without the chat. In Ireland, in 2021, community-based youth mental health services increased by 24 %, appointments by 54 % (35 000 appointments), online live chat service demand by 104 % and email support by 144 %.

## Improving quality

### Reducing overmedication and over-medicalisation

Pharmaceuticals play an important role in addressing poor mental health. In 2022, antidepressant usage was particularly high in Portugal, Spain and Sweden (at least 98 daily doses per 1 000 inhabitants), and lowest in Hungary and Latvia (30 or fewer per 1 000) ([10]). In the EU, in 2022, 7.5 % of people aged 50 years and older reported using drugs for anxiety or depression at least once a week, up from 7.2 % before the pandemic (2020) and increasing among women (from 9.4 % to 10.2 %) but decreasing among men (from 4.6 % to 4.4 %) (Survey of Health, Ageing and Retirement in Europe data analysis). National data confirm that antidepressant and anti-anxiety drug use has increased in recent years, especially among women and young people.

- In Bulgaria, from 2020 to 2021, sales of various anti-anxiety drugs increased (etifoxine by 10.3 %, hydroxyzine by 12.4 %, tofisopam by 34.2 %), as did sales of antidepressants (noradrenaline transport inhibitors by 5.5 %, serotonin transport inhibitors by 5.3 %).
- In Denmark, psychotropic drug use increased by 1.4 % from 2012 to 2022. While the usage of sedatives such as benzodiazepines decreased (by 39 %), that of antipsychotics (up 15 %) and antidepressants (up 1.5 %) increased (Olsen et al., 2023).
- In France, in a study of people aged 25 years or younger, prescriptions for psychotropic medications increased from 2016 to 2022 – especially antidepressants, mainly among women (by 13 %, versus by 3 % among men). Anti-anxiety drug prescriptions increased only among women, by 5 % (Fond et al., 2025).
- In Norway, antidepressant prescriptions among adults have been stable since 2010, but have increased for young adults (particularly women).
- In Portugal, of those who underwent some kind of treatment, 65 % took medication including antidepressants, anxiolytics, hypnotics or other drugs, and around half underwent psychotherapy, while 31 % used 'natural products' and 27 % used relaxation and meditation practices. Psychotherapy has the highest level of user satisfaction.
- In Slovenia, prescriptions for drugs to treat poor mental health increased by almost 50 % between 2008 and 2015, with particularly high rates (73 %) among people aged 15–19 years. Antidepressants and psychostimulants contributed most to the increase among children and adolescents.
- In Spain, 19 % of people aged over 18 years use psychotropic drugs (73 % of them daily), mostly for anxiety (62 %) and depression (47 %). Benzodiazepines are prescribed particularly often, especially among women and people over 65 years of age; their use has grown rapidly since 2018 (CES, 2024). GPs are the main prescribers (55 %), followed by psychiatrists (35 %) (Confederación Salud Mental España, 2023).
- In Sweden, in 2022, around 30 000 people aged 10–17 years used antidepressants. From 2018, usage per 100 000 inhabitants increased from 1 000 to 7 000 for girls, and from 500 to 5 000 for boys. Among adults, antidepressant usage also increased steadily (Busch, 2023).

Reports mention the medicalisation of poor mental health and the insufficient attention given to addressing poor mental health in other ways, without the side effects that pharmaceuticals have, while providing a more sustainable solution. Prolonged usage of pharmaceuticals beyond the context of crisis situations seems particularly problematic. For instance, in Belgium, of the 11 % of adults reporting having taken benzodiazepines or Z-drugs (nonbenzodiazepines used to treat insomnia or anxiety, for example) in the two weeks prior to a 2023 survey, 78 % had taken them for longer than a year, 66 % of them daily (Sciensano, 2024a). Over-medication tends to be more prevalent among older people and people with lower education levels (Colman et al., 2023). Lack of health and social care personnel, with little time per patient, plays a role in overprescription, for instance in Hungary and Italy (Bessone, 2020; Holló, 2022).

Member States take action to reduce drug use, especially where more addictive medications are concerned.

- In Belgium, GPs are provided with information on their prescription behaviour compared with that of other GPs.
- Since 2017, Denmark has recommended avoiding long-term use of anti-anxiety drugs (e.g. benzodiazepines) and sleeping medications.

([10]) See https://www.statista.com/statistics/283072/antidepressant-consumption-in-selected-countries/.

- In 2020, Lithuania issued a ministerial order on the methodological recommendations for prescribing, reducing or discontinuing the use of benzodiazepines, benzodiazepine derivatives and medicines with a similar mechanism of action (including training and monitoring). Since 2017, there were already efforts to decrease long-term use, focused on raising awareness and reminding GPs about prescription procedures. This resulted in increased referrals to psychiatrists.
- Norway has set guidelines restricting the use of addictive drugs, including benzodiazepines, to acute episodes for a maximum of four weeks.

Overmedication is partly caused by over-medicalisation and overdiagnosis (Jønsson and Brodersen, 2022). A predominantly medical perspective on mental health, with limited attention to following up, improving quality of life and training for other types of interventions, has been pointed out as contributing to over-medicalisation more generally (in care service and medicine use), including the 'medicalisation of the problems of everyday life' (e.g. in Bulgaria, Greece and Spain) (Conrad and Slodden, 2013; Confederación Salud Mental España, 2023).

Medicalisation also arises from limited attention to underlying factors. These may be socioeconomic, but could also include, for instance, menopause. Poor mental health can also be a side effect of pharmaceuticals that is probably underestimated (Celano et al., 2011; Department of Health, 2022; Bryant et al., 2023). For instance, where poor mental health is linked to unemployment, patients could benefit especially from employment, economic and social inclusion (Eurofound, 2014). 'Medicalisation of unemployment' seems stronger in countries with little unemployment support but generous healthcare provision (Buffel et al., 2017).

### Shift away from inpatient care, move towards primary mental healthcare

Policies emphasise reducing institutionalisation, in favour of home, community and outpatient care. For instance, Portugal's strategy aims to deinstitutionalise people living in psychiatric hospitals or social sector institutions, in favour of care by the National Network for Integrated Continuing Care, which includes residential community care. Portugal's recovery and resilience funds are being used to integrate institutionalised patients into the community through residential approaches. Poland's adult mental health centre pilots have run since 2018 as part of a strategy to restructure psychiatric services. Its mental health strategy seeks to improve access to care and assistance and enable living in the community (Biechowska et al., 2022). Malta's strategy aims to reduce inpatient care while enhancing the role of GPs in caring for people with mild and moderate mental health problems. This involves training, incentivising and supporting GPs to be a first point of contact and provide follow-up care within shared care programmes and protocols.

In the EU, the number of psychiatric hospital beds per 100 000 inhabitants decreased from 76 in 2010 to 72 in 2022, only increasing from 2020 to 2021, probably due to the pandemic. The pandemic also led to increased occupancy of psychiatric hospital beds (e.g. in Cyprus). However, other psychiatric wards were closed during the pandemic to make space for COVID-19 patients (e.g. in Malta, with a dip in bed numbers in 2021). In some countries (e.g. Latvia and Lithuania), bed numbers continued to reduce during the pandemic. In Germany, inpatient treatments for psychological disorders decreased from 1 238 830 in 2014 to 1 023 355 in 2021. In Austria, hospital stays for acute inpatient care for mental and behavioural disorders decreased from 126 332 in 2012 to 84 561 in 2022 (with a low of 80 306 in 2020). In Poland, hospitalisations decreased slightly, although the average stays increased from 37.1 days in 2013 to 38.4 days in 2018 (National Health Fund, 2024).

However, inpatient capacity reductions have not always been accompanied by equivalent increases in alternative services, such as home, community and outpatient care. Reductions may primarily have served to cut costs rather than ensuring comprehensive, deinstitutionalised patient support. Furthermore, care does not need to be inpatient for it to be of an institutionalised nature (i.e. limiting user autonomy). Also, while stated policy aims can include the deinstitutionalisation of mental healthcare, practice may not keep up with this aim. For instance, in Romania, although policies support deinstitutionalisation, its full implementation has not yet been realised, due to regional inequalities in access to outpatient services, among other factors. In several countries, inpatient care has reduced, while outpatient, community or home care has not increased.

- In Bulgaria, national analyses point to the poor conditions of state psychiatric hospitals and to cases of human rights violations in these facilities. The 2022 National Mental Health Strategy and its action plan envisage the integration of psychiatric services into general healthcare. Psychiatric hospital admissions declined from 9 554 in 2015 to 7 378 in 2021. However, admissions to mental health centres also decreased, from 22 824 in 2015 to 12 569 in 2021. Furthermore, mental health centres were intended to provide aftercare and outpatient services, but in the past decade their function has shifted towards a predominantly inpatient service and beds have been added. Psychiatric care outside institutions is rare (ESC, 2023; Ministry Council, 2023; NSI, 2023).

- In Czechia, the number of long-term psychiatric care beds decreased from 9 308 to 7 406 between 2010 and 2022 (beds in acute care facilities increased from 1 287 to 1 977 in the same time frame). However, the number of entities providing outpatient psychiatric services also decreased, from 1 054 in 2010 (147 providing child and adolescent psychiatric care) to 1 046 in 2022 (138 providing child and adolescent psychiatric care).

In some other countries, increases in alternatives to inpatient mental healthcare have been observed. Inpatient care levels may also have increased, but at a slower pace.

- In Cyprus, community mental health nurses play an increasing role in care, conducting 17 167 home and 12 083 community health centre visits in 2023.
- In Greece, outpatient visits per 100 000 inhabitants increased from 21 in 2014 to 3 754 in 2017 and to 8 520 in 2020. Inpatient admissions per 100 000 inhabitants decreased from 216 in 2014 to 155 in 2017, but increased to 318 in 2020 (WHO, 2022).
- In Ireland, referrals to child and adolescent mental health services increased by 24 % from 2012 to 2018. Admissions to adult acute inpatient units decreased by 4 138 between 2008 and 2017. Readmission rates fell by 8 % in the same period. This suggests the shift from institutional to community care is progressing (Department of Health, 2020). There has been an overall downward trend in inpatient admissions since the late 1980s, partly due to deinstitutionalisation (HRB, 2024).
- In Malta, community and inpatient treatment orders increased from 25 and 50, respectively, in 2015 to 163 and 78, respectively, in 2020. The Crisis Resolution Home Treatment service was established in 2021. This consists of a specialist mental health team providing free care for people referred by the acute care hospital. It aims to reduce the risk of future crises and enhance quality of life while cutting the number of psychiatric hospitalisations (by June 2022, only 9 of the 159 patients referred to the team had been hospitalised), with follow-ups conducted at the service provider's clinic, at home or in the community (NAO, 2022). In 2024, patients with the mildest conditions were moved to existing public home and community services, and patients at the main psychiatric hospital were moved to new facilities.
- In Norway, in 2012, mental healthcare responsibilities were transferred to GPs and municipalities, contributing to a higher number of patients contacting GPs.
- In Slovenia, users of primary care for mental and behavioural disorders reached their highest level since 2013 in 2022 (92 969) after a low during the pandemic (75 942 in 2020). In contrast, secondary and tertiary hospital care decreased somewhat.
- In Sweden, psychiatric hospitalisations per 100 000 inhabitants decreased from 1 012.5 in 2019 to 976.9 in 2022, while overall visits to outpatient and inpatient care increased from 414 541 in 2017 to 496 695 in 2023 (SKR, 2023).
- In the Netherlands, the number of patients receiving mental healthcare from GPs increased steadily (except in 2020) from 566 463 in 2017 to 642 700 in 2021. Meanwhile, patients receiving generalist mental healthcare decreased from 247 590 in 2019 to 237 628 in 2021, as did those receiving specialised mental healthcare (from 549 892 in 2018 to 515 369 in 2021) and long-term mental healthcare (from 2 710 in 2017 to 2 364 in 2021).

Information on the precise context of outpatient services is scare. In France, in 2016, 80 % of adults receiving psychiatric treatment from health establishments (1.6 million people) were treated exclusively on an outpatient basis (DREES, 2019). Over 21 million outpatient procedures were carried out in 2016, 75 % of them in general psychiatry. Most of these procedures were medical consultations or care interviews provided in medical-psychological centres (CMPs) (60 %). Others were in part-time therapeutic reception centres (13 %), patients' homes or institutions replacing the home (8 %), general hospital units (5 %), prisons (4 %) or other locations (12 %).

Within inpatient care, there are examples of moves away from more restrictive methods. International guidelines have been developed. They state, for instance, that upon being taken to hospital, the patient should receive all relevant information and be able to bring personal belongings and stay in contact with relatives and authorities (Fiorillo et al., 2010). Since 2023, the management teams in Ireland's 66 mental health centres (containing 2 566 inpatient beds) have been bound by revised rules and a code of practice requiring centres to maintain a record (and inform a national commission) of when and for how long restrictive practices were used and whether they were used safely. Centres must have an oversight body to review the use of restrictive practices and assess whether other interventions could have been used. The code also requires staff training. Patients subject to restrictive practices must be made aware of what is happening and be able to discuss what happened afterwards. The use of seclusion and restraints decreased by 9 % and 25 %, respectively, from 2022 to 2023.

## Support beyond mainstream mental healthcare

Examples of support beyond mainstream mental healthcare, as part of a wider effort to address and prevent poor mental health, include the following.

**Mental health first aid officers from outside mental healthcare.** In Luxembourg, 6 900 mental health first aid officers have been trained in basic knowledge about poor mental health and how to approach a person who is showing signs of mental distress or experiencing a crisis. They are taught how to help and inform them and encourage them to seek professional support.

**Therapies not directly addressing poor mental health.** In Portugal, the 2023–2025 LoucaMente Health Project (part of the recovery and resilience plan) promotes mental health by creating art. As relationship problems can contribute to poor mental health, relationship therapies can also serve to prevent or improve poor mental health.

**Peers.** France has stepped up peer support systems, such as mutual aid groups. In 2022, there were 690 such groups, 34 more than in 2021, and at least one per region, subsidised with up to EUR 83 000. In addition, since 2006, France has provided workshops for the relatives of people with poor mental health. These are run by peers (other relatives of people who are ill).

**Meeting spaces not primarily focused on mental healthcare.** 'Alternative spaces' in Belgium may be used by people who are not likely to access mainstream services, for instance due to negative prior experiences (Eurofound, 2024a). There are multiple examples of initiatives to address loneliness, especially among older people, including during the pandemic (Eurofound, 2022a). An example focusing on all ages is Resto VanHarte, restaurants in the Netherlands seeking to facilitate social contact in neighbourhoods through lunches and dinners.

**Supportive physical environments.** Physical environments that facilitate convenient and safe active transport (walking, wheelchair usage, cycling and public transport) and access to green spaces are associated with better mental health, as they enhance social contact and physical health (Gössling, 2020; Eurofound, 2022a; OECD, 2023b). In Portugal and Spain, the use of public natural spaces during lockdown was associated with lower levels of stress, and viewing nature from home was associated with better mental health (Ribeiro et al., 2021).

## Integrated care

Several of the mental healthcare services discussed in this report are provided by multidisciplinary teams, such as Greece's mobile mental health units and Bulgaria's Zona ZaKrila. Portugal's 2021 and 2023 laws on community mental health teams require them to be composed of at least seven specific professionals: a psychiatrist, two nurses (at least one specialised in mental health), a clinical psychologist, a social worker/senior social service technician, an occupational therapist and a technical assistant. However, it proves challenging to attract the necessary human resources, especially in this public system.

Multidisciplinary support can also be achieved by coordination among different entities. For instance, the Latvian 2023–2025 plan to improve mental healthcare advocates improved cooperation among specialists and between family doctors and psychiatrists. It also proposes measures for transitioning patients with long-term mental health disorders from child to adult treatment facilities, ensuring continuity of care.

# 4 Policy pointers

Improving population mental health is paramount. It benefits individual quality of life and society more generally. Support for people with poor mental health is unlikely to meet all needs, even when financial and human resources increase considerably, if population mental health is not improved. Mental health should be improved more broadly, but this chapter focuses on preventing poor mental health. It then considers how to improve access to support, especially person-centred, non-institutionalised care (including psychotherapy as an important form of care) and support outside mental healthcare settings (from peers and social workers).

## Broader action to prevent poor mental health

Addressing factors that contribute to (or exacerbate) depression and anxiety, at both the societal and individual levels, can reduce support needs and medication usage, providing a longer-term, sustainable solution without side effects. Action is needed with regard to multiple aspects of life. The 2022 Dutch action plan 'Mentale gezondheid: van ons allemaal' ('Mental health: for all of us'), for instance, advocates a mentally healthy society, including neighbourhoods, education, workplaces and online environments. Awareness should be raised among mental healthcare providers of the socioeconomic causes of poor mental health, such as poverty, to enable effective referrals to sources of support (Catthoor et al., 2023). It is important to equip people with the knowledge, skills and competencies to take care of their own mental health and support others. This enables people to deal independently and individually with life's psychological challenges, so that they can try out and implement strategies that suit them and their situation (Jacobi, 2020). This discussion, however, focuses on creating an environment that improves mental health as much as possible.

### Tackling discrimination

Policymakers seeking to prevent poor mental health should fight social exclusion and discrimination based on 'sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation' (Article 21 of the EU Charter of Fundamental Rights). To illustrate the importance of this, four groups at higher risk of discrimination are featured: people who have had poor mental health in the past, people with disabilities, LGBT+ people and women.

#### People who have had poor mental health in the past

Stating that people who have suffered from poor mental health in the past are more likely to face poor mental health again in the future can contribute to stigmatisation and discrimination. This can cause a self-fulfilling prophecy, heightening their risk of poor mental health.

Furthermore, reducing the negative consequences (i.e. discrimination, stigmatisation) of having been diagnosed with poor mental health can increase willingness to seek support among people with poor mental health. This can be done through a combination of awareness campaigns and specific measures to stop discrimination (see 'Stop stigmatising and discriminating against people with poor mental health').

#### People with disabilities

Physical and social barriers faced by people with disabilities heighten their risk of poor mental health. They also face additional barriers to accessing mental healthcare and other support. Reducing these barriers is key in preventing and addressing poor mental health among this group.

#### LGBT+ people

Homosexuality was considered a mental illness by the American Psychiatric Association until 1973, when it was removed from the *Diagnostic and Statistical Manual of Mental Disorders*. The WHO followed in 1990, removing homosexuality from the International Classification of Diseases. In medicine, psychiatry and other mental health professions, this contributed to a shift from asking questions about what 'causes' homosexuality and how it can be 'treated' to focusing on the health and mental health needs of LGBT+ patient populations (Drescher, 2015). However, focusing more on stopping the social exclusion and bullying of, and discrimination against, people in the LGBT+ population can help to prevent poor mental health from happening among this group in the first place.

#### Women

While men are less likely to access mental health support when needed and also face mental health risk factors (see 'Enhancing early intervention'), women more often face risk factors such as gender-based discrimination, an unequal share of household tasks and informal care provision, work–life imbalance, expectations about physical appearance, and domestic violence. They are also over-represented among workers in occupations with higher mental health risks (i.e. health professionals, care workers and teachers).

More attention also needs to be paid to postpartum depression, which is often due to a high care burden, life stress, lack of social support or abuse. Men are also prone to this type of depression (they may not feel involved, they can be overwhelmed due to chaotic experiences or a transitional phase, or they may be worried about their partner), but less so (Hutchens and Kearney, 2020; Álvarez-García et al., 2024). To address this, it is key to train midwives and gynaecologists to recognise symptoms, and to raise awareness among pregnant women and their partners. Before resorting to pharmaceuticals, care providers should put more effort into investigating the specific causes of postpartum depression and addressing them in other ways, for a longer-term solution without side effects.

In the long run, reducing gender stereotypes from an early age can help reduce risk factors for women, for instance dividing household tasks and informal care more equally. It is telling that the gender gap in the risk of depression (with women being disadvantaged) is nearly absent among adults in their twenties in the most gender-equal countries, while it is particularly large among older adults in gender-unequal countries (Bracke et al., 2020). Reducing the emphasis on physical appearance and addressing bullying can also help.

## Preventing and addressing loneliness, social and employment exclusion, and bullying

### Loneliness and social exclusion

Loneliness is a driver of poor mental health. It increased during the pandemic (e.g. Eurofound, 2022a). This was followed by decreases. For instance, in Greece, 14 % of workers felt isolated in 2022, down from 17 % in 2021 (EY, 2023). In the 13 Member States where ESS data were collected in all three years, the proportion of people feeling lonely most/all of the time decreased between 2006 (7.6 %) and 2014 (6.5 %), and remained about the same in 2024 (6.6 %).

Ideally, loneliness is addressed naturally by facilitating social interaction in daily activities, rather than with services specifically focused on addressing loneliness (e.g. because usage of such services may be stigmatising and many people may not access them regardless). A key factor is to ensure that people can engage in meaningful activities, such as employment (even if only for a few hours per week), volunteering and cultural or sporting activities. For people with poor health or disabilities, care services that enable them to participate in society are key. Rhetoric with less emphasis on 'usefulness' can also help people to feel included in society (Eurofound, 2022a). Finland has examples of facilitating the social inclusion of people leaving care facilities by involving them in group music initiatives.

Social engagement can also help. In Poland, individuals who actively supported Ukraine showed significant reductions in post-traumatic stress disorder symptoms, pointing to the potential mental health benefits of community involvement (Szepietowska, 2023).

The physical and social aspects of people's neighbourhoods can also contribute, for instance public squares that are inviting for social interaction, methods of transport on which people can interact and feel safe, and high-quality pavements that enable people to walk or use a wheelchair through their neighbourhoods (Eurofound, 2022a).

### Exclusion from employment

Being employed can help to prevent and improve poor mental health, including through economic status, self-efficacy and empowerment. However, stigma and discrimination pose key employment barriers for people with prior or current poor mental health. These barriers can be overcome through legislation and anti-stigma campaigns. For instance, in 2020, Lithuania removed mental disorders as conditions that could result in the suspension of a medical licence. However, employment integration initiatives can also play a role, especially those that consider job satisfaction, turnover and recruitment of employment specialists and involve peer support (Subramaniam et al., 2020; Moe et al., 2021). For instance, an initiative in Valencia in Spain aimed at integrating people with poor mental health into education and employment was among the four best practices annually selected by the NGO Confederación Salud Mental España as part of its 'Buenas Prácticas con Salud Mental' ([11]).

### Bullying

Bullying (including cyberbullying) should be better addressed in workplaces and schools. Prevention and early intervention are key (Gómez Tabares et al., 2024). For instance, in schools, interventions by staff trained in this topic can play a role, as can interventions during break times by trained peer monitors from higher classes.

## Improving working conditions

Measures to improve mental health could address a wide spectrum of working conditions issues for all workers: employment status, working time duration and planning, work organisation, learning and training, physical and psychosocial risk factors, health and

([11]) See https://buenaspracticasconsaludmental.org/.

safety, work–life balance, worker participation and earnings and financial security. Measures could also target aspects and sectors with specific mental health risks. For instance, exposure to adverse behaviour in care work can be reduced or mitigated by better staffing and training (Eurofound, 2020c). Nurturing mental health awareness, strengthening supervisor and co-worker support and establishing mental health and return-to-work policies are also key (EU-OSHA, 2024).

## Enhancing social protection

### Financial and service entitlements

Social insecurities, such as income, employment and housing insecurity, are linked to poor mental health (Eurofound, 2018). Social protection can mitigate this, especially if coverage gaps and the inadequacy of financial and service entitlements are addressed and support for integration into employment (including access to adequate training) is strengthened (Eurofound, 2024b).

### Over-indebtedness

Over-indebtedness contributes to poor mental health. It can be prevented by effective regulation, discouragement of large debts, effective social protection and quality employment security. When prevention fails, over-indebtedness can be addressed by well-designed debt settlement procedures. For early intervention, proactive support is key, for instance with rent, mortgage or utility arrears (Eurofound, 2020b, 2023).

### Housing First

Improving access to mental healthcare for people experiencing homelessness is important. However, the long-term solution is providing them with a stable home and access to support that fits their needs. Housing First programmes are effective in this regard (Eurofound, 2023). Access to support services can help to get lives on track and to prevent and address poor mental health.

## Facilitating physical health

Poor physical health can contribute to poor mental health. Healthy eating and physical activity are key, as are access to clean air and unpolluted environments. Policies that facilitate healthier lives can also contribute to a cleaner environment and reduce the cost of living (Eurofound, 2022a, 2023).

# Improving access to support

Ideally, poor mental health should be prevented. Furthermore, it is key to equip everyone with the knowledge, skills and competencies to take care of their mental health and support others (Jacobi, 2020; Winkler et al., 2024). However, when prevention and self-help do not suffice, access to support is needed.

Use of mental healthcare services, especially outpatient care, has increased over the past few years in most of the countries for which data were available, and the level of unmet mental healthcare needs reported has increased as well. This may reflect an increased prevalence of poor mental health, but probably mainly reflects increased awareness, reduced stigma and discrimination and increased access to publicly funded care. This suggests societies are moving in the right direction, as does the focus on mental health by various national mental health strategies and NGOs and the rapid decrease in suicide deaths over the past few decades. However, it is important not to reduce the focus on mental health, but rather to step it up. The downward trend in suicide has stalled or even reversed, and the barriers to accessing support (stigma, discrimination, waiting lists, quality issues) remain significant.

## Improving quality

To ensure high-quality, person-centred support, it is key to involve support users and people who have had poor mental health in the past (and used services or faced access problems) in the design and monitoring of policies and services, the training of care/support workers and the definition of future priorities, including at the EU level. This includes the co-creation of mental healthcare services, as is happening, for instance, with people experiencing homelessness in Ireland (Awil and Delaney, 2023).

For mental healthcare to meet people's needs, care providers need to be well trained. Patients' rights should not be violated, and medicalisation, inpatient care and medication should be reduced where possible. Training programmes that prioritise person-centred care, reducing coercion, fostering user involvement in decision-making, and safeguarding autonomy can play a role.

The importance of support beyond formal mental healthcare (e.g. by social workers) should be acknowledged. Peer support workers, empowered to advocate for service users' rights while providing support to uphold their dignity and autonomy throughout recovery, can play a role (Mental Health Europe, 2024).

To make sure that support meets users' needs, the right type of support should be available and also accessible. Enhancing coordination and facilitating information flows are key (CNS, 2019). Facilitating the identification

of specific care workers can help. For instance, in 2000, Romania established an online platform that lists mental health specialists and specifies their expertise. In Denmark, the website Mindhelper.dk also helps young people find offline support in their local communities (see 'Measures for pupils, workers and carers').

## Enhancing early intervention

### Stop stigmatising and discriminating against people with poor mental health

Anti-stigma and awareness-raising campaigns have limited effectiveness in encouraging people to seek support if those who have or have had poor mental health are discriminated against and stigmatised. For instance, people (and sometimes their relatives) who have had poor mental health in the past face barriers when purchasing life, mortgage or supplementary healthcare insurance. They may need permission from a medical doctor to engage in employment or get married, may face difficulties in holding a driver's licence or may be excluded from certain professions. Due to such consequences, people with poor mental health may not seek support, despite the work of well-intended anti-stigma campaigns.

Thus, it is key to stop discrimination against people with poor mental health. People who have experienced poor mental health themselves, or have a loved one who has, exhibit less prejudice, resulting in reduced social distance and more favourable anticipated behaviours when interacting with individuals facing mental health challenges (Grigutytė et al., 2022). It is not surprising, therefore, that mental health stigma seems to have decreased during the pandemic, when poor mental health increased and the media paid more attention to it. Further reducing stigma around mental health and mental healthcare usage, including among care providers, will help to remove a key barrier to seeking support.

### Discuss mental health in society, workplaces and schools

General awareness-raising campaigns in society can reduce stigma. It is also important to encourage discussions on the topic in environments where people spend much of their time and can be exposed to risk factors: school and work. School staff and employers should be encouraged to raise awareness of mental health, ways to prevent poor mental health and support options.

### Reduce 'toughness' stereotypes preventing people from seeking care

Women seem more likely to face poor mental health than men (see 'Broader action to prevent poor mental health'). However, men are less likely to access mental healthcare services when needed due to societal masculinity norms that add to care-seeking stigma (Gough and Novikova, 2020). Such norms are also held by care providers, causing some to overlook or ignore depressive symptoms in men who do seek support (Swedish Gender Equality Agency, 2021).

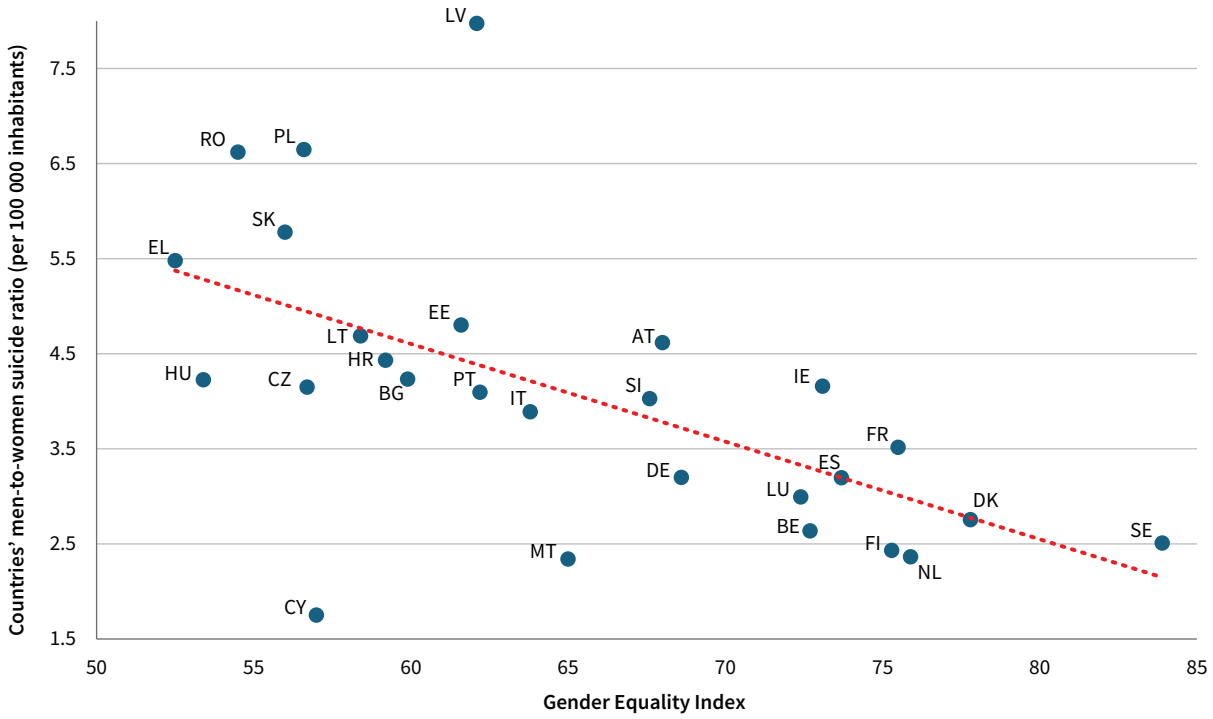
From a young age, boys more than girls are told to be tough and not to complain when hurt. This is a result of, and further nourishes, gender stereotypes. It eventually contributes to not seeking help when needed, underusing mental health services and not speaking about depressive, anxious or suicidal feelings with care providers or in surveys. Such underuse and under-reporting nurtures the idea that men are at lower risk of poor mental health. Both men and women are more likely to recommend self-care as a solution to poor mental health for men than for women. The gender gap in mental health service use is due not only to men and their negative attitudes towards help seeking, but also to structured social norms reconstructed in interactions. Women contribute to masculinity norm maintenance (Pattyn et al., 2015).

All this can lead to escalated poor mental health (i.e. hospitalisations), substance and alcohol abuse and suicide. In each of the Member States, men are over-represented among suicide deaths. The process could be described as 'boys don't cry, but die'. This suicide gender gap is smaller in countries with greater gender equality (Figure 25). More in-depth research is needed to investigate causality. However, gender differences in support-seeking stigma and in feeling responsible for breadwinning (and feeling a 'failure' because of job loss or not meeting socioeconomic expectations) are probably smaller in countries with greater gender equality. Indeed, the smaller suicide gender gap in more gender-equal countries stems largely from lower suicide rates for men. Suicide rates for women hardly differ, possibly due to women being more exposed to work-related mental health risks in countries with higher female employment rates while maintaining similar levels of care and housework, elevating work–life imbalances.

### Train non-specialists in mental healthcare

Social service workers (including in care homes), prison workers, schoolteachers and medical specialists and nurses in areas outside mental health can be key in recognising support needs and in raising awareness of support options. However, they may lack the knowledge to do so. Stepping up basic mental health training for them would help. This is particularly important for workers dealing with people facing life events that come with mental health risks, such as being diagnosed with a severe physical illness, a relationship breakdown, leaving prison, becoming a parent, becoming unemployed, retiring or moving to secondary or tertiary education.

Figure 25: Gender equality and suicide deaths, correlation of Member State values, 2021




**Note:** *Pearson's r = – 0.60 (measuring the strength and direction of the correlation, ranging from – 1 to 1).*
**Source:** *Eurofound analysis of Eurostat and European Institute for Gender Equality data.*

### Strengthen primary care's role in mental healthcare

Primary care is highly trusted, accessible and used in the EU (Eurofound, 2020a). More attention to, and screening for, poor mental health by primary care providers can help in early intervention.

In the Nordic countries, approximately 75 % of those who die by suicide have been seen by their primary care provider within the previous 12 months, pointing to deficiencies in care provision (Nordic Council of Ministers, 2024). For instance, in the Netherlands, GP practices generally employ a mental healthcare assistant, usually a psychologist or social worker, to treat milder psychological problems. Croatia aims to integrate psychologists into community health centres, allowing citizens to access psychological services without a referral. Psychotherapy can play a role in preventing poor mental health through primary care (Löffler-Stastka et al., 2023).

### Establish an EU-wide helpline number

Many countries have mental health helplines. However, sometimes they are difficult to identify (e.g. because different lines are available for specific subgroups) or are closed between certain hours, or they require a fee. While there is an EU-wide number (112) for physical health emergencies, this is not the case for mental health emergencies. To put mental health on an equal footing with physical health, as envisaged in the European Commission (2023a) communication on a comprehensive approach to mental health, establishing and disseminating an EU-wide free number, available 24/7, should be considered.

## Improving availability and affordability

### Look beyond formal entitlements

Recent crises (the Great Recession, the COVID-19 pandemic, environmental disasters) have demonstrated that people who were not in vulnerable situations before can suddenly face vulnerabilities, including poor mental health. People are also confronted with difficult life events, such as divorce or the death of someone close to them, that put them at risk of poor mental health. Poor mental health not only negatively affects people who experience it, it also has an impact on the well-being of people close to them as they see their nearest and dearest struggling. An indication of the magnitude of this wider group can be seen in Lithuania, for example, where 22.3 % of the population in general reported that a significant other or a family member had been diagnosed with a mental health disorder in 2022 (Grigutytė et al., 2022). People may generally be more likely to favour using public funds to provide support for people hit by such common risk factors, partly as they, or people close to them, may at some stage need support themselves.

Indeed, overall, people in the EU are entitled to free or low-cost mental healthcare services, especially for emergency situations but also for mild or moderate care

needs. However, these entitlements are often moot due to care-seeking stigma and discrimination (see above), in addition to long waiting lists for or unavailability of publicly funded services, especially in rural areas and for certain specialised care needs (notably for children). Policymakers should thus look beyond formal entitlements alone.

### Care for mild or moderate needs

Waiting lists can often be circumvented, especially for care for mild or moderate needs, by using providers outside the public system. Providers outside the public system also need to be relied upon for services that are not covered by the public system, such as relationship or parenting therapy. Supplementary healthcare insurance is becoming more common in many Member States and increasingly covers mental healthcare services. However, these services and supplementary insurance are unaffordable for many people, especially for some of the groups most likely to face poor mental health: people on a low income, those who are unemployed or those facing financial problems.

As care for particularly urgent needs is usually more accessible and better funded, there is a risk that mild or moderate care needs will be left to escalate, or that people with them will be steered into using types of care that may not fit their needs. It is thus essential to improve access to care, including psychotherapy, for mild or moderate care needs.

Amid capacity challenges, it is particularly important to at least provide people with a preliminary intake conversation to assess needs and to make people aware that they are not alone (this was introduced in Germany in 2017; since 2024, an 'exploratory conversation' has been publicly covered in the Netherlands). Where judged to be of benefit, peer support, group therapies or online sessions could be offered to provide some basic care within capacity boundaries. Online therapies, possibly blended with online or face-to-face professional sessions, can also be an option. For instance, computerised cognitive behavioural therapy platforms can address mild depression or anxiety; these platforms could be improved, for instance by adjusting them better to suit the user's age (Wickersham et al., 2022). Such support may not always fit people's needs. For instance, following the pandemic in Austria, group sessions were provided to people under the age of 21. However, these proved to be less popular than expected: of the 202 group settings offered (June 2023), 55 were held, 22 with only two participants.

### Affordable psychotherapy

Countries can learn from Italy's scheme facilitating access to psychotherapy for low-income households. Anxiety and depression symptoms were 45 % and 24 % lower, respectively, after sessions ended, and 38 % and 20 % lower, respectively, six months later. Productivity increased by an estimated five working days monthly, equivalent to 1 % of GDP (CNOP, 2024). Most recipients (72 %) received psychotherapy for the first time; 81 % of them had previously forgone therapy for financial reasons. In Denmark, the 2018 abolishment of co-payments for treatment by a psychologist for anxiety and depression for those aged 18–21 years contributed to a doubling of treatment numbers among this group and reduced the number of suicide attempts (Kruse et al., 2022).

### Rural areas

Better access to mental healthcare in less populated areas can be achieved through mobile service providers, by stepping up mental healthcare at primary care facilities or by training GPs to provide basic mental healthcare support. Improved access to online sessions can also help, ideally after a first face-to-face session. It is key to ensure clear professional conduct standards, secure technological platforms and high therapy quality.

### Child mental healthcare services

More needs to be done to improve mental health among children. Answers may lie in measures that facilitate social interaction, reduce inappropriate/addictive social media usage and gaming, fight bullying and stereotyping based on appearance, sexual orientation and other factors, improve the natural environment, stimulate physical activity and so on.

Otherwise, the availability of mental healthcare workers who specialise in child mental health will remain insufficient. However, increasing the number of care providers can help. In the short term, it can also be important to guarantee that the intake conversation and a first session happen as soon as possible (see also 'Care for mild or moderate needs'). For triage, it is important to identify support needs that may be met while waiting for specialised care and to ensure that children in need and their families do not feel left alone.

## Reducing administrative burdens

It can be a challenge to find adequate support, especially when capacity is as limited as it is in mental healthcare, and when it is such a sensitive topic that people hesitate to ask others how to access services. The pathways to starting adequate treatment can also be difficult and long (Volpe et al., 2015).

It may be particularly challenging for people with poor mental health to struggle through the necessary paperwork to request reimbursements, and to find out whether a certain type of support qualifies for reimbursement. This probably leads to lack of take-up of the services or reimbursements to which people are entitled. This can lead to deteriorating mental health due to non-receipt of support, financial problems due to non-receipt of reimbursements, and feeling lost. Simplifying the procedures can help. Phasing out the reimbursement system removes both a financial barrier

(some cannot afford upfront payments, even if they are reimbursed later on) and an administrative obstacle. Plain-language websites and information campaigns targeted towards risk groups (e.g. leaflets in unemployment agencies and family law offices) can also help.

## Increasing data availability

A European Parliament study (2023b) on mental health in the EU noted 'collecting data is crucial for monitoring mental health, developing effective policies and addressing the growing mental health challenges'. However, while the EU's comprehensive approach to mental healthcare is putting mental health on an equal footing with physical health, they are not yet equal with regard to data availability.

To understand how the mental well-being of people in the EU can be improved, it is key to continue developing and measuring the multiple dimensions of quality of life. However, here the focus is specifically on data on poor mental health and mental health(care).

**Identifying people with poor mental health.** Survey data can capture how people feel, including people not using care. Currently, relevant surveys are conducted infrequently (especially those including measures of anxiety), do not cover all Member States and ask varying questions. Furthermore, groups in particularly vulnerable situations are typically under-represented or excluded from samples (e.g. people under the age of 15, in institutions or experiencing homelessness). The EHIS and the Survey of Health, Ageing and Retirement in Europe exceptionally include people in care homes, which is crucial to understanding the situation of older people.

**Suicide.** Suicide prevention policies could benefit from EU data on suicide attempts, the reasons for suicide attempts and deaths and the socioeconomic characteristics of the people involved. To improve services, it would also be helpful to know whether those who attempted or died by suicide had received mental healthcare and, if so, what type.

**Mental healthcare.** Databases containing information about people's entitlements to services are useful. However, the main problems in accessing mental healthcare have to do with the lack of enforcement of entitlements due to capacity limitations and the lack of care seeking due to stigma and discrimination. For the same reason, service usage data are of limited use in investigating the prevalence of poor mental health.

Thus, in addition to regular survey data on unmet mental health support needs (and reasons for them), the following types of data on access problems are key:

- stigma and discrimination: data on access problems to insurance, licences and occupations for people with past or current mental health diagnoses (and possibly their relatives);
- waiting lists: the proportion of people waiting over a certain amount of time for an initial consultation and treatment;
- quality: care/support users' experiences and outcomes (OECD, 2022a);
- human resources: EU-level data on full-time equivalent mental healthcare workers, including nurses and non-medical workers (e.g. psychologists), in the public and private sectors;
- private care: usage of private care and whether it was paid out of pocket or through supplementary insurance (a key dimension of social inequalities is timely access to mental healthcare).

**Medication.** Data on the sociodemographic characteristics of users of prescription medication and the usage duration can help policymakers address overprescription, especially beyond short-term usage for crises situations.

**Deinstitutionalised care.** As policies seek to deinstitutionalise care, data should better capture this. Currently the focus is on healthcare-type capacity and usage data (e.g. number of psychiatric hospital beds, number of hospitalisations). Information on user experiences, with a focus on person-centred care, and on the involvement of service users and people who have had poor mental health in the past in the design of policies, services and treatment is key for monitoring quality. Data on the usage of complaint procedures and the number of complaints addressed can also be useful.

**Policy practice databases** are useful to learn from. However, policymakers should not be misguided into fragmented, ad hoc approaches leading to ineffective public funds allocation. It is important to take a broad perspective, primarily focusing on improving population mental health and, when poor mental health arises, on addressing its causes and providing person-centred support.

# Conclusions

Poor mental health increased during the COVID-19 pandemic, but has decreased since. Suicide rates have fallen in recent decades, but the decrease now seems to have stalled and increases have recently been observed.

Mental healthcare service usage has increased over the past several years, partly due to greater awareness, reduced stigma and increased availability. Several Member States have increased entitlements to mental healthcare, and urgent care needs in particular are usually free or low cost. However, in practice, care-seeking stigma and major capacity problems render these entitlements void, especially for non-emergency care. Timely care for mild or moderate needs is often only accessible to people who can afford to pay for it outside the public system.

Schools, workplaces, primary care providers, social workers and medical specialists in areas other than mental healthcare can play a key role in early intervention and improving population mental health.

It is also vital to encourage people to seek support in the early stages of poor mental health by reducing stigma and discrimination against people with current and past poor mental health and by addressing gendered stereotypes about care seeking. Furthermore, to ensure that high-quality support is available, it is important to involve people who have experienced poor mental health in the design of policies, services, care/support worker training and treatment plans.

However, the long-term answer largely lies in improving population mental health and preventing poor mental health as much as possible, while equipping people to deal with life's psychological challenges. Measures that improve living and working conditions contribute to this. They include making societies more inclusive and cohesive, fighting discrimination, addressing loneliness and (cyber)bullying, reducing work–life balance issues, improving physical health, enhancing social protection and raising awareness of the importance of caring for one's own and others' mental health.

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# Annex: Network of Eurofound Correspondents

### Table A1: National correspondents or experts who contributed to the report

| Country | National correspondent(s) | Organisation |
|---|---|---|
| **Austria** | Bernadette Allinger | Working Life Research Centre (FORBA) |
| **Belgium** | Dries Van Herreweghe and Noah Vangeel | HIVA Research Institute for Work and Society – KU Leuven |
| **Bulgaria** | Ekaterina Markova | Institute of Philosophy and Sociology at the Bulgarian Academy of Sciences (IPS-BAS) |
| **Croatia** | Predrag Bejaković | University of Split |
| | Irena Klemenčić | University of Zagreb |
| **Cyprus** | Loucas Antoniou | Cyprus Labour Institute (INEK-PEO) |
| **Czechia** | Aleš Kroupa | Research Institute for Labour and Social Affairs |
| **Denmark** | Laura Juhl Madsen | Moos-Bjerre |
| **Estonia** | Mariliis Öeren, Anni Kurmiste and Miriam Lehari | Think Tank Praxis |
| **Finland** | Mikael Lundqvist | Oxford Research |
| **France** | Victória Fonseca, Emma Godemet and Frédéric Turlan | IR Share |
| **Germany** | Thilo Janssen and Timo Hanke | Institute of Economic and Social Research (WSI) |
| **Greece** | Elena Kousta | Labour Institute of the General Confederation of Greek Workers (INE-GSEE) |
| **Hungary** | Szandra Kramarics | HUN-REN Centre for Social Sciences |
| | Nóra Krokovay | Kopint-Tárki Institute |
| **Ireland** | Martin Frawley | Industrial Relations News Report |
| **Italy** | Barbara De Micheli and Roberta Cupertino | Fondazione Giacomo Brodolini |
| **Latvia** | Krišs Karnītis | EPC Ltd |
| **Lithuania** (expert input) | Said Dadašev | Vilnius University |
| | Sigita Doblytė | University of Oviedo |
| **Luxembourg** | Jordane Segura and Gaetan de Lanchy | Luxembourg Institute of Socio-economic Research |
| **Malta** | Luke Fiorini | University of Malta |
| **Netherlands** | Jacqueline Snijders and Thomas de Winter | Panteia |
| **Poland** | Anna Chowaniec | Ecorys |
| **Portugal** | Heloísa Perista | Centre for Studies for Social Intervention (CESIS) |
| **Romania** | Nicoleta Voicu | Association Centre for Public Innovation |
| **Slovakia** | Miroslava Kordošová and Daniela Kešelová | Institute for Labour and Family Research |
| **Slovenia** | Maja Breznik | University of Ljubljana |
| **Spain** | Iñigo Isusi | IKEI Research and Consultancy |
| **Sweden** | Vera Lindström and Henrietta Skarland | Oxford Research |
| **Norway** | Ståle Østhus | National Institute of Occupational Health (STAMI) |

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Anxiety and depression were already prevalent in the EU before the COVID-19 pandemic, during which they increased before levelling off again. Suicide death rates have declined significantly over the past few decades, but they have moved upward again recently. Poor mental health seems to have become more common among some groups, especially among older men and young women. In the EU, people typically have a formal entitlement to mental healthcare for free or at low cost, especially for particularly urgent care needs. However, people often do not seek care because of stigma and discrimination against people with poor mental health and because of the lack of access to care that is trusted and fits people's needs. Mental healthcare services are frequently rated as low quality. Furthermore, care capacity is lacking, especially in rural areas and for children. Timely care for mild or moderate needs, particularly psychotherapy, is often only accessible to people who can pay for it. Nevertheless, care seeking, coverage and capacity have increased in many Member States. Greater emphasis is needed on the prevention of poor mental health by improving working and living conditions, making societies more inclusive, addressing loneliness and (cyber)bullying and enhancing social protection.

**The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency established in 1975. Its role is to provide knowledge in the area of social, employment and work-related policies according to Regulation (EU) 2019/127.**

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