CARE, COHESION, AND GROWTH: ADVANCING MENTAL HEALTH THROUGH THE WELLBEING ECONOMY

Headway Mental Health Index 5.0 - Report

December 2025

Focus Mental Health
Headway
A new roadmap in Brain Health

TEHA

Angelini Pharma

This Report arises from the initiative **“Headway – A new roadmap in Brain Health: Focus Mental Health”**, realized by TEHA Group[1] in collaboration with Angelini Pharma[2]. The information contained in this publication do not necessarily reflect the opinion or the position of the individuals and institutions referred to within the report. Decisions regarding the final analysis were ultimately made by TEHA Group.

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[1]TEHA Group, controlled by The European House – Ambrosetti S.p.A., is a company with 300 people operating since 1965. It has grown significantly over the years, thanks also to the contributions of many of its Partners, developing numerous activities in Italy, Europe and the rest of the world. Since 2013, TEHA Group has been named — in the category Best Private Think Tanks — the no. 1 think tank in Italy, the no. 4 think tank in the European Union and among the most respected independents in the world out of 11,175 on a global level (source: “Global Go To Think Tanks Report” of the University of Pennsylvania). TEHA Group was recognized by Top Employers Institute as one of the 151 Top Employers 2025 in Italy. TEHA Group has specific expertise in the healthcare sector with a dedicated professional practice, which for over 15 years has been developing different types of projects for all the players - both public and private - in the health ecosystem. For more information, please visit www.ambrosetti.eu and follow on twitter.com/Ambrosetti.

[2] Angelini Pharma is an international pharmaceutical company, part of the privately owned multi-business Angelini Industries. The Company researches, develops and commercializes health solutions with a focus on the areas of Brain Health, including Mental Health and Epilepsy, and Consumer Health. Founded in Italy at the beginning of the 20th century, Angelini Pharma operates directly in 20 countries, employing more than 3,000 people. Its products are marketed in over 70 countries through strategic alliances with leading international pharmaceutical groups. For more information about Angelini Pharma please visit https://www.angelinipharma.com.

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1. Introduction on Mental Health

Brain Health is a broad concept defined by WHO as the functioning of **cognitive, sensory, emotional, behavioural, and motor domains**, shaped by a wide range of biological, environmental, and social factors across the life course.

Mental Health is a **vital component of Brain Health**, encompassing psychological, emotional, and social well-being. It is **dynamic, influenced by internal, structural, and social determinants**, and requires a culturally sensitive definition to guide effective interventions.

Mental and neurological health **are deeply interconnected**, with overlapping symptoms and shared risk factors. Evidence shows, for example, a **bidirectional link between depression and epilepsy**, underlining the need for integrated care approaches.

The Headway initiative has **embraced a unified Brain Health perspective**, expanding its scope to address both mental and neurological conditions, fostering **more effective, person-centred, and system-wide strategies**.

This year's edition intersects with the concept of "wellbeing economy", that sits at

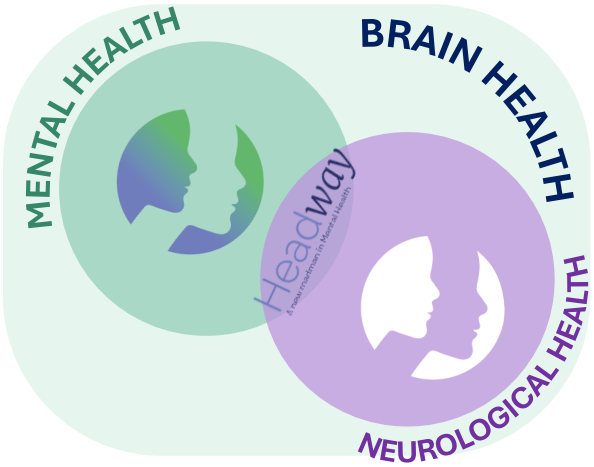


Figure 1. Interconnections between Mental, Neurological and Brain Health – *Source: TEHA, 2025*

the intersection of the **"traditional economy" and social priorities**, challenging the idea that GDP alone can reflect true societal progress. It incorporates dimensions left out of conventional metrics, such as **health and Mental Health, gender equity, inclusion**.

Mental Health is a **central pillar of the wellbeing economy**, which prioritizes individual and collective resilience, equity, and the conditions needed for people to lead fulfilling lives.

Worsening Mental Health outcomes across Europe reveal the **limitations of GDP-based progress**, as GDP does not capture the most relevant factors for wellbeing: quality of relationships, community support, or the value of **unpaid caregiving**.

Note: For further information on the relationship between Mental, Neurological and Brain Health please refer to TEHA Group (2024), "Mental Health Index 4.0 Report" and TEHA Group (2025), "Brain Health in uncertain times: A strategic investment for Europe's future".

Protective factors like social support are crucial to Mental Health: **33.3% of EU citizens** report strong support networks, which buffer against depression and anxiety, while **92.8%** say they have **someone to turn to**, underscoring the centrality of formal and informal care.

The **cost of neglecting social and emotional needs is high**: loneliness alone raises the risk of depression by **over 40%**, showing that social capital is not a "soft" metric, but a Mental Health determinant with **measurable outcomes**.

A wellbeing economy is an approach to economic development that **places people and the planet at the centre of policymaking**. This model recognizes that economic systems must support **broader human and environmental goals** to be truly inclusive and resilient.

Its four core pillars are **human, economic, planetary** and **social wellbeing**. **Human wellbeing** refers to health, education, and the ability to live a fulfilling life. **Economic wellbeing** includes income, employment, and basic needs, while **planetary wellbeing** reflects environmental factors such as clean air, water, and climate stability.

Social wellbeing involves strong relationships, inclusion, and access to care.

In recent years, the Headway initiative has addressed the **first three pillars in relation to Mental Health**. For example, last year it focused on economic wellbeing by estimating the **return on investment (ROI)** of Mental Health interventions. This year, it will **deepen the social wellbeing dimension** by analysing the **social value of informal caregiving**.

The complexity of Mental Health's aetiology

The understanding of the **multifaceted determinants** underlying Mental Health disorders remains an ongoing challenge. While precise causal links are still elusive, it is clear that a **diverse array of elements contributes** to the emergence of Mental Health disorders.

Zooming out to the **societal level** reveals the profound impact of social determinants on Mental Health. Factors include employment conditions, housing quality, neighbourhood environments, and access to education collectively influence mental well-being.

Environmental factors also play a pivotal role. Stressors linked to climate change are increasingly associated with Mental Health challenges. Urban settings, characterized by limited green spaces and high levels of noise and air pollution, also exert influence on mental well-being.

Recognizing these **interconnected determinants** underscores the imperative need for comprehensive, **multidisciplinary interventions** to effectively address Mental Health concerns. From individual behaviours to societal structures and environmental conditions, each facet contributes to the broader understanding of Mental Health and must therefore be addressed through **comprehensive Mental Health plans and initiatives**.

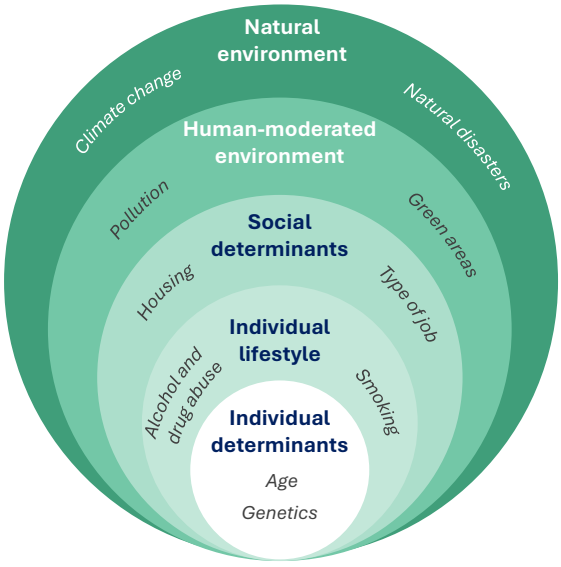


Figure 2. Determinants of Mental Health – *Source: TEHA on BMC Geriatrics data, 2025*

Long term trends and gender differences in Mental Health prevalence

After a long period of relative stability, the prevalence of Mental Health disorders in the EU **surged sharply after 2019**, indicating a significant shift in the Mental Health landscape **following the pandemic**.

Specifically, **anxiety** cases increased by **43.9%** between 2015 and 2023, while **depression** saw a **22.3%** rise, highlighting these two conditions as **key contributors** to the recent Mental Health crisis.

The post-pandemic surge reflects both a **real increase in Mental Health burden** and possibly **improved awareness and reporting**, though systemic underdiagnosis may persist in certain countries.

This trend underscores the need for **urgent policy attention** in order to reverse the increase in prevalence and start converging **back towards pre-pandemic levels**.

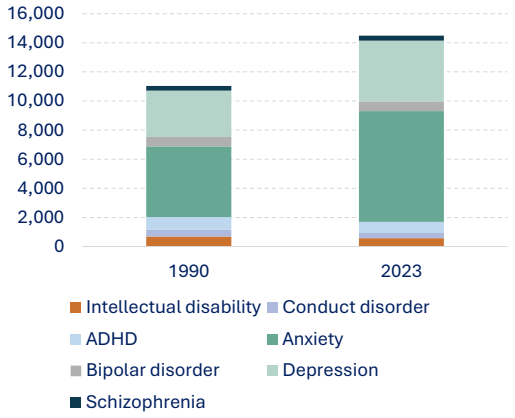


Figure 3. Prevalence of Mental Health disorders in EU-27 + UK countries – *Source: TEHA on Global Burden of Disease data, 2025*

Mental Health disorders are **increasingly affecting younger age groups**, with prevalence rates peaking between 15 and 19.

This trend signals a **growing vulnerability among adolescents**, potentially linked to rising psychosocial stressors, digital exposure, and academic or **socioeconomic pressures**.

Despite this shift, the total number of cases is **not increasing dramatically** due to population ageing.

This trend is confirmed by a **recent WHO report**, which found an increase in the prevalence of Mental Health disorders of **over 30% among under-20-year-olds** in the last 15 years.

In terms of gender differences, across all EU-27+UK countries women **consistently report higher rates of moderate or severe depression** symptoms than men.

The gender gap ranges from **0.7% in Greece** to **5.4% in Luxembourg**. Overall, **19.5% of women report having a Mental Health condition**, compared to just **11.0% of men**, with significant disparity in Mental Health burden.

While **biological factors** partly explain the gap, social determinants, caregiving responsibilities and **gender-based violence** play a substantial role in shaping Mental Health outcomes for women.

Underreporting among men may also contribute to the observed gap. Social stigma can **discourage men from acknowledging Mental Health struggles** or seeking help, resulting in artificially lower prevalence.

The data reinforces the need for **gender-sensitive Mental Health strategies**. Tailored approaches can help design more effective and equitable Mental Health policies.

European and Member States' projects and initiatives

The EU has demonstrated a **strong commitment to safeguarding Mental Health** through targeted projects and policy initiatives. Under Horizon Europe and EU4Health, **several projects have been launched** to address different dimensions of mental well-being.

The "WellCare project" focuses on **strengthening the Mental Health and resilience** of both informal and professional caregivers, bringing together academic institutions, NGOs, and EU networks to generate collaborative solutions. The Advance project seeks to **develop preventive strategies** for vulnerable populations, tackling factors such as climate change and digital stressors.

"IceHearts" is aimed at **supporting vulnerable children and youth** by fostering social inclusion and emotional wellbeing through sports and mentorship. Similarly, the "Mentality" **project promotes resilience among children, migrants**, and **caregivers** using anti-stigma programs and holistic educational practices.

In October 2024, the European Commission unveiled the **"EU Support Package on Stigma,"** which aims to eliminate the stigma and discrimination surrounding Mental Health, a **key barrier to care access and recovery**. The package also introduced a **new tracking framework to monitor Member State** actions and launched the "#InThisTogether" campaign, which leverages storytelling and social media to **raise public awareness**.

Complementing these efforts, the European Psychiatric Association (EPA) introduced its **2025–2027 Action Plan**. The plan emphasizes personalized care, stigma reduction, and strengthening clinical skills through **advocacy, research, and training**. It proposes the creation of thematic task forces, development of clinical guidelines, **promotion of transnational research**, and advocacy with EU institutions. Collaborative work with WHO Europe and scientific societies is also prioritized to promote the **dissemination of best practices** across countries.

At the national level, a number of effective practices for **Mental Health promotion and prevention** have been highlighted by the OECD as models worth scaling across the EU.

The "@ease" initiative in the Netherlands stands out as a **youth-focused Mental Health program** offering free and anonymous walk-in centres, where trained young volunteers provide motivational interviewing and support.

This model significantly improves **resilience and psychological functioning** in young people.

In France, the "VigilanS program" has made **substantial strides in suicide prevention** by introducing post-discharge monitoring. This intervention not only facilitates better coordination of care but also **reduces the risk of suicide re-attempts by 24%.** Its long-term benefits are notable, with an estimated gain of **17,700 DALYs** by 2050.

Poland's "Next Stop: Mum" project **addresses postpartum depression** by screening women during late pregnancy and postpartum. It has reached **over 21,600 women in 40 health centres** and 7 hospitals, leading to better treatment pathways.

Germany's "iFightDepression" is an online platform built on CBT for individuals with depression. Active since 2016, the platform is **accessible in 16 languages** and is designed as a complementary tool to traditional therapy.

Scaling up these best practices across the EU would **yield substantial benefits**. OECD modelling shows that broader implementation of "iFightDepression", "Next Stop: Mum", and "VigilanS" would result in **gains of 0.3, 0.8, and 1.4 DALYs per 100,000 inhabitants** annually until 2050. These interventions are not only effective but also economically sound: "iFightDepression" would be **cost-saving in 7% of EU countries** and cost-effective in 79%. "Next Stop: Mum" would be **cost-saving in up to 28% of countries**, while "VigilanS" would be cost-effective in nearly all Member States.

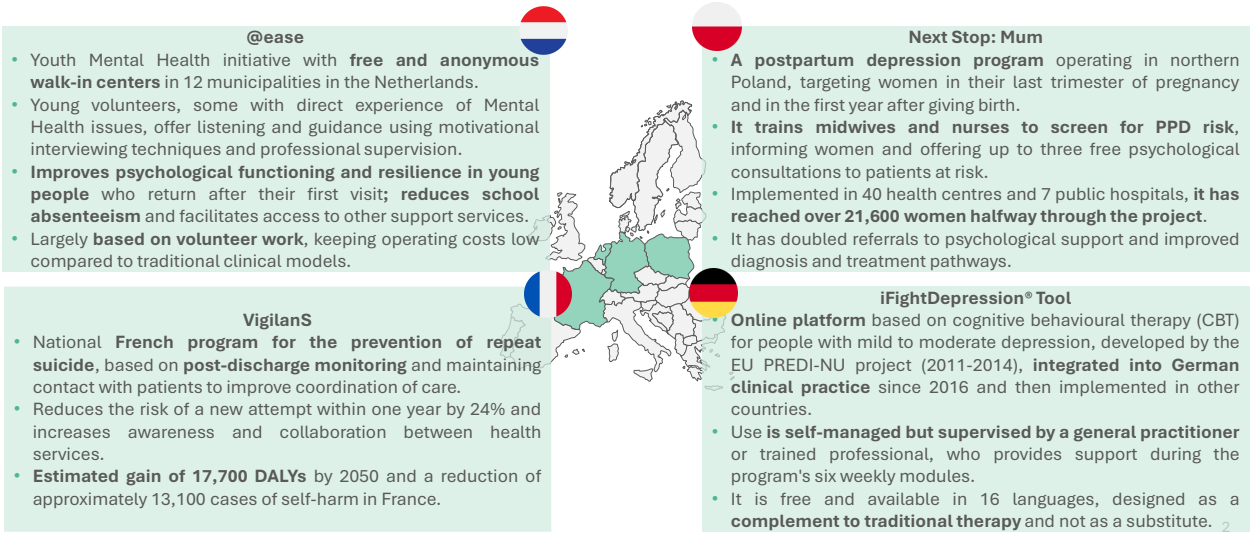


Figure 4. Recent examples of best practices on Mental Health at the national level – *Source: TEHA on OECD data, 2025*

2. Headway – Mental Health Index 5.0

Monitoring the responsiveness of a Country, **assessing its trend over time and comparing it to other systems**, allows for a dynamic picture of the effects of **health, social, employment, educational and environmental policy** interventions on the Mental Health status of the population.

The "Headway Mental Health Index 5.0" is designed to provide a **multidimensional picture on Mental Health** across European countries (EU-27 + UK). It is a framework aimed at measuring indicators representing **key aspects of Mental Health** and selected based on the comparability and availability of data. The Index consists of 4 sub-indices and 54 different KPIs.

The **relationship between the Mental Health status** of the population, its determinants and the response factors (both in healthcare and in workplaces, schools and society) **is not linear**.

The factors that determine the Mental Health status are in fact **intertwined and influence each other**, and the Mental Health status of the population has an **impact on them too**.

For example, prevention campaigns conducted by national healthcare systems may be successful in **reducing risk factors such as alcohol and drug abuse**. Also, an improvement in socioeconomic determinants may lead to an improvement in environmental determinants **because of lower carbon emissions.**

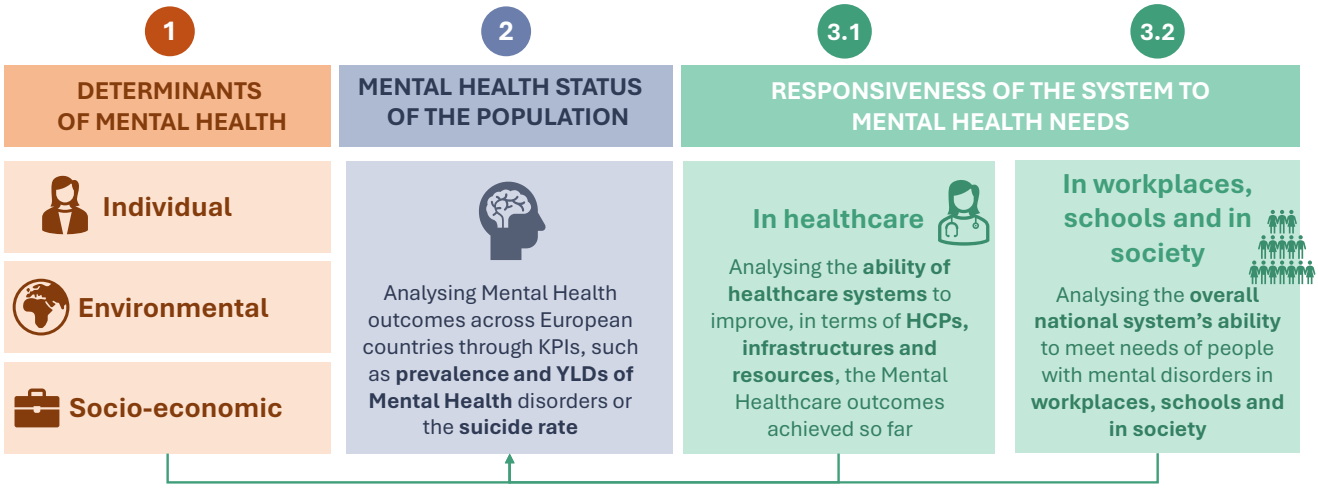


Figure 5. Structure of the Headway Mental Health Index 5.0 – *Source: TEHA, 2025*

Methodology

The "Headway - Mental Health Index 5.0" **considers 54 Key Performance Indicators (KPIs)** related to 3 macro-areas: Determinants of Mental Health, the Mental Health status of a population and the responsiveness of the Systems to needs in healthcare, workplaces, schools and society in general. While the macro-area **Determinants of Mental Health** assesses the impacts of the surroundings on Mental Health, the macro-area **State of Mental Health of the population** measures the Mental Health outcomes, whereas the macro-area related to the **Responsiveness of the Systems** takes into consideration the quality of health, welfare, social and educational services provided and of the policies implemented to promote Mental Health wellbeing:

- The area of the **Determinants of Mental Health** considers 19 KPIs;
- The area of **Mental Health status of the population** considers 6 KPIs;
- The area of **Responsiveness to healthcare needs** 14 KPIs;
- The area of **Responsiveness to needs in the workplaces, schools and society** in general, respectively 6 KPIs, 6 KPIs and 3 KPIs.

For each of the 54 KPIs, a maximum score (10) and a minimum score (1) has been assigned to the best and worst performing countries, respectively.

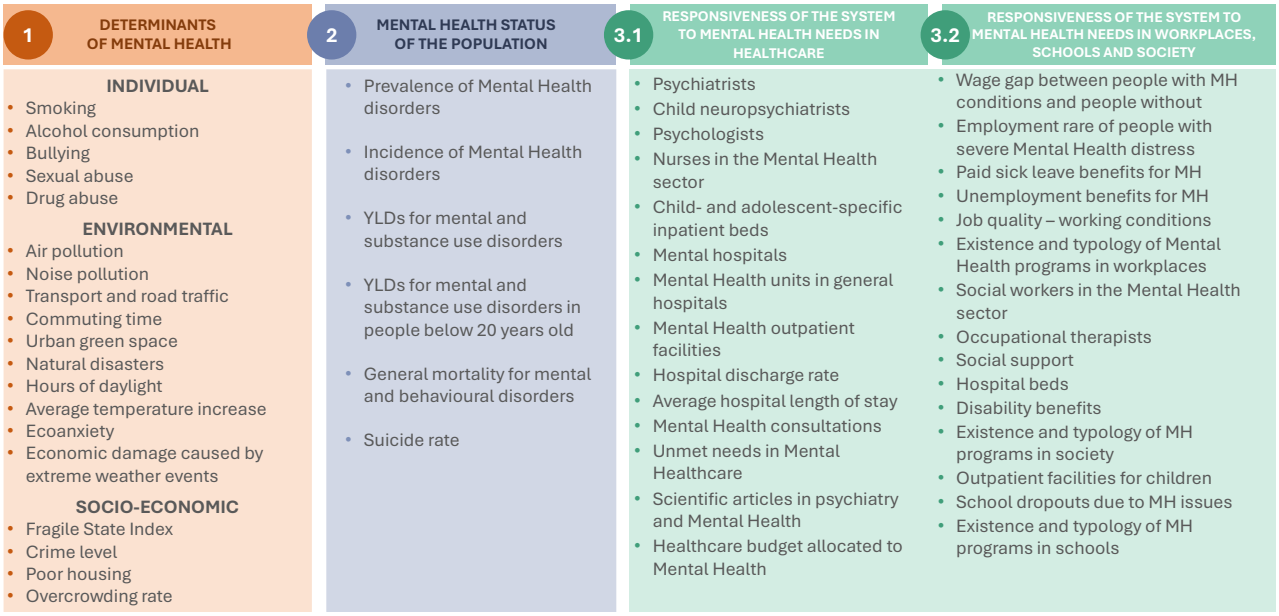


Figure 6. The 54 KPIs of the «Headway's Mental Health Index 5.0» – *Source: TEHA, 2025*

For each country with an intermediate performance **a score from 1 to 10 was assigned**. The KPIs were then standardized on a 1-10 scale with respect to their point value, to make the performance comparable.

The scale was assigned **according to an algorithm** applied to all indicators:

- scale = (best performer - worst performer) / (max score - min score)

After fixing the scale, the **score for each country** is calculated as:

- score = [(value of country - worst performer) / scale] + 1

When the KPI is **composed of multiple sub-indicators**, the score is assigned to each of them. The final score is given by the average, or the weighted average, of the scores. After calculating the score for each KPI, a score **is assigned for each area based on the average** of the KPI scores.

When the scores of sub-indicators were not distributed regularly from 1 to 10 due to the presence of one or more outliers, **the KPIs were normalized**, adopting the following method:

- Z-score = (score of country - average) / standard deviation
- [=NORMDIST(z-score)] x 10

The KPIs sourced from the **Global Burden of Disease** for countries that were under-reporting data **were adjusted using an "adjusting ratio",** computed from the suicide rate, to mitigate underestimation;

- Adjusting ratio = average of (suicide rate of each selected country / median of all suicide rates) = 1.1612

In the following analysis, it is important to emphasize the difference between the countries considered. **Some caveats should be considered.**

The methodological framework of the "Headway - Mental Health Index 5.0" focuses on providing a **multidimensional picture on Mental Health**. However, structural differences exist and create **limitations in terms of data comparability**.

The choice of different KPIs and the design of the "Headway - Mental Health Index 5.0" aim at **balancing between the application of analytical principles and qualitative interpretation** of responsiveness in terms of Mental Health. Given that, the lack of available data might induce some biases.

Mis- and under-reporting can be identified as an area of improvement for many European countries as well as the **adoption of standardized approach to data collection** and monitoring.

Determinants of Mental Health

Mental Health is shaped by a **multifaceted set of factors**, with ongoing research continually expanding our understanding of these dynamics.

While **genetic predispositions** and **biological mechanisms** are fundamental, influencing neural chemistry and susceptibility to Mental Health conditions, **behavioural choices** also play a pivotal role.

Crucially, **socioeconomic determinants** profoundly impact mental well-being by shaping access to resources and support systems. In the last years, scientific research has dedicated substantial efforts in uncovering the **relationship between the socio-economic context** and its impact on Mental Health.

Additionally, environmental factors such as **air quality** are increasingly recognized for their significant contributions to Mental Health. This intricate interplay reveals that Mental Health is **not solely a product of individual actions** or inherent biology but is also deeply embedded within and influenced by **broader social and environmental frameworks**.

Smoking and alcohol use are **well-known risk factors for Mental Health**, but their relationship is bidirectional: they can contribute to mental illness and simultaneously are used as **coping mechanisms for existing distress**.

Among adults, there is a **negative correlation** between daily smoking and heavy episodic drinking across EU countries. In countries with high rates of alcohol consumption, smoking rates tend to be lower, and vice versa, possibly reflecting **different cultural dynamics** that therefore need country-specific policies.

Few countries fall in the green and red areas, characterized by low or high prevalence of both risk factors, respectively. Almost all of them fall in the orange area, where **one risk factor tends to dominate** over the other.

The share of adults who **smoke daily** varies widely: from **8.8%** in **Sweden** to **35.2%** in **Latvia**. Heavy episodic drinking is similarly uneven, ranging from **3.6%** in **Cyprus** to a high **36.4%** in **Romania**.

In adolescents, **both risk factors are closely linked to Mental Health risks** such as depression, anxiety, and self-harm. Early exposure can also increase the likelihood of **long-term dependence**.

Unlike adults, adolescent smoking and alcohol use are **positively correlated across countries**: higher smoking prevalence is typically accompanied by **higher levels of reported drunkenness**. This likely reflects common social settings and peer dynamics that foster multiple risk behaviours.

For this reason, most countries are either in the **green area** – mostly Northern European countries – and in the **red area** – Southern and Eastern European countries.

Adolescent smoking prevalence ranges from **7.4%** in **Ireland** to **31.6%** in **Bulgaria**, while drunkenness spans from just **7.8%** in **Portugal** to **44.7%** in **Denmark**.

Hungary and Bulgaria stand out with **very high levels of both smoking and alcohol** consumption, indicating a need for integrated strategies on both fronts.

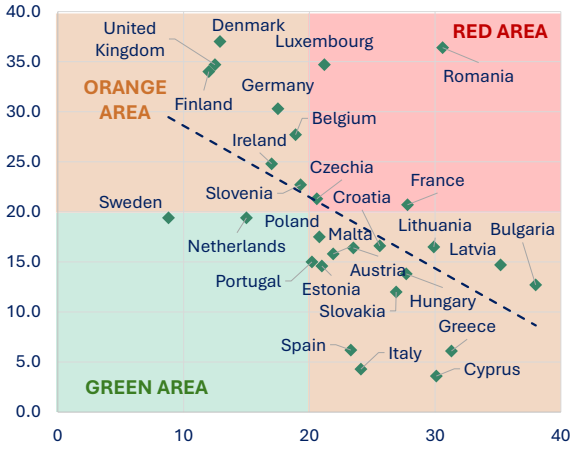


Figure 7. Correlation between smoking (% of adults who smoke daily; x-axis) and alcohol consumption (% of adults reporting heavy episodic drinking; y-axis), 2024 – *Source: TEHA on OECD data, 2025*

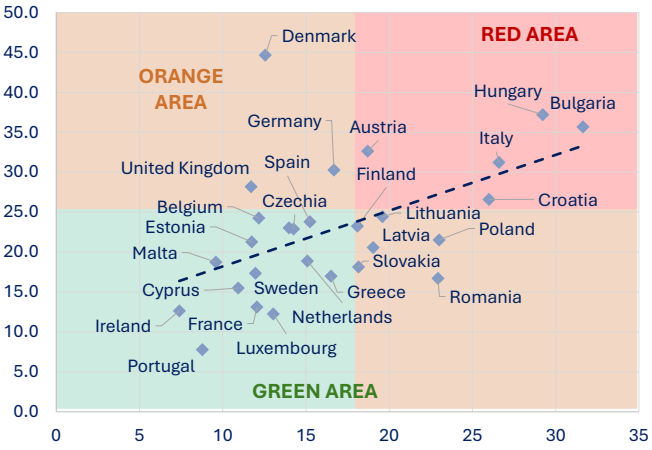


Figure 8. Correlation between smoking (% of 15y.o. who smoked at least once in the last month; x-axis) and alcohol consumption (% of 15y.o. reporting drunkenness; y-axis), 2024 – *Source: TEHA on OECD data, 2025*

The relationship between rising temperatures and Mental Health is increasingly clear: for **every 1 °C increase** in ambient **temperature**, Mental Health-related **mortality rises by 2.2%,** while mental illness-related morbidity **increases by 0.9%**[1].

Climate change intensifies **direct psychological impacts** through more frequent and severe heatwaves, which have been shown to worsen Mental Health conditions.

Countries across Europe have already experienced **significant warming** (up to **3.4 °C since the 1951–1980 baseline** in countries like Croatia and Poland) raising concern about the compounding Mental Health burden in the years ahead.

[1]Liu J et al. (2021), "Is there an association between hot weather and poor Mental Health outcomes? A systematic review and meta-analysis". Environment International.

Beyond physiological impacts, climate change is also **contributing to rising levels of eco-anxiety**, particularly among young people.

As the climate continues to warm, addressing the Mental Health implications must become a **core part of adaptation strategies** through early intervention, expanded Mental Health services, and greater societal resilience.

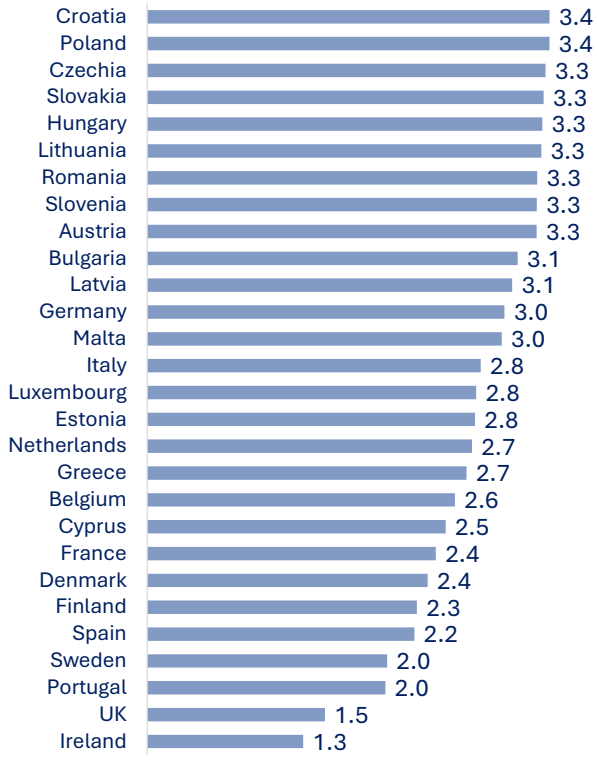


Figure 9. Temperature increase (in °C; with respect to 1951-1980 baseline), 2024 – *Source: TEHA on IMF data, 2025*

Air pollution is an **emerging Mental Health risk**, with studies showing that even modest **increases in fine particulate matter (PM2.5)** are associated with higher rates of depression and anxiety.

According to the scientific literature, long term exposure to PM2.5 particulate is linked to an **increase in the prevalence of depression of about 6%**[2].

In 2024, average annual PM2.5 exposure **varied widely across Europe**, from 4.2 µg/m^3 in Estonia to 15.1 µg/m^3 in Romania, with many Eastern and Southern European countries **showing the highest levels**.

These differences are not trivial: countries with higher **PM2.5 exposure could face significantly greater Mental Health burdens**, especially where long-term exposure intersects with other social or economic stressors.

The fight on climate change therefore increasingly **intersects with the promotion of good Mental Health** and can lead to shared benefits if adequately tackled.

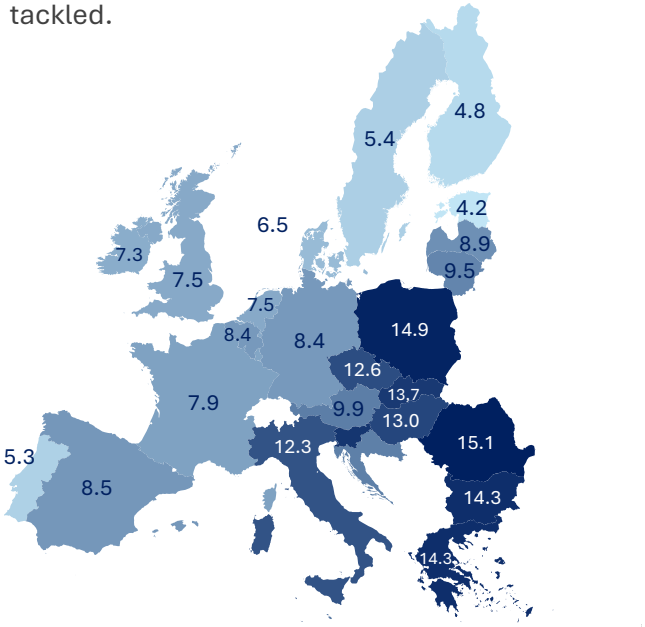


Figure 10. Air pollution (average annual PM2.5 exposure), 2024 – *Source: TEHA on EEA data, 2025*

[2] Zeng Y et al. (2019), "Ambient air pollution exposure and risk of depression: a systematic review and meta-analysis of observational studies". Psychiatry Research.

Overcrowding and poor housing conditions have been consistently linked to negative health outcomes, including mental illness. Research highlights that limited personal space correlates with a **greater risk of depressive symptoms** and psychological distress.

Beyond crowding, **broader housing quality** plays a critical role in **shaping mental wellbeing**. The effects of inadequate housing appear to be long-lasting: poor housing conditions leads to poorer Mental Health **even after relocation**.

Across the EU-27 and UK, both **housing quality and crowding differ significantly** by country. Poor housing conditions are particularly widespread in **lower-income Member States**, with **Romania** reporting **40.7%** of its population affected.

In contrast, overcrowding tends to be **more prominent in wealthier nations** where housing is more expensive. This suggests that both housing affordability and quality remain **critical levers for improving Mental Health** outcomes.

Mental Health status of the population

This area aims at **evaluating the outcomes related to the Mental Health** achieved by different European countries through different indicators:

- **Prevalence** (per 100,000 inhabitants) of depression, anxiety, schizophrenia, bipolar disorders, autism, attention deficit hyperactivity disorder - ADHD (for <20 years), conduct disorders (for <20 years) and intellectual disorders (for <20 years). It measures the proportion of a population with a specific characteristic in a given period;
- **Incidence** (per 100,000 inhabitants) of depression, anxiety, schizophrenia, bipolar disorders, autism, attention deficit hyperactivity disorder - ADHD (for <20 years), conduct disorders (for <20 years) and intellectual disorders (for <20 years). It measures occurrence of new cases of disease, over a specified time period;
- **Disability** measured in YLD (Years Lived in Disability) per 100,000 inhabitants of mental and behavioural disorders (general population and <20 years). It quantifies the burden of living with a mental disorder;
- **Age-standardized mortality rate** of mental and behavioural disorders and suicide. It measures mortality net of the demographic structure.

In 2023, Mental Health disorders affected an **estimated 16.5% of the population across the EU+UK**, reflecting a rising trend in Mental Health challenges in recent years.

Prevalence varies markedly by country, reaching nearly **1 in 4 inhabitants** in the **Netherlands**. Northern and Western European countries generally report higher rates, **likely due better reporting**, despite the adjusting ratios applied by the Headway Report.

Anxiety disorders are by far the **most prevalent category**, affecting **8.3%** of the population, followed by **depression** at **4.7%**. Together, these two conditions account for most of the Mental Health burden.

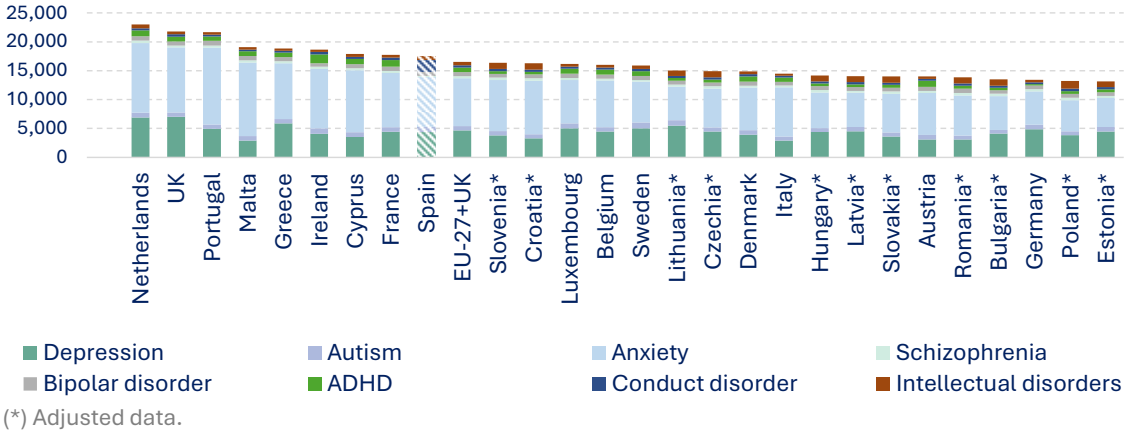
Years Lived with Disability (YLD) reveal a similarly uneven picture. The **UK** has the highest burden with **3,183 YLDs** per 100,000 inhabitants, while **Bulgaria** reports the lowest at **1,534**.

YLDs capture how long and severely individuals live with these conditions, offering a **measure of societal impact**.

Between 2021 and 2023, the overall prevalence of Mental Health disorders across the EU-27 and UK **increased by 514 cases per 100,000 inhabitants**.

This growth was primarily driven by a **substantial rise in anxiety disorders**, which surged by **1,440 cases per 100,000**. **Intellectual disabilities** also saw a notable increase in reported prevalence (**+285**), followed by a more modest rise in **schizophrenia** (**+43**).

Interestingly, the prevalence of depression declined during the same period, but **remained the second most prevalent disorder**. Smaller declines were also observed in **bipolar disorder** (**−213**), **ADHD** (**−159**), and **conduct disorders** (**−30**), highlighting a diverging trend across different Mental Health conditions.



(*) Adjusted data.

Figure 11. Prevalence of the main Mental Health disorders (per 100,000 inhabitants), 2023
– Source: TEHA on Global Burden of Disease data, 2025

These shifts underline the importance of **tailoring Mental Health strategies to emerging needs**, with anxiety taking centre stage as the fastest growing area of concern.

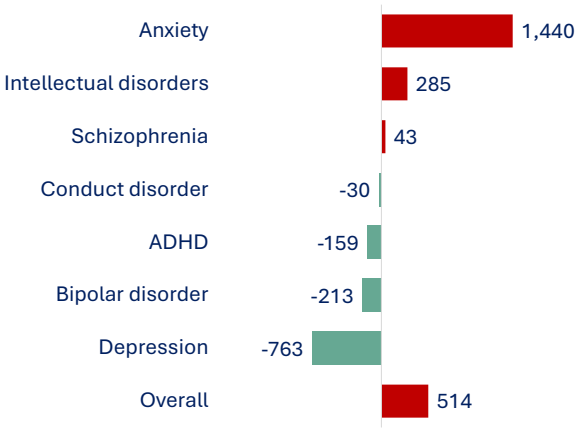


Figure 12. Changes in the prevalence of the main Mental Health disorders (per 100,000 inhabitants), 2021-2023 – *Source: TEHA on Global Burden of Disease data, 2025*

In 2022, nearly **270,000 deaths** in the EU-27 and UK were attributed to mental and behavioural disorders, **up from 177,000** a decade earlier, highlighting their rising burden and long-underestimated lethality.

Mental Health conditions are **often incorrectly perceived as non-lethal**, yet they directly contribute to mortality through suicide and severe neurodegenerative disorders.

Indirectly, mental illness significantly **increases the risk of premature death** by exacerbating chronic diseases like cardiovascular conditions, diabetes, and cancer.

This occurs through **poorer health behaviours,** delayed help-seeking, biological stress responses, and **reduced adherence to treatments**.

Standardized death rates vary widely across Europe, from **23.6 per 100,000** in **Slovenia** to **84.0** in the **UK**. The consistently higher death rates observed in countries like Germany, the Netherlands, and the UK may partly stem from **more robust diagnostic** and recording systems.

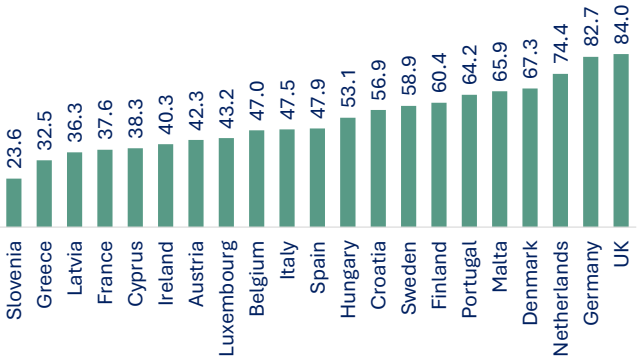


Figure 13. Standardized death rate of mental and behavioural disorders (per 100,000 inhabitants), 2022 – *Source: TEHA on Eurostat and ONS data, 2025*

In the EU-27+UK, suicide **remains a leading public health concern,** with **10.7** cases per 100,000 inhabitants and rates varying from **18.0** in **Lithuania** to just **4.5** in **Greece**. Eastern and Central European countries report the highest rates.

Men account for 76.3% of all suicide deaths, possibly due to stigma around help-seeking. While older adults (≥65) represent a significant share of suicides (34.1%), the majority of deaths occur among working-age adults (25–64), making up nearly 60% of cases.

Alarmingly, suicide is now the **leading cause of death among young people** aged 15–29 in Europe, according to recent data. The rise in youth suicide reflects a **growing Mental Health crisis** among adolescents and young adults.

The recent uptick in suicide rates across several EU countries follo**ws a brief period of decline**, with the reversal attributable to compounding social pressures, economic uncertainty, and **insufficient access to Mental Health support**.

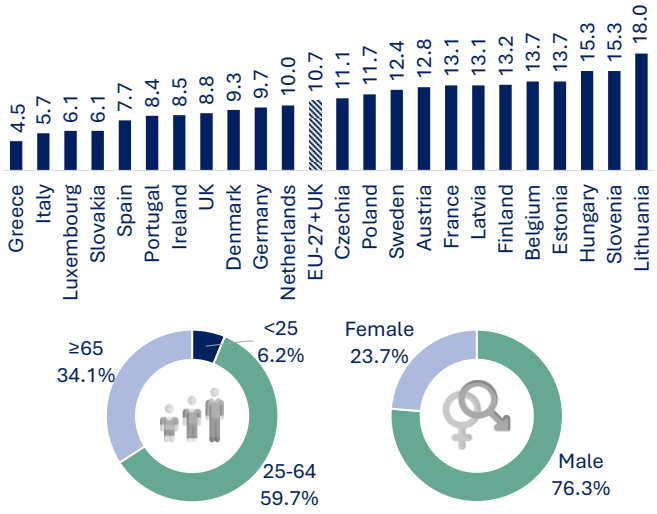


Figure 14. Top: Suicide rate (per 100,000 inhabitants), 2023. Bottom left: Suicides by age (in %), 2022. Bottom right: Suicides by gender (in %), 2022 – *Source: TEHA on Eurostat, Eurofound and OECD data, 2025*

Hospitalization for psychiatric disorders is a **critical period of vulnerability**. The risk of suicide remains elevated for many patients in the year following discharge. In 2023, **suicide rates post-discharge** ranged from **1.4 per 1,000** in the **UK** to **6.3** per 1,000 in **Slovenia**.

There is notable cross-country variation, pointing to **systemic differences in post-discharge support** and follow-up care. Countries like the UK and Denmark show relatively low post-discharge suicide rates, which may reflect **more effective community reintegration** and aftercare practices.

Overall, some progress has been made in reducing post-hospitalization suicide risk. Compared to 2013, **many countries have seen modest declines** in **suicide rates** within a year of discharge. However, in others, rates remain high and in some cases are growing.

The findings emphasize the need for **stronger continuity of care**. Transitioning from inpatient psychiatric care to outpatient or community-based support remains a necessity.

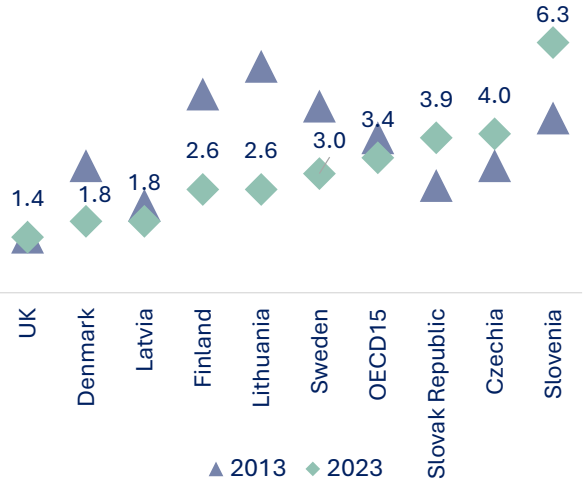


Figure 15. Suicide following hospitalisation for a psychiatric disorder, within one year of discharge (per 1,000 patients), 2013 and 2023 – *Source: TEHA on OECD data, 2025*

Responsiveness of the system to Mental Health needs in healthcare

The aim of this area is to assess the ability of healthcare systems to **improve current Mental Health outcomes** in the near future. The indicators considered are:

- **Availability of healthcare professionals** specialized in Mental Health (rate per 100,000 inhabitants) such as psychiatrists, child neuropsychiatrists, psychologists and nurses;
- **Availability of structural resources** for Mental Health at hospital and community level (rate per 100,000 inhabitants) such as hospital beds and number of facilities at community level;
- **Appropriateness of Mental Healthcare** such as hospitalizations, length of stay and psychological/psychiatric consultations, number of scientific publications;
- **Economic resources for Mental Health** measured as the % on total healthcare expenditure.

Some of the European countries lack data on some of the above-mentioned indicators, signalling a **major problem in monitoring the capacity to respond** to Mental Healthcare needs. Thus, in the analysis, estimates were made **based on available knowledge** of specific countries and based on the average performance of the EU27+UK countries.

Healthcare professionals **are the backbone** of any effective Mental Health system. Their availability and integration across services **directly influence access to timely diagnosis**, treatment, and long-term support

A clear East–North divide emerges from the data: countries such as Germany and Sweden **tend to have a higher concentration of psychiatrists** and psychologists, while most Eastern and some Southern countries **remain significantly underserved**.

The distribution of psychiatrists is **relatively more balanced across Europe**, reflecting institutional efforts to strengthen Mental Health infrastructure, while the availability of psychologists is **far more uneven**.

This divergence may signal that while health systems are **moving forward** in scaling psychiatric care, societal stigma toward Mental Health **continues to limit demand in many parts of Europe**.

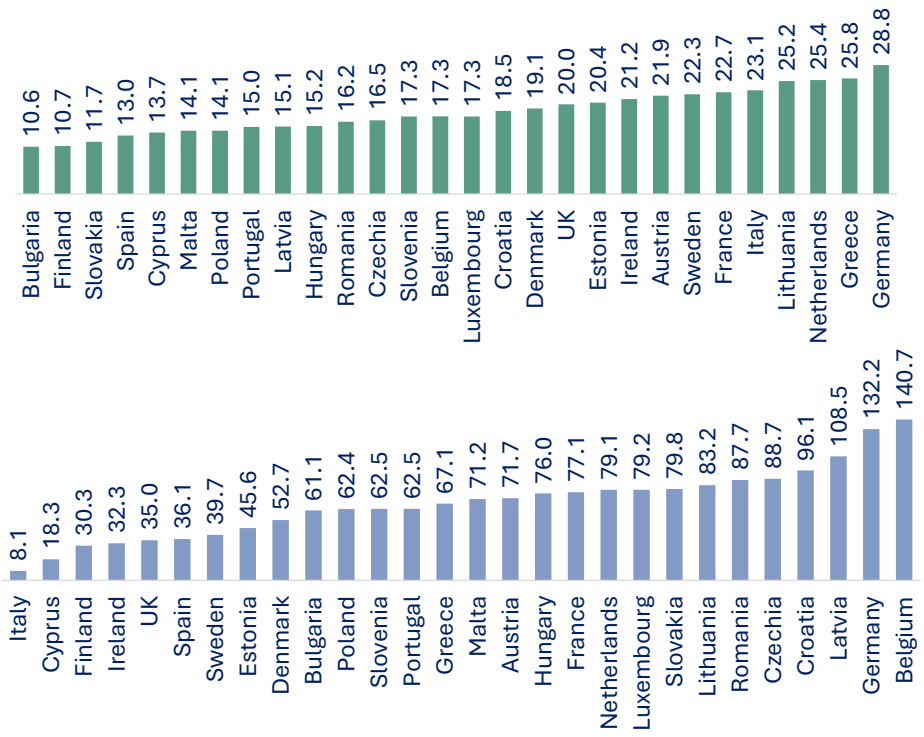


Figure 16. Top: Psychiatrists (per 100,000 inhabitants), 2022. Bottom: Psychiatric hospital beds (per 100,000 inhabitants), 2022
– Source: TEHA on OECD data, 2025

The number of psychiatric hospital beds varies widely across Europe, ranging from **8.1** per **100,000 inhabitants in Italy** to over **140** in **Belgium**. Such disparity reflects not only different levels of investment but also **different organizational models**, from hospital-centric to more community-based approaches.

Some of the countries with low bed availability have historically **prioritized deinstitutionalization** and community-based care. However, without sufficient outpatient infrastructure, this shift can **lead to care gaps**, especially for individuals with severe mental illnesses.

Conversely, high bed density may suggest a **continued reliance on institutional care**. While beds are essential for acute crises and severe conditions, **overemphasis on hospitalization** risks neglecting long-term rehabilitation, social integration, and preventive services.

Infrastructural adequacy also involves **geographic accessibility**: even countries with relatively high bed numbers may suffer from regional inequalities.

Future-oriented systems **must also account for digital infrastructure**, enabling scalable and equitable access to telehealth, digital screening, and follow-up care.

Due to its overall impact on health and productivity, **investing in Mental Health issues is paramount**. The allocation of these resources, however, varies considerably across EU states: **France** (**15.0%**), **Germany** (**11.3%**) and the **UK** (**10.3%**) are the principal investors, significantly exceeding the EU27+UK average of **5.7%**.

The results are likely to be **influenced by the overall healthcare system design**, cultural factors, varying data reporting across countries and lack of updated data.

Insufficient data production and collection in the field of Mental Health **present a major obstacle**, hindering the comprehensive understanding of Mental Health issues, **effective resource allocation**, development of targeted interventions, and evaluation of policy impacts.

Many OECD countries, in fact, **gather Mental Health data sporadically**, with more than half **experiencing gaps of 4 to 10 years** between survey rounds.

Additionally, available data from various countries are **often challenging to interpret** due to discrepancies in data collection methods, data quality, and differences in service definitions, especially **when associated with treatment outcomes**.

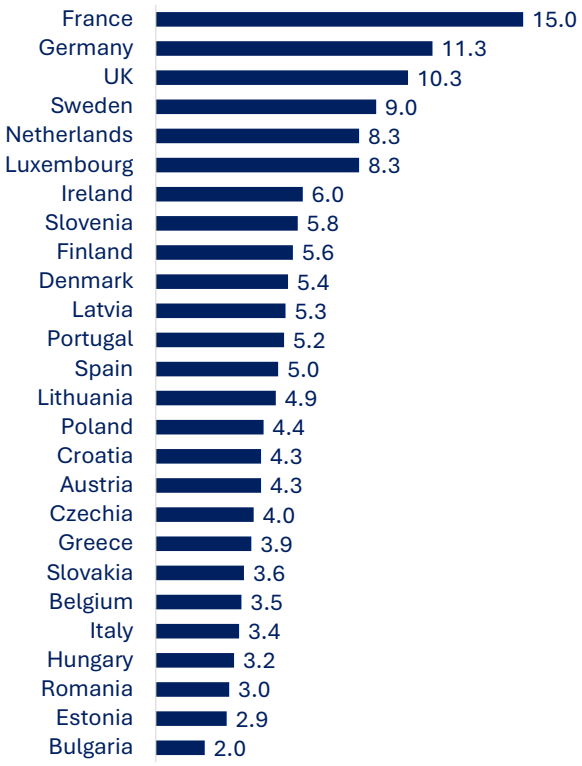


Figure 17. Economic resources (% of total healthcare expenditure), 2022 or latest available year – *Source: TEHA on WHO and other sources, 2025*

Government spending and investment in Mental Healthcare are **critical components of any strategy** that wishes to improve the Mental Health status of the population. The availability of psychologists and psychiatrists, the quality of care and the healthcare system's infrastructure are all **key in addressing the needs of the population**.

Once Mental Healthcare has reached a high level of quality, however, **additional spending on Mental Healthcare is subject to diminishing returns** in terms of marginal benefits to the population.

In other words, beyond a certain threshold, **increased funding may not necessarily lead to proportionate improvements** in Mental Health outcomes.

Beyond this threshold (point X in the graph), which is hard to quantify, Mental Health would therefore **benefit more from social expenditure** than from spending on Mental Healthcare. In fact, social expenditure **directly addresses the social determinants of Mental Health** (income, poverty, occupation…), which represent a heavy burden for many individuals with Mental Health issues.

Achieving optimal Mental Health outcomes thus **necessitates a balanced approach** that combines investments in Mental Healthcare and social expenditure.

Mental Health expenditure **remains low as a percentage of the total healthcare expenditure** in many countries, especially given that the Lancet Commission prescribed a level of at **least 10% for high-income countries** and **5%** for l**ow-medium-income countries**.

On average in Europe, **35%** to **60%** of this expenditure is used for **healthcare professionals**, while the rest is divided between pharmaceutical, non-pharmaceutical and other expenses.

On the other side, social protection in Europe comprises many public services, especially **supporting pensions** (**53%**), **sickness and disability** (**14%**) and **families** (**10%**). On average, in the EU-27+UK, countries spend **21.2%** of **GDP** in **social protection**.

Social services that are connected the most with Mental Health are **paid sick leave, disability, unemployment benefits** and **pensions**, as well as mental-health-related governmental programs.

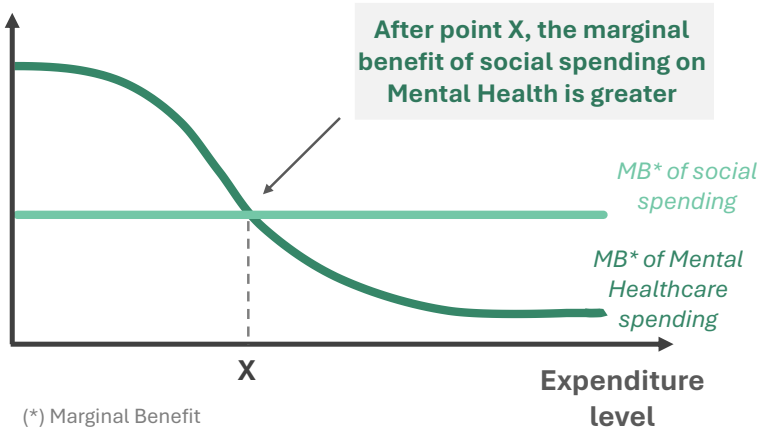


Figure 18. Relationship between expenditure on social services and Mental Healthcare and its MB* to the Mental Health status of the population – *Source: TEHA, 2025*

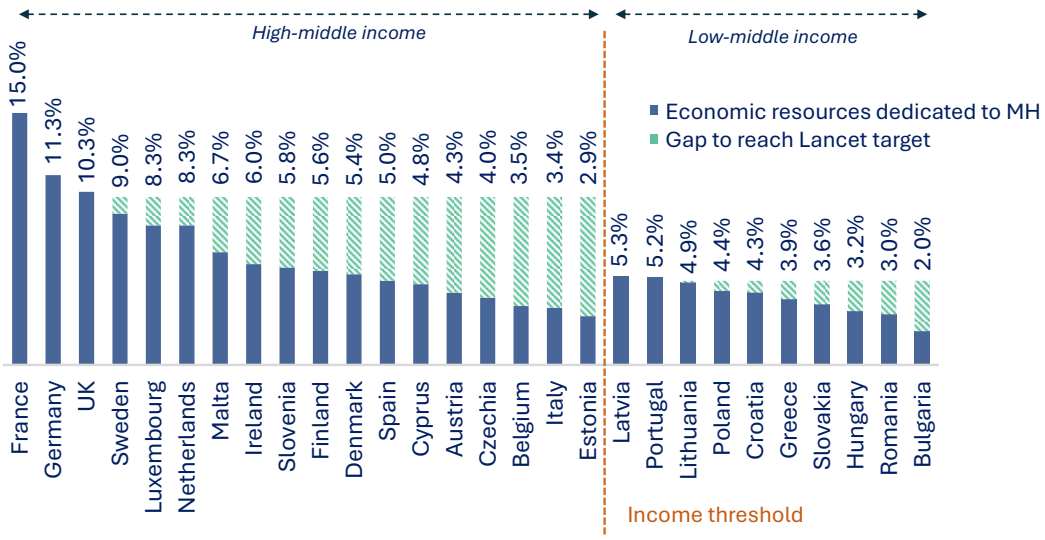


Figure 19. Economic resources dedicated to MH and gap to the Lancet target (% of total healthcare expenditure), 2022 or latest available year – *Source: TEHA on OECD data, 2025*

Mental Health remains significantly **under-researched relative to its burden**: while over **2,000** clinical trials are currently ongoing in oncology, **only 177 target Mental Health** conditions across the EU.

Depression dominates the clinical research landscape in Mental Health, accounting for **nearly half** (**84** out of **177**) of all trials. Other conditions like **schizophrenia** (**39**), **anxiety** (**23**), **bipolar disorder** (**18**), and **ADHD** (**11**) receive comparatively less attention.

Scientific output on psychiatry and Mental Health is **highly uneven across countries**. Denmark leads with **14.2 publications per 100,000 inhabitants**, while **Romania** and **Bulgaria** register fewer than **1**.

This disparity in research intensity may **reflect broader structural imbalances**, such as disparities in funding availability, institutional capacity, and stigma around Mental Health.

Closing the Mental Health research gap is **critical for improving diagnosis**, treatment options, and the integration of evidence-based care into healthcare systems across Europe.

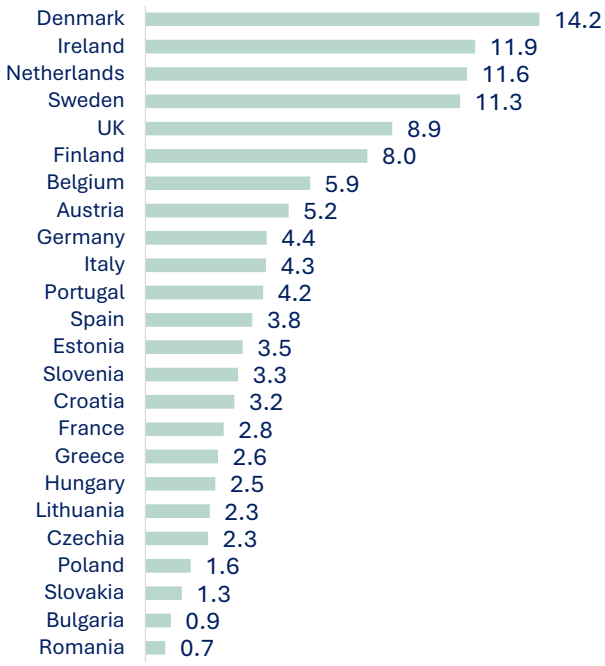


Figure 20. Scientific articles on psychiatry and Mental Health (per 100,000 inhabitants), 2024 – *Source: TEHA on Scimago data, 2025*

Responsiveness to the needs of individuals with Mental Health disorders in workplaces, society and schools

The aim of this area is to **assess the responsiveness of the systems** to the needs in work, schools and society of people with Mental Health disorders.

Workplaces:

- **Employment situation** of people with MHP such as lost work productivity and employment rate;
- People with MHP receiving illness and **unemployment benefits**;
- The **satisfaction of workers** with their job in terms of work-life balance and the overall level of fairness and support in the workplace;
- **Existence of Mental Health promotion programmes** in the workplaces to raise awareness and fight stigma.

Society:

- Social support evaluated through the **number of social workers**, social support received and **availability of residential** and semi-residential centres;
- People receiving **social disability benefits**;
- Existence of **Mental Health promotion programmes** outside of the working and educational environment.

Schools:

- the overall responsiveness is assessed by monitoring the **rate of day centres for young people** with a mental disorder, the percentage of **youth with mental disorders dropping out of school** and the existence of Mental Health promotion programmes in schools.

Various European countries lack data on some of the KPIs taken into account.

The economic burden of Mental Health disorders in Europe is estimated to **exceed 4% of GDP**, or **over €600 billion annually**.

These costs encompass direct healthcare expenditures amounting to **€190 billion**, social security costs of **€170 billion**, and indirect productivity losses of **€240 billion**.

These high costs have a bright side: the analysis conducted for the **Headway Mental Health Index 4.0** report found a **Return on Investment (ROI)** of Mental Health interventions **equal to 4.5**. In other words, every **€1** invested in Mental Healthcare returns **€4.5**.

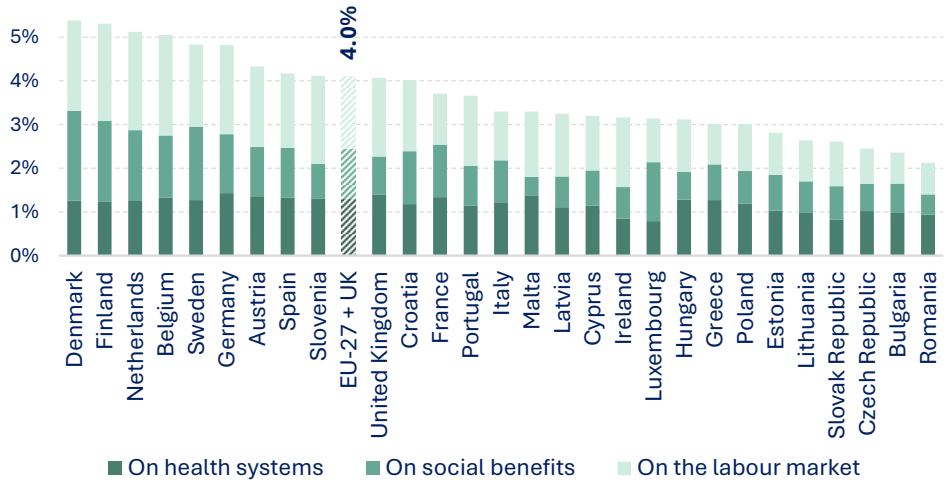


Figure 21. Direct and indirect costs of Mental Health disorders in Europe (% of GDP), latest data available – *Source: TEHA on OECD data, 2025*

The employment rate for people with Mental Health conditions is **23 p.p. lower than for the general population**, standing at just **42.7%**.

According to the literature, individuals with stress-related mental disorders were **more likely to rely on sickness** and unemployment benefits, and to experience long-term wage loss. Studies show that affected individuals **spend 30 more weeks** on **sick leave benefits annually** and faced a risk of long-term unemployment nearly twice as large as the general population.

Furthermore, it has been observed that individuals with Mental Health conditions are **often marginalized in the labour market**, experiencing higher rates of absenteeism, low wages (**about 30% lower according to the OECD**), and early exit from employment. This limits access to stable incomes, career opportunities, and associated benefits.

The economic marginalization of people with Mental Health conditions **often leads to financial instability**, increased reliance on social welfare programs, and reduced quality of life. Moreover, the lack of meaningful employment can **negatively impact self-esteem** and social inclusion.

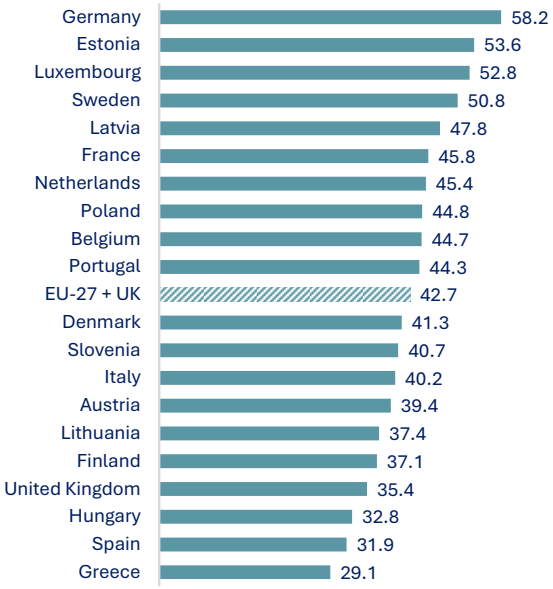


Figure 22. Employment rate of people with severe mental distress in EU27+UK (% of total population aged 25-64), latest data available – *Source: TEHA on OECD data, 2025*

Workplaces impact the Mental Health status of both general population and those with diagnosed mental conditions. Employees experiencing **adverse social behaviour or discrimination** at work report lower mental well-being and higher levels of anxiety, exhaustion, and other negative health outcomes compared to those who did not face such risks.

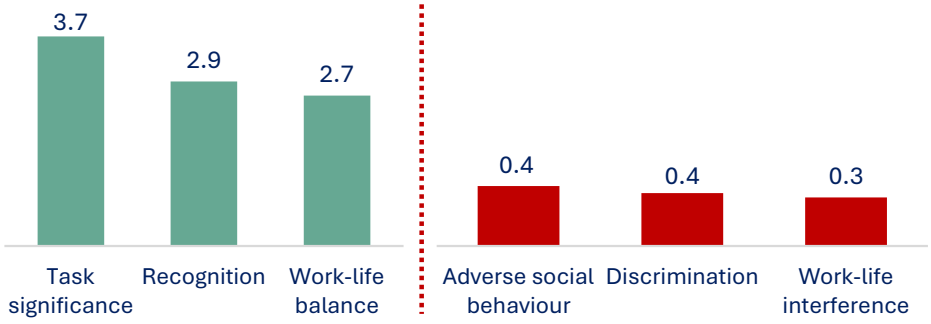
On the other side, **task significance, recognition and work-life balance** have the largest positive effects on workers and can mitigate the negative effects of psychosocial risks, thus **contributing to better mental well-being** and engagement.

Mental Health problems related to workplace psychosocial risks **have significant societal and economic implications**, such as loss of productivity and absenteeism.

For instance, in **Germany**, absences due to mental illness **increased by 41% over 10 years**, reaching a record high in 2021.

There is a need for EU-level initiatives to **address psychosocial risks**, as proposed by the European Commission's communication on a comprehensive approach to Mental Health in June 2023.

Childhood represent a critical time **both for the promotion of well-being** – at least 50% of Mental Health disorders **debut before the age of 15 and 80% of the latter before 18** – and the formation of skills that prepare students for their work life. Taking into consideration the considerable amount of time spent there by children, schools are therefore **key to the development of good Mental Health** of future adults.



Explanatory note: A ratio of 1 indicates no effect between the variable and mental wellbeing. Above 1, there is a positive effect (e.g. recognition improves mental wellbeing), while values below 1 indicate a negative effect of the variable on mental wellbeing

Figure 23. Main factors affecting mental wellbeing in the workplace (odds ratios from a logistic regression analysis), 2021 – *Source: TEHA on Eurofound data, 2025*

European data, however, shows alarming statistics: about **20% of children experience Mental Health problems** during their school years, and **1 in 5 children report growing up unhappy** and anxious about the future due to bullying, challenges with schoolwork and loneliness.

Research indicates that **incorporating socio-emotional learning**, Mental Health, well-being and **bullying prevention** programs in schools is one of the most effective ways to **support the psychological well-being of children** and young people, including those experiencing disadvantage and marginalization.

Addressing learners' well-being is also **key to raising educational outcomes**. Scientific research, in fact, shows that the onset of Mental Health conditions such as depression and anxiety are **linked with decreased school performance**: mental illness may cause some students to perform poorly or drop out of school.

Teachers are also concerned: in Europe, **24% of teachers** report that their job has a negative impact **on their Mental Health**, and **22% report the same** in relation to their **physical health**.

Beyond health services, social benefits are key mechanisms **through which Governments provide support**.

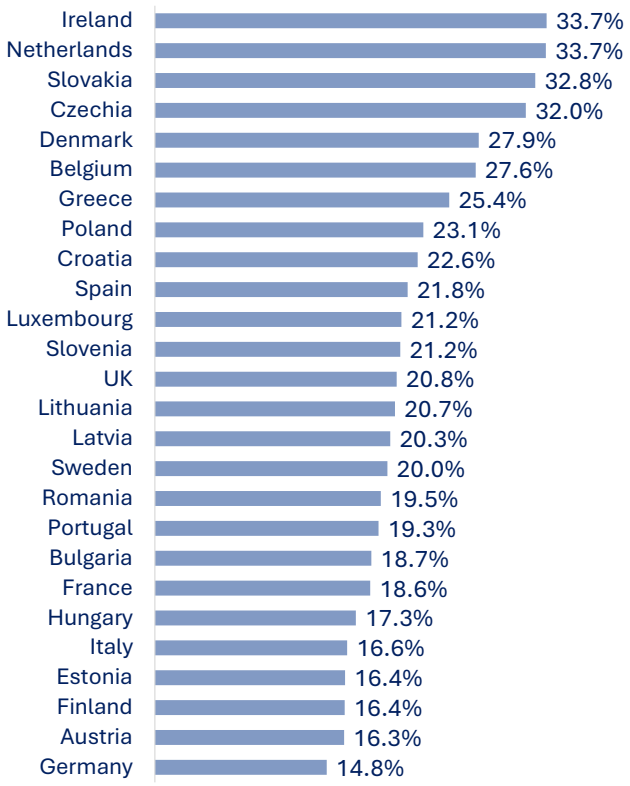


Figure 24. School dropouts due to Mental Health disorders (% of total dropouts), latest available data – *Source: TEHA on Eurofound data, 2025*

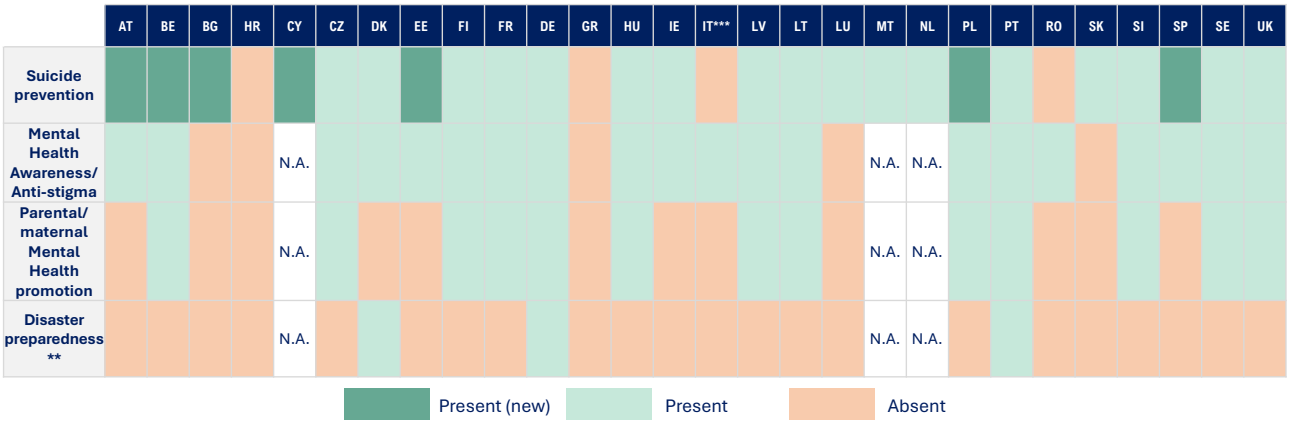
Social support is **mediated by many services**, one of them being the paid sick leave benefits for Mental Health. Having high levels of paid sick leave is correlated with a **general lower levels of poor perception of social support**, showing that workers might be giving high importance to paid sick leave when evaluating the social support they receive.

Countries like **Austria**, **Ireland**, **Cyprus and** Spain report the lowest level of poor perception of social support among the population, while offering **top-tier paid sick leave benefits** for Mental Health.

A growing body of research **analyse the institutional structures** and social determinants of health, highlighting the **potential of paid sick leave** to improve behavioural health.

A recent study from US showed that workers without paid sick leave experience **significantly higher levels of psychological distress** and are 1.45 times more likely to report that their distress severely interferes with their daily lives compared to those with paid sick leave.

The responsiveness to Mental Health needs in society has been assessed also by **looking at the existence of national strategies** and programmes focusing on Mental Health promotion and prevention. According to the last **WHO Mental Health Atlas data,** a mapping of the existent functioning programmes has been conducted along different dimensions, including **suicide prevention, anti-stigma campaigns**, etc.



(*) The analysis takes into consideration only programs with dedicated financial & human resources; a defined plan of implementation and documented evidence of progress and/or impact.
(**) Plans and actions to safeguard Mental Health and tackle the psychosocial aspects after natural or human disasters (e.g., tsunami, war, ...).
(***) In June 2022, to fill the regulatory gap, Italy passed a motion committing the Government to adopt a national suicide prevention plan.

Figure 25. Presence of programs for Mental Health promotion and prevention in society, 2025 or latest available data – *Source: TEHA on WHO data, 2025*

Results of the «Headway - Mental Health Index 5.0»

The **final results** of the **"Headway – Mental Health Index 5.0"** are summarized in the graph:

- The **responsiveness of the system to healthcare needs** and to needs in workplaces, schools and society are displayed on the x-axis and y-axis, respectively.
- The dimension of the bubbles shows the **Mental Health status of the population** and the bubbles' colour shows the performance of the **determinants**.
- This elaboration shows a **positive correlation** between the responsiveness in the healthcare system and the responsiveness in **workplaces, schools and society**, indicating that progress goes together in these areas, perhaps due to government intervention.

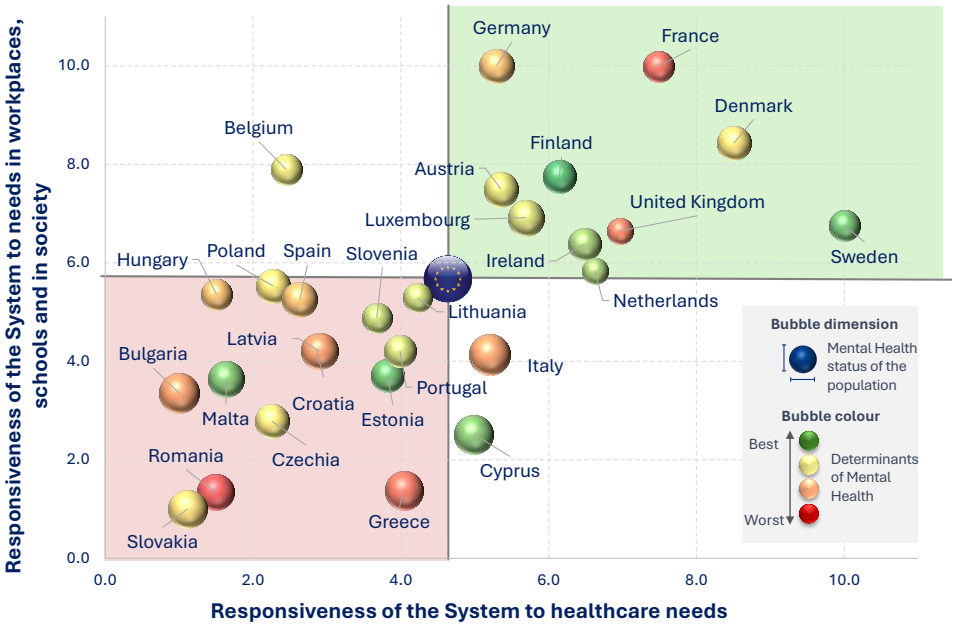


Figure 26. Results of the «Headway - Mental Health Index 5.0» – *Source: TEHA, 2025*

Compared to the first edition of Headway, in 2021, the Mental Health status of the population has **improved slightly at EU-27+UK level**, with a **0.5 points increase**. However, this average masks high heterogeneity. While there is **no clear geographical pattern** in the country-level score variations, Eastern European countries such as **Latvia** (**+2.7** points), **Bulgaria** (**+2.7**) and **Lithuania** (**+2.2**) have improved substantially.

The responsiveness of healthcare systems presents a more concerning picture. On average, the EU-27+UK score **declined by 0.3 points**. Only a handful of countries, such as **France** (**+1.8**) and **Luxembourg** (**+1.5**) show measurable improvements, while several countries with already mature systems, like the **Netherlands**, saw noticeable drops.

The dimension assessing the responsiveness of broader societal systems **is the most dynamic**. **Poland, France, and Hungary** registered particularly large gains, suggesting strong efforts to mainstream Mental Healthcare **outside clinical settings**.

Interpretation of score changes **must be nuanced**. A drop in a country's score may not mean a real deterioration in services. Instead, it may reflect **faster progress by other countries**.

Overall, the data **suggests growing divergence**: while some countries are making significant strides in integrating Mental Health into policy and practice, **others risk falling behind**.

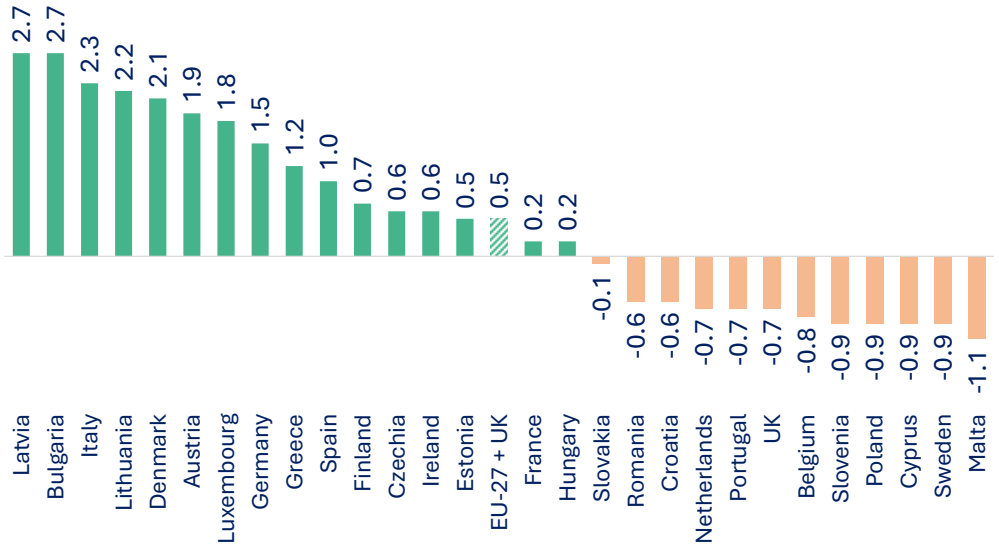


Figure 27. Mental Health status of the population (final score var. HMHI 2025 vs. HMHI 2021) – *Source: TEHA, 2025*

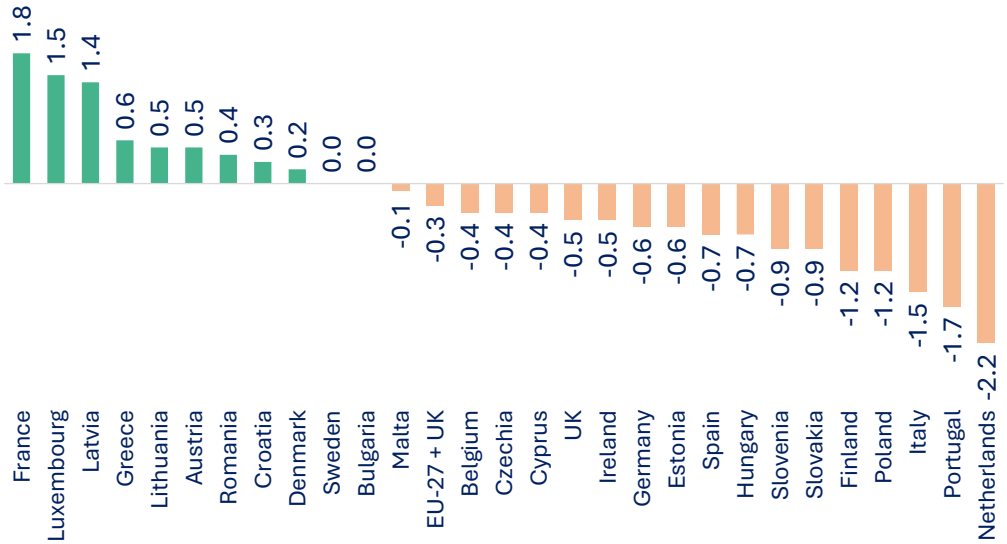


Figure 28. Responsiveness of the healthcare system to Mental Health needs (final score var. HMHI 2025 vs. HMHI 2021) – *Source: TEHA, 2025*

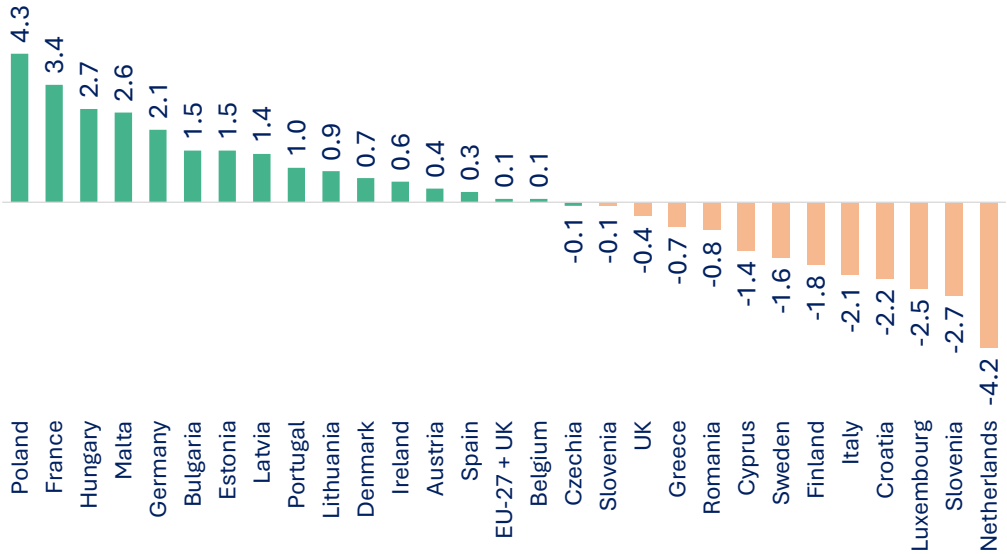


Figure 29. Responsiveness of the system to Mental Health needs in schools, workplaces and society (final score var., HMHI 2025 vs. HMHI 2021) – *Source: TEHA, 2025*

3. The value of informal caregiving in Mental Health

Informal and unpaid caregivers play an **indispensable yet often invisible role** in supporting people with Mental Health conditions. As formal care systems face increasing strain, **informal caregiving fills critical gaps**. However, this contribution remains largely **unrecognized in national accounts**, leading to a chronic underestimation of both its human and economic weight.

The analysis conducted aimed to **correct for this invisibility** by assigning an economic value to unpaid Mental Health caregiving. This is crucial for three reasons:

- **Policy Visibility and Investment Rationale:** Mental Health systems are underfunded compared to physical health domains. Quantifying the economic value of unpaid care highlights the scale of informal contributions and underscores the societal cost of neglecting this sector. It strengthens the case for increased public investment in Mental Health services and caregiver support.
- **Equity and Care Burden Recognition:** Unpaid caregiving is disproportionately performed by women, often at the expense of their own economic, social, and health outcomes.
- By measuring the monetary value of this care, we make visible the inequitable distribution of care burdens and create a basis for social protection measures, such as caregiver allowances or pension credits.
- **Health System Planning and Reform:** Recognizing the scale of unpaid caregiving allows policymakers to better understand how health and informal social care systems truly operate. Unpaid care is not a peripheral supplement but a central component of European care systems. Any attempt to redesign Mental Health services must account for this informal infrastructure and plan accordingly, whether through respite services, integration with formal care, or hybrid care models.
- Informal caregivers represent **17% of the EU-27 + UK total population**. This figure reflects the widespread reliance on informal networks to support dependent individuals, including those with Mental Health conditions.

Women are significantly overrepresented in caregiving roles (**20% of women** are caregivers vs. **15% of men**). This persistent gender imbalance underscores the **unequal distribution of unpaid labour**.

Caregiving is most concentrated in working life, with **21.2%** of **individuals aged 35–64** identified as **informal carers**, the highest share among all age groups. This is followed by **18.4% in the 65+ cohort** and **12.3% among young adults** aged 18–34.

Mental Health disorders are a **major driver of informal caregiving**, cited as a reason for care in **nearly 48% of cases**, placing them alongside chronic physical and cognitive conditions.

Care recipients often live with **multiple overlapping conditions**. This highlights the complex, multi-dimensional nature of caregiving, where Mental Health needs **frequently intersect with physical**, neurological, or age-related impairments.

Alcohol and substance addiction, while cited less frequently (**3.3%**), remains a critical concern due to its strong association with underlying or co-occurring Mental Health conditions.

Mental Health is central to caregiving and is often **entangled with other chronic** and disabling health issues that shape the scope and burden of informal care.

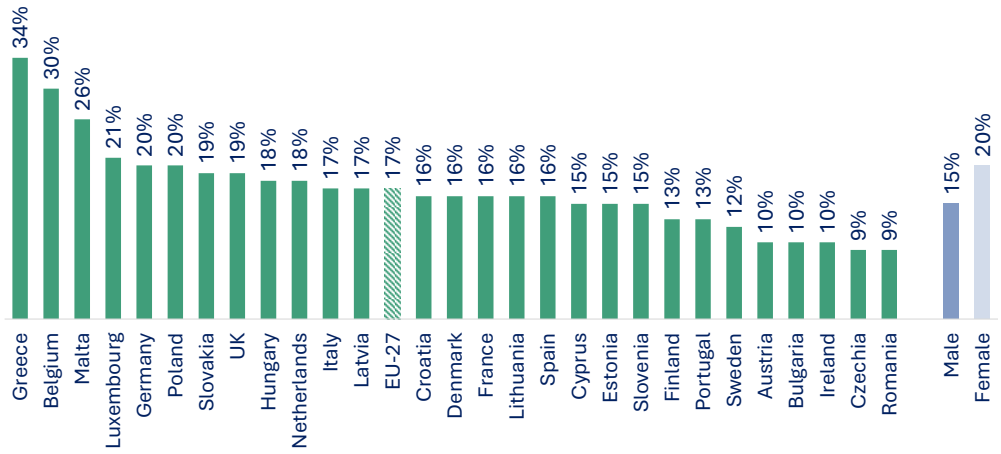


Figure 30. Informal carers (% of total population), 2016 – *Source: TEHA on European Commission data, 2025*

A dedicated model was developed to **estimate the economic value of unpaid Mental Health caregiving** across the EU-27 and the UK, using country-specific data on caregiver prevalence, time spent caregiving, and GDP per hour worked.

The formula accounts only **for working-age caregivers (18–64)**, applying a correction factor to focus on those most likely to experience opportunity costs in terms of lost productivity.

The model approximates the **economic value not accounted for** in traditional models, which only account for the value of market transactions.

The total estimated value of informal Mental Health caregiving **is €214.3 billion**, equivalent to **1.0% of the combined GDP** of EU-27 and the UK, a substantial contribution that remains **largely invisible in national accounts**.

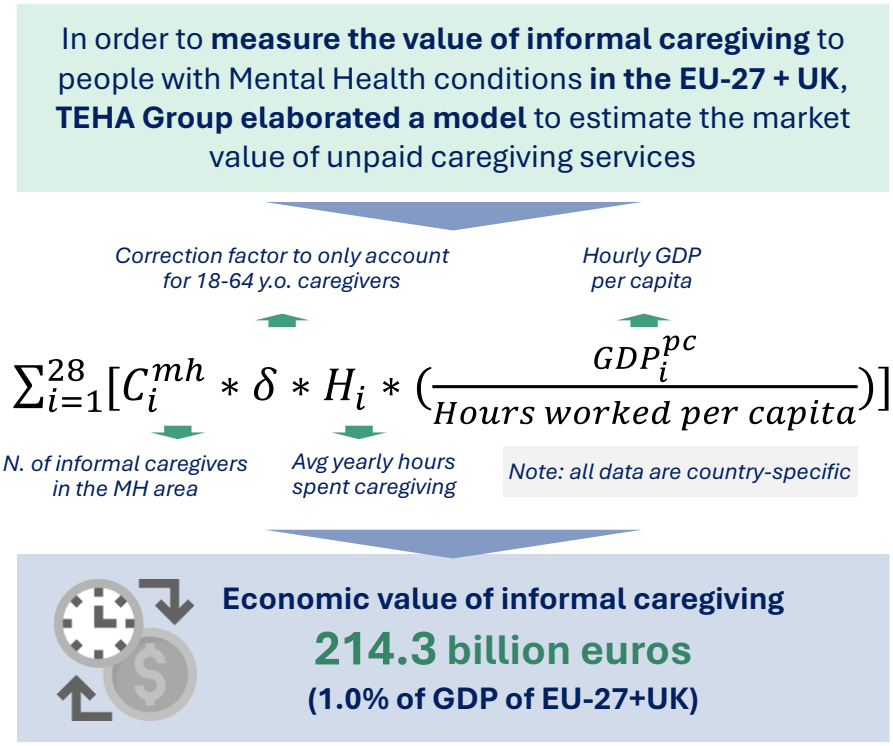


Figure 31. Economic value of the social production of caregivers in the Mental Health sector throughout EU-27 + UK countries – *Source: TEHA on Eurostat, European Commission, Eurocarers, OECD and ONS data, 2025*

The economic value of informal caregiving in the Mental Health sector **varies widely across countries**, from **0.3% to 1.5%** of GDP in 2025.

This variability is shaped by several structural factors, including demographic composition, cultural norms, and the **level of investment in formal long-term care** (LTC) systems.

For example, the Netherlands, which allocates the **highest share of GDP to formal LTC** among OECD countries, shows one of the **lowest economic values of informal caregiving** (**0.6%**).

On the other side, **Greece**, where investment in formal LTC is the lowest, **registers the highest value** (**1.5%** of GDP).

This underscores the extent to which families and communities **step in to fill systemic care gaps**, with countries without access to formal infrastructure for Mental Health and LTC registering a **heavier burden on unpaid caregivers**.

Informal caregiving also has a **clear impact on paid employment,** with many workers adjusting their professional lives to accommodate care responsibilities.

This in turn implies **significant costs for the wider economy**.

The most common impacts include **changing work schedules** (**18.3%**) and **seeking flexible arrangements** (**15.6%**), revealing a widespread need for adaptable working conditions among carers.

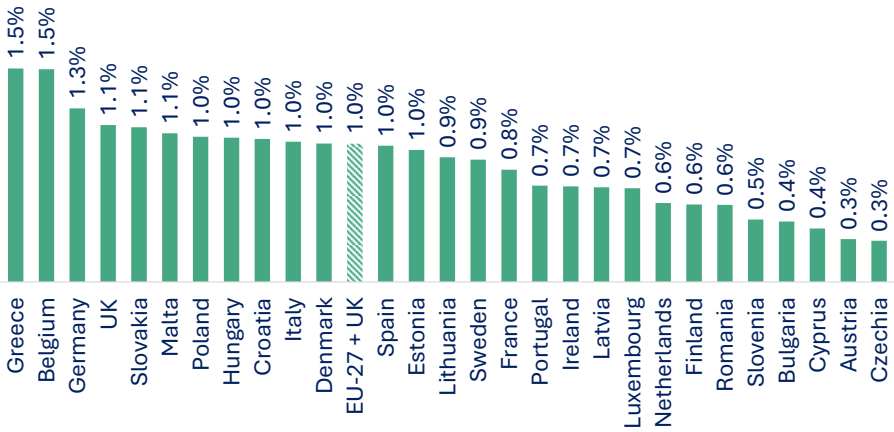


Figure 32. Economic value of informal caregiving (% of GDP), 2025 – *Source: TEHA on Eurostat, European Commission, Eurocarers, OECD and ONS data, 2025*

Almost **1 in 10** extend time out of the workforce, and nearly **5% are forced to leave their job entirely** due to caregiving demands, mostly women.

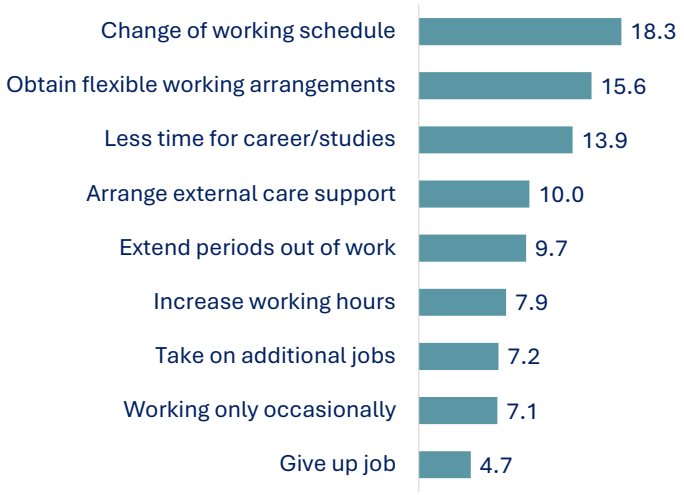


Figure 33. Informal carers in the EU-27 in paid work reporting implications of caring responsibilities on their working life (in %), 2022 – *Source: TEHA on Eurofound data, 2025*

These findings underscore the **economic and gendered toll of unpaid care**, reinforcing the need for workplace policies and public support systems that reduce their burden.

Informal caregiving, **especially when sustained over long periods**, places individuals at high risk of Mental Health distress, including depression and anxiety.

A 2019 meta-analysis of 84 studies found that **32% of informal carers experienced depression**, compared to **16% of non-carers**.

Moreover, **24% of carers** suffered from **anxiety**, compared to **14% among non-carers**, highlighting the emotional toll caregiving can exact.

These figures reflect not only the chronic stress of supporting others, but also the **social isolation, interrupted employment**, and **emotional burden** that often accompany caregiving, particularly in Mental Health contexts.

Without adequate support, informal caregivers face a **substantial threat to their own mental well-being**, underlining the importance of targeted psychological services and systemic relief measures.

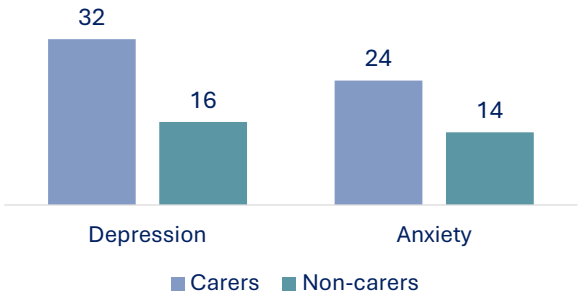


Figure 34. Prevalence of Mental Health disorders (% of reference population), 2019 – *Source: TEHA on Pinquart M et al. (2019), "Differences between caregivers and non caregivers in psychological health and physical health: A meta-analysis" and Eurocarers data, 2025*

The European Care Strategy (2022)

The **European Care Strategy**, launched in 2022, is built on two pillars: a proposal for a Council Recommendation on early childhood education and care, and another on long-term care.

The Recommendation on LTC, published in December 2022, calls on Member States to **develop national action plans** that make care services more timely, comprehensive, and affordable, ensuring that individuals with long-term needs, including Mental Health conditions, **can maintain a good standard of living**.

Mental Health is prioritized by encouraging a **broader mix of professional care services** (home, community, and residential), many of which support individuals with psychiatric needs.

Emphasis is placed on **supporting informal carers**, who are predominantly women and family members. Member States are urged to **provide training, counselling, psychological** and financial **assistance**, and to ensure carers are not left to shoulder the burden unsupported.

To achieve these goals, the Recommendation calls for **mobilizing funding for LTC**, leveraging national budgets as well as EU-level resources to invest in infrastructure, digital tools, and **care workforce development**.

Figure 35. European Care Strategy, 2022 – *Source: TEHA on European Commission data, 2025*

Unpaid and informal caregiving in the Mental Health sector: policies to support informal caregivers

Informal caregivers supporting individuals with Mental Health conditions need a **coherent system of support** that goes beyond recognition and **addresses their practical, financial, and emotional needs**.

Legal frameworks should **formally acknowledge their role** and provide pathways to compensation or mixed employment. Access to **respite services**, day programs, and home care assistance helps **reduce pressure and share responsibility** with formal care systems.

Support groups and peer networks are essential, particularly in the **emotionally demanding context of Mental Health**.

Caregivers also require **flexible leave** and **employment protections** to remain in the workforce. Crucially, their own health must be safeguarded through **access to regular checkups** and Mental Health services.

Strengthening these supports is essential not just to protect caregivers themselves, but to **ensure the sustainability** of Mental Health care systems.

Recognition	Policy	**Employment & income**	Direct employment
	Legal frameworks		Mixed employment
Formal care support	Respite care		Allowances
	Day care	**Social connections**	Support groups
	Home care assistance		Peer support
Social protection	Employment protection	**Physical & Mental Health**	Health checks
	Leave entitlement & flexibility		Mental Health support

Figure 36. Key policy areas to support informal caregiving in Mental Health - *TEHA on Eurofound data, 2025*

4. Key takeaways

Mental Health disorders are **becoming increasingly prevalent**, especially among **younger generations**. The latest data confirm a clear generational shift, with prevalence rates now peaking in adolescent and young adult age groups. This trend poses a **serious concern given the long-term implications for individuals' life prospects** and the sustainability of healthcare and welfare systems

Resources must be **targeted to where they are most needed**. Children, adolescents, people in poverty, those in remote areas, and socially excluded groups remain **disproportionately affected and underserved**. Tailoring interventions to these populations will deliver the highest impact in terms of equity and long-term cost-effectiveness

Proactivity is essential in meeting Mental Health needs. Unlike many physical conditions, Mental Health issues **often go unreported or unrecognized**. Systems must therefore pivot **from a reactive model to a proactive one focused** on prevention, early identification and outreach, particularly through schools, workplaces, and community-based platforms

Informal and unpaid caregivers play an indispensable role in the Mental Health ecosystem. Their contribution, often unrecognized, holds **considerable social and economic value**, equal to over **214 billion euros in EU-27 + UK countries, or 1% of GDP**. Supporting caregivers through training, respite services, or financial aid is not only an ethical imperative but also a strategic **investment in societal resilience**

Mental Health is shaped not only by healthcare quality but also by **individual, environmental, social, and economic factors**. Effective Mental Health strategies therefore require a holistic and multidisciplinary approach - **grounded in a "Mental Health in all policies" perspective** - to ensure that actions across sectors collectively support **improved mental wellbeing of the population**

After a period in which Mental Health had gained **increasing visibility within European health strategies**, current shifts in the policy landscape — including emerging priorities in areas such as defence — may inadvertently reduce the attention devoted to this issue. It is therefore crucial to maintain the progress made so far. Losing momentum at this **stage could weaken the advances achieved in recent years**, with potential implications for wellbeing, social cohesion, and economic growth

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Sitography

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TEHA Group – www.ambrosetti.eu

Notes

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Thank you for taking the time to read this Report. If you have any questions or would like to discuss our findings further, please contact TEHA Healthcare Practice at **healthcare@ambrosetti.eu**