POLICY BRIEF
September 2025

FEPS
FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES

HEALTHY MINDS, STRONGER EUROPE: PROGRESSIVE SOLUTIONS FOR MENTAL HEALTH AND WELLBEING IN EUROPE

ABSTRACT

Deteriorating mental health has emerged as one of the defining challenges for Europe and its citizens in the 21st century. The COVID-19 pandemic, growing digital pressures, precarious labour conditions and the rising problem of addictive behaviour have underscored the urgency of a comprehensive European strategy. This policy brief demonstrates that mental health is not just a health sector issue, but a cross-cutting priority affecting productivity, social cohesion and resilience of both individuals and our society. The analysis reviews EU policy evolution, highlights progress with the 2023 Commission communication and identifies gaps where European action is most needed. Three key domains are explored: workplace wellbeing and mental health; impact of digital technologies on mental health; and the link between addictions and mental health. Each issue is also addressed through a gender-sensitive approach. Context, existing evidence, best practices and analysis are highlighted. Recommendations are presented under each headline. The policy brief concludes that the EU must advance a comprehensive mental health strategy, mainstreaming mental health into policies, supporting prevention and early intervention, introducing adequate monitoring practices, regulating harmful practices, and fostering coordination through a harm-reduction lens.

AUTHORS

TOMÁŠ PETŘÍČEK
Senior Non-resident Fellow at Institute of International Relations and Director of Progressive Analytical Centre

JANA MICHAILIDU
Assistant Professor,
University of Chemistry and Technology Prague;

AIDA BIKIC
Associate Professor, PhD, Psychologist,
University of Southern Denmark

SARA BOJARCZUK
Assistant Professor, University of Warsaw

IN PARTNERSHIP WITH

PAC
Progresivní analytické centrum

institute for rational addiction policies

Policy Brief published in September 2025 by

FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES (FEPS)

European Political Foundation - Nº 4 BE 896.230.213
Avenue des Arts 46 1000 Brussels (Belgium)
www.feps-europe.eu
@FEPS_Europe

Progresivní analytické centrum (PAC)

Nuselská 262/34
Nusle, 140 00, Praha 4, Czech Republic
www.progresivnicentrum.eu
@ProgresivniC

Institute for Rational Addiction Policies

Hilleho 1842/5
602 00, Brno, Czech Republic
https://addiction-policy.eu/en
@IRAP_ThinkTank

This policy brief was produced with the financial support of the European Parliament. It does not represent the view of the European Parliament.

Copyright © 2025 by the Foundation for European Progressive Studies,
Progresivní analytické centrum (PAC) and Institute for Rational Addiction Policies.
Content editor: François Balate, Policy Analyst on Social, FEPS
Copy editing: Rosalyne Cowie
Design: Triptyque
Cover photo: Shutterstock/Melitas
Legal deposit registration number: D/2025/15396./34
ISBN number: 978-2-39076-039-9

Suggested citation

Petříček, T; Michailidu, J; Bikic, A; Bojarczuk, S. (2025). “Healthy minds, stronger Europe: Progressive solutions for mental health and wellbeing in Europe”. Policy Brief, Foundation for European Progressive Studies, Progresivní analytické centrum (PAC), Institute for Rational Addiction Policies, Brussels.

TABLE OF CONTENTS

ACKNOWLEDGEMENT OF CONTRIBUTORS

FEPS would like to thank the members of the FEPS Expert Group on Mental Health and its coordinators for their valuable insights in the development of this policy brief: Aida Bikic, Antonio J. M. Fernández, Dimitra Theodori, François Balate, Hannes Jarke, Helena Gherasim, Jana Michailidu, Jiří Sedlář, Julia Wild, Laeticia Thissen, Ludmila Raskova, Mie Oehlenschläger, Monty Aal, Raluca Stana, Sara Bojarczuk, Sonia Nawrocka , Sophie Prober, Teodora Ciolompea, Tomáš Petříček, Viktor Mravcik, Virginia Mahieu, Xheimina Dervishi.

1. Introduction

The European Union (EU) has long acknowledged the importance of mental health – through initiatives like the 2005 Green Paper on Mental Health and the 2008 European Pact for Mental Health and Well-being.[1] However, the urgency of the matter has intensified in recent years. The COVID-19 crisis starkly revealed gaps in services and heightened psychological distress across the EU, triggering an acceleration of political engagement.[2] Even before the pandemic, mental ill-health exacted an economic toll of approximately 4% of EU GDP.[3] In response, the 2022 State of the European Union address emphasised mental health as a core public health and socio-economic priority requiring coordinated EU action.[4]

Statistical evidence highlights the scale of the challenge. Eurostat reports that around 7.2% of adults suffer from chronic depression, with rates significantly higher among women (8.7%) than men (5.5%),[5] as mental health risks differ between genders with distinct causes, symptoms and ways of coping. Nonetheless, the number of people suffering from depression could be even higher due to stigma associated with mental ill-health. More than 84 million Europeans – approximately one in six – struggle with mental health challenges, with young people disproportionately affected.[6] The World Health Organization (WHO) calculates that one in seven Europeans live with a mental health condition, and suicide – particularly among youth – remains a major cause of premature death.[7]

Public perception underscores the need for strategic policy reform. An EU-wide Eurobarometer revealed that 15% of citizens sought professional help for psychological issues in the past year, reflecting strong public demand for accessible services.[8] Among young Europeans, emotional wellbeing has emerged as a central concern: nearly 90% consider it fundamental to their lives.[9]

Moreover, approximately half of young people aged 15-24 report unmet mental healthcare needs, while the incidence of depressive symptoms more than doubled during the pandemic in some countries.[10]

These data reinforce the argument for a comprehensive EU mental health strategy – one that goes beyond healthcare system responses and embraces a cross-sectoral, intersectional and gender-sensitive approach, integrating mental health into employment, social policy, education, digital regulation and justice.

2. Why social democrats and progressives should lead on EU mental health policy

Social democratic and progressive parties are uniquely positioned to spearhead a comprehensive EU mental health strategy – one grounded in worker wellbeing, youth empowerment, care, social cohesion, gender equality and a people-centred economic model. As political attention on mental health at the EU level has recently waned, the momentum must be reinstated and a strategic ownership must be claimed, especially with regards the clear omission of it in the past two *State of the European Union* addresses, despite stressing the anxieties faced by citizens.

Protecting worker wellbeing

Social democrats consistently champion policies that place worker welfare at the heart of the economy. Mental health must be integrated into occupational health and safety frameworks to address the increasing psychosocial risks of modern workplaces. Progressive proposals advocate embedding mental health criteria in environmental, social and governance reporting and supporting employers to promote mental health through training, flexible working and stigma reduction.[11] This aligns with their core prioritisation of safe, humane and dignified labour conditions.

Investing in youth and prevention

Youth mental health has rapidly become a growing concern. Social democratic policies emphasise prevention throughout the lifecycle, especially in early education settings. For example, progressive strategies call for embedding mental health literacy, counselling and early intervention programs into schools and higher education.[12] Effective policy demands a shift from one-off pilots to sustained, system-level interventions that reach young people broadly.[13]

Ensuring dignity at all ages

Progressive platforms advocate for inclusive policies that protect dignity at all stages of life – not only in care settings, but also in the workplace, in civic participation and in retirement. This includes integrating mental health into long-term care, community services and social protection, while also addressing ageism in the labour market and ensuring that digital services remain accessible to older generations. By aligning mental health and aging policies with broader measures for inclusion and accessibility, social democrats advance intergenerational equity and uphold social rights for all life stages. As highlighted in recent policy briefings, safeguarding older workers from psychosocial risks and promoting workplace wellbeing is not only a matter of health but also of fairness and economic sustainability. By tackling structural barriers and fostering supportive environments, progressives can ensure that longer working lives remain both dignified and fulfilling.

Embedding mental health in a people-centred economic model

The Nordic social democratic tradition – characterised by strong welfare states, trade union cooperation and generous public investment – shows how mental wellbeing can be woven into the economic core of society. A people-centred EU economic model would elevate mental health not simply as a healthcare issue, but as a cornerstone of inclusive prosperity – one that balances economic growth with social and environmental justice.

Drawing on the principles of a wellbeing economy, it would reorient policy toward what truly matters: enabling people and respecting the planet; promoting sustainable livelihoods; reducing inequality; and ensuring those most vulnerable aren't left behind. Crucially, this requires rejecting the limitations of a narrow market-capitalist approach, which reduces wellbeing to economic outputs, and instead recognising mental health as a public good and essential public service – inseparable from decent work, strong communities and healthy societies.

Anchoring mental health in social rights

The European Pillar of Social Rights (EPSR) sets the foundations for fairness in labour, inclusion and social protection.[14] A progressive-led mental health policy ensures this framework is translated into real-world support, linking mental wellbeing with housing, employment, education and social security.[15]

Addressing structural inequality

Social democratic thinking naturally foregrounds social determinants of mental health: poverty; inadequate housing; and gender disparities. The S&D Group urges an EU strategy to tackle these root causes, rather than merely treating symptoms.[16] By confronting inequality, progressives ensure a deeper, more just mental health response. Any EU approach to mental health must pay special attention to gender: women, men and gender-diverse people face distinct risks, vulnerabilities and coping patterns. Gender-sensitive measures across workplaces, addictions and digital environments are essential to strengthening the prevention of mental health problems, harm reduction, ensuring equitable access to support and treatment and, finally, stigma reduction.

3. Evolution of EU mental health policy

The EU's engagement with mental health has evolved gradually over the past three decades, reflecting both external pressures and internal political dynamics. The first formal reference to mental health in EU policy dates back to the 1994 Council Resolution, which acknowledged the need to examine "the kind and extent of actions that have to be undertaken at Community level in order to assist member states" in addressing mental illness.[17] This early step was largely symbolic, but it placed mental health within the Community's public health agenda and initiated the framing of mental health as a shared European concern, rather than solely a national competence. By 1999, the Council further underlined this orientation by inviting the Commission to report on mental health, exchange best practices and consult member states on future action.[18]

The early phase of EU mental health policy was shaped by knowledge exchange with expert organisations, most notably the WHO. Already in the 1980s, the European Community began to engage with the issue of mental health, reflecting wider international developments, such as the 1986 Ottawa Charter for Health Promotion, which identified equity, social justice and participation as prerequisites for wellbeing. This early recognition underscores that mental health has long been seen not only as a matter of healthcare, but as a societal and political priority linked to the broader conditions of life in Europe. In April 1999, a joint WHO-European Commission conference in Brussels produced the now well-known maxim, "There is no health without mental health", reflecting efforts to broaden the discourse beyond psychiatry to encompass socio-economic and public health dimensions.[19] This marked a key moment in establishing mental health as relevant to EU-level public health cooperation, legitimised by external expertise and the emerging European networks of mental health professionals.

A second phase began in the mid-2000s with a series of landmark developments. The 2005 WHO Ministerial Conference in Helsinki and its Mental Health Action Plan for Europe provided a roadmap for shifting from institutional care to community-based services.[20] The European Commission built on this momentum by publishing the Green Paper "Improving the mental health of the population" in 2005, which explicitly linked mental health to productivity, social inclusion and quality of life.[21] The Green Paper opened a broad consultation and reframed mental health as a socio-economic and rights-based issue, aligning EU discourse with the WHO's emphasis on preventive, community-oriented approaches. Scholars note that this reflected an incremental but important narrative shift within EU policy circles, as the Commission moved away from a narrow biomedical framing towards recognising social determinants of mental health.[22]

The momentum culminated in the 2008 European Pact for Mental Health and Well-being, endorsed at the EU High-Level Conference in Brussels. The pact did not have binding force but served as a coordination platform, encouraging member states to adopt common approaches in five priority areas: prevention of depression and suicide; youth and education; workplace settings; older people; and combating stigma. This focus revealed the EU's recognition of the cross-sectoral relevance of mental health – linking education, labour and ageing policies with health.[23]

Between 2013 and 2016, the Joint Action on Mental Health and Wellbeing brought further structure to EU-level cooperation. Funded under the EU Health Programme, the joint action sought to build practical frameworks for member states, including the development of community-based models of care and workplace interventions. Its outcomes highlighted persistent fragmentation but also produced concrete policy guidance on integrating mental health across sectors. However, while the joint action consolidated networks of policymakers and experts, it lacked the political authority and funding to generate a comprehensive strategy.

Despite these initiatives, the EU entered the late 2010s without a unified mental health strategy. Instead, its role was limited to "soft law" instruments, such as green papers, pacts and joint actions. Competence constraints under the Treaties, combined with divergent national traditions in healthcare, made binding EU-level policy politically contentious.[24] Nevertheless, mental health remained indirectly embedded in broader EU frameworks – including strategies on employment, social inclusion and non-discrimination – which underscored its socio-economic and human rights dimensions.[25]

The outbreak of the COVID-19 pandemic in 2020 marked a critical juncture. Widespread lockdowns, economic insecurity and social isolation brought mental health to the political forefront, exposing systemic vulnerabilities in national systems. In France, depression symptoms among adults reached 20% during lockdown. data show that, in 2020-21, almost 15% of EU citizens reported chronic depression symptoms, with younger age groups reporting the sharpest increase.[26] The European Commission responded by integrating mental health into the EU4Health Programme, which earmarked resources for mental health promotion, digital health tools and cross-border cooperation.[27] Moreover, the 2022 State of the European Union address explicitly recognised mental health as a Union-wide priority – the first time mental health featured among the EU's top strategic commitments.[28]

While the pandemic opened a "window of opportunity"[29] for new policy entrepreneurship, it also revealed the persistence of institutional path dependencies. Research indicates that EU institutions, rather than creating a transformative mental

health regime, largely adapted existing governance instruments – consultations, frameworks and health programmes – rather than creating a transformative mental health regime.[30] Discursive institutionalism helps explain this continuity: EU institutions expanded the communicative discourse around mental health as a societal crisis but stopped short of embedding this discourse into binding legislative frameworks.[31]

Nevertheless, the pandemic era saw mental health become mainstreamed across EU agendas. The EPSR action plan identified mental health as being integral to quality jobs and social inclusion. Similarly, the EU Strategic Framework on Health and Safety at Work 2021-2027 prioritised psychosocial risks, reinforcing the link between mental health and labour policies. These moves demonstrate that mental health is now seen as inseparable from the Union's socio-economic model, with implications for productivity, resilience and social cohesion.[32]

Yet, despite heightened political salience, the EU still lacks a comprehensive, binding strategy. Current frameworks remain fragmented, relying heavily on member state implementation and voluntary coordination. Unlike issues such as cancer, no single integrated EU mission exists for mental health. This limits the Union's capacity to address disparities across member states, where service provision, stigma reduction and preventive policies vary widely. Scholars argue that this piecemeal approach reflects both treaty-based limitations and political caution in expanding EU competences in health.[33]

In conclusion, the evolution of EU mental health policy demonstrates a gradual but incomplete trajectory. From the early resolutions of the 1990s to the Pact of 2008 and the Joint Action of 2013-16, mental health has been progressively recognised as a European concern. The COVID-19 pandemic accelerated this recognition, placing mental health at the centre of public discourse and policy experimentation. However, the absence of a comprehensive strategy means that progress remains uneven, overly dependent on soft law instruments and member state goodwill. Without a binding EU framework, mental health risks remaining a secondary priority, undermining the Union's ambitions for social resilience and equality.

The state of play is still far from what progressives should aim for. While mental health has gained more visibility at the EU level, the measures adopted to date fall short of driving real systemic change. A true, genuine, European mental health strategy would require not only cross-sectoral integration but also binding commitments, sufficient funding both at the EU and especially at the member state level, coordination mechanisms, well-defined best practices to share, and robust monitoring. In the absence of such measures, the Union risks perpetuating fragmentation, leaving millions of Europeans without adequate support, and falling short of its own ambitions to build a healthier, more resilient Europe. The creation of the first Intergroup on Mental Health in the European Parliament this year marks an important milestone but also highlights the urgency of translating political recognition into systemic and sustainable action.

4. Mental health and addictions

4.1 Context

Mental health and addiction are deeply interconnected phenomena that often co-occur and share common social, psychological and biological determinants. Substance use disorders, such as those related to alcohol, tobacco, pharmaceutical products (such as psychopharmaceuticals or painkillers) and illicit drugs, are among the leading contributors to the global burden of disease, while behavioural addictions like gambling and gaming are emerging challenges with significant public health implications. Both substance-related and behavioural addictions can exacerbate or mask underlying mental health conditions, creating complex "dual diagnoses" that strain healthcare systems and require integrated approaches.

The COVID-19 pandemic intensified these challenges. Lockdowns, economic uncertainty and social isolation increased rates of problematic alcohol consumption, online gambling and compulsive digital use, amplifying pre-existing vulnerabilities. At the same time, access to treatment and harm-reduction services was disrupted, particularly for marginalised populations. The intersection of addiction and mental health has thus become an urgent policy priority, not only for healthcare systems but also for social inclusion, economic productivity and democratic resilience.

In this context, the EU has a unique opportunity to develop integrated frameworks that address mental health and addictions together under a comprehensive public health approach.

At the EU level, policy responses to addiction and mental health have historically been siloed. Addiction has primarily been addressed through the EU drugs strategy and action plans, as well as specific tobacco and alcohol control measures. Mental health, meanwhile, has been framed under public health or social policy initiatives, but rarely in tandem with addiction.

The EU Drugs Agenda 2021-2025 emphasises a balanced approach, combining supply reduction with demand reduction and harm-reduction measures. However, it remains largely focused on illicit drugs, with limited integration of mental health considerations. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), since 2024 the European Union Drug Agency (EUDA), has called for more systematic integration of mental health into addiction services, highlighting the prevalence of dual diagnoses.

On alcohol, the EU has implemented very limited measures, such as labelling requirements, while tobacco regulation has advanced significantly through the Tobacco Products Directive. When it comes to gambling, there is no EU-wide regulation, except for several directives that touch on advertising, consumer protection and anti-money laundering. In most cases, member states set the real restrictions. Yet, these approaches remain fragmented, and the link with mental health outcomes is insufficiently mainstreamed into EU strategies.

The European Parliament has on several occasions urged the Commission to adopt a comprehensive mental health strategy that includes addiction. However, political sensitivities, particularly around issues such as cannabis regulation or gambling, have slowed progress.

The EU4Health programme (2021-2027) offers a potential vehicle for integrated action, with funding opportunities for mental health promotion and substance use prevention. Still, without an explicit framework linking the two, efforts risk duplication and missed synergies.

4.2 Existing evidence

The co-occurrence of mental ill-health and addiction is well documented. Studies suggest that more than 50% of individuals with substance use disorders also experience a mental health condition, most commonly depression, anxiety or PTSD. Conversely, individuals with severe mental illness are significantly more likely to engage in harmful substance use, often as a form of self-medication.

Substance use disorders impose enormous social and economic costs. Alcohol alone is responsible for an estimated 7.6% of male and 4.1% of female deaths globally. In Europe, alcohol-related harm costs approximately €125 billion annually, equivalent to 1.3% of GDP, when healthcare, productivity losses and crime are included. Tobacco smoking remains the leading preventable cause of death in the EU, killing around 700,000 people annually.

Behavioural addictions, though less studied, are gaining attention. Online gambling has surged with the rise of digital platforms, and gambling-related harm is increasingly recognised as a mental health issue. A study in the UK found that gambling addiction was associated with higher rates of depression, suicidal ideation and substance misuse. Problematic social media use has also been associated with increased psychological distress and loneliness among adolescents, while emerging evidence points to potential mental health risks from anthropomorphised AI systems, including reinforcement of delusional thinking in vulnerable users. This evidence underscores the urgent need for integrated prevention, treatment and harm-reduction strategies that transcend the traditional boundaries between "mental health" and "addiction services".

Addiction prevention and treatment must address the distinct needs of women, men and gender-diverse people, recognising gendered patterns of risk, stigma and access. For women, perinatal risks require particular attention. Alcohol use in pregnancy can cause foetal alcohol spectrum disorder, a preventable yet lifelong condition that remains under-recognised and under-supported. Men experience higher rates of substance misuse and often underdiagnosed mental ill-health, while gender-diverse people face additional barriers to affirming care. A trauma-informed, gender-responsive approach – centred on prevention and early intervention – should guide policy and services.

4.3 Analysis

Experts have highlighted the importance of public health over punitive approaches. It is argued that addiction must be addressed through prevention, harm reduction and treatment, rather than criminalisation. Evidence from Portugal's decriminalisation model, which treats drug use as a health issue, shows reductions in problematic use, HIV infections and drug-related deaths, while also improving access to treatment.

Experts also stress the need for dual-diagnosis care models. Currently, many health systems treat mental health and addiction separately, leading to fragmented care. Integrated care pathways – where addiction and mental health services are delivered together – improve outcomes and reduce relapse rates.

4.4 Best practices

Best-practice examples exist across Europe. In Finland, addiction services are embedded within primary healthcare, ensuring early identification of mental health comorbidities. In France, Centres de soins, d'accompagnement et de prévention en addictologie (CSAPA) offer integrated services

that combine prevention, harm reduction and psychiatric care.

In the UK, the Forward Trust runs prison-based programmes that address both substance misuse and mental health, recognising the high prevalence of co-occurring conditions among incarcerated populations.

Behavioural addictions have also prompted innovative responses. Italy has piloted educational programmes targeting gaming and gambling addiction among youth, combining digital literacy with mental health support. In Sweden, gambling companies are required by law to provide self-exclusion mechanisms and fund addiction research.

Experts warn, however, that progress remains uneven. Many member states lack comprehensive harm-reduction services, particularly in Central and Eastern Europe. Stigma also continues to deter individuals from seeking help, reinforcing the need for EU-level leadership.

4.5 Where more evidence is needed

Despite growing awareness, several evidence gaps persist. Firstly, there are insufficient comparative data on the prevalence and impact of behavioural addictions. While EMCDDA collects robust data on illicit drugs, systematic EU-wide monitoring of gambling, gaming and digital addictions is lacking. Without reliable statistics, policy responses remain reactive and fragmented.

Secondly, more research is needed on the long-term effectiveness of harm reduction for behavioural addictions. While harm reduction has strong evidence in substance use (e.g., needle exchange, opioid substitution therapy), its application to gambling or gaming remains experimental.

Thirdly, there is a lack of intersectional analysis. Addiction and mental health disproportionately affect marginalised populations, including migrants, LGBTQIA+ communities and individuals in poverty. Yet, most research generalises across populations, obscuring specific vulnerabilities and barriers to care.

Fourthly, cost-effectiveness evidence remains limited. While studies show that integrated services save costs in the long run, few EU-wide evaluations exist. Policymakers, therefore, struggle to make the economic case for scaling up comprehensive services.

Finally, there is insufficient research on the impact of regulatory environments. While some member states experiment with cannabis legalisation or gambling regulation, there is little EU-level analysis of how such policies affect mental health outcomes.

4.6 Recommendations

To close these gaps and advance integrated approaches, the following recommendations are proposed. By pursuing these recommendations, the EU can create a coherent policy framework that addresses addiction and mental health as interdependent challenges, ensuring that no individual falls through the cracks of fragmented systems.

Adopt a comprehensive, integrated EU framework for addiction
Develop a European strategy that brings together harm reduction, recovery, prevention, early intervention and early detection into a coherent framework across all member states. This should include both legal substances (alcohol, tobacco, prescription drugs) and behavioural addictions (gambling, gaming, social media, pornography,

shopping), treating them as interlinked public health priorities.

Embed harm reduction in EU strategy with sustainable funding
Ensure EU support for supervised use sites, needle and syringe programmes, opioid substitution, and safer supply initiatives. Expand harm-reduction guidance to cover alcohol, gambling and digital addictions, introducing measures such as mandatory self-exclusion tools, spending limits, default time/use controls and targeted public awareness campaigns.

Promote trauma-informed prevention and life skills education
Strengthen school-based and youth programmes that teach emotional regulation, decision-making and resilience, as recommended by EUDA. Ensure that prevention addresses not only substances, but also digital and behavioural compulsions, and is sensitive to diverse socio-demographic backgrounds.

Enable recovery-oriented care models
Encourage member states to integrate housing, employment and peer support into treatment through models, such as Housing First and dual-diagnosis community teams. Recovery services should be embedded alongside harm reduction, with EU4Health funding supporting pilot projects and knowledge exchange between member states.

Ensure lived experience and vulnerable voices are central
Involve people with lived experience of addictions in designing and delivering services, ensuring that EU and national programmes reflect real needs and strengthen community trust.

Expand and align the EU Drugs Agenda
Broaden the scope of the EU Drugs Agenda to explicitly include legal substances (alcohol, tobacco, prescription misuse) and behavioural addictions (gambling, gaming, digital compulsions). Align this agenda with the EU's comprehensive mental health strategy to ensure coherence across policies.

Address intersectionality and gender dimensions
Implement strategies that reflect how gender norms, socio-economic status and migration shape both substance use and behavioural addictions. Ensure prevention, harm reduction and recovery services are gender-responsive, trauma-informed and inclusive. Explicitly address the links between gender-based violence and substance use disorders.

Strengthen regulation of manipulative and addictive design
Embed an "addictive design" risk lens across the DSA, the Audiovisual Media Services Directive and the AI Act. Require platforms to identify and mitigate compulsive-engagement features, apply proportionate safeguards for minors, introduce default use/time controls, ensure researcher access to platform data and establish corporate accountability.

Explore evidence-based regulation of certain substances
Support research on the mental health impacts of psychoactive substances according to their risks. Where appropriate, consider evidence-based regulation and explore regulated access models with strict public health safeguards, including the prevention of youth use and robust monitoring.

Develop interoperable EU data systems
Strengthen the mandate of EUDA to systematically cover both legal and illegal substances, as well as behavioural addictions. Build real-time monitoring systems linking addiction and mental health data across member states, supporting better policy making and rapid response to emerging trends.

5. Mental health in the workplace

5.1 Context

The workplace is one of the most influential environments shaping mental health outcomes. Across Europe, most adults spend a substantial proportion of their daily lives at work, meaning that conditions, relationships and organisational cultures in the workplace have profound impacts on psychological wellbeing. The WHO estimates that depression and anxiety disorders cost the global economy $1 trillion annually in lost productivity.[34] In the EU, mental ill-health already accounts for nearly 4% of GDP in economic losses, including absenteeism, presenteeism, turnover and early retirement.[35]

Surveys by the European Agency for Safety and Health at Work show that stress, depression and anxiety are the second-most-reported work-related health problems in Europe, affecting up to a quarter of the workforce in certain sectors.[36] Younger workers are particularly affected: recent surveys found that almost one in three Europeans aged 18-24 took time off in the last year due to mental health reasons, compared with only one in ten older workers.[37] At the other end of the age spectrum, older workers face challenges related to ageism, late-career adaptation and isolation, which also negatively affect mental health.[38] Women and gender-diverse people often face greater workplace precarity and unpaid care burdens; men may encounter workplace norms and stigma that penalise help-seeking or openness about mental distress – discouraging the use of support services (for instance, in a male-dominated team, a man who schedules an employee assistance programme session is often told to "toughen up" and later marked down on "resilience" in his performance review). Increased digitalisation is also blurring the boundaries between work and private life and driving technostress – the mental strain from constant connectivity, ICT overload, interruptions and errors, digital surveillance, and continual system change.[39]

The concept of the psychosocial safety climate (PSC) highlights the role of organisational culture in shaping wellbeing. High levels of PSC correlate with reduced burnout, lower absenteeism and stronger organisational performance.[40] This perspective reflects a paradigm shift: workplace mental health is increasingly regarded not as an individual issue of resilience, but as a structural responsibility for employers and policymakers.

5.2 Existing evidence

Evidence linking work to mental health outcomes is well established. Meta-analyses of workplace wellbeing programmes indicate significant returns on investment (ROIs), with every €1 spent on prevention yielding up to €4 in reduced healthcare costs and improved productivity.[41] Interventions focusing on job design, workload management and leadership development often have greater effects on mental health than isolated wellbeing initiatives.[42]

The EU formally recognised psychosocial risks in the 1989 Framework Directive on Safety and Health at Work (Directive 89/391/EEC)[43]. Despite this, employers often report that psychosocial risks are more difficult to manage than physical hazards, citing a lack of tools and knowledge.[44] According to EU-OSHA's ESENER survey, while 79% of workplaces acknowledge psychosocial risks, only around 30% have procedures in place to manage them.[45]

The COVID-19 pandemic further underscored the challenges. Remote work blurred the boundaries between professional and personal life, increasing stress levels and creating issues such as

digital fatigue and constant connectivity. These trends strengthened calls for a European right to disconnect, some of which have been implemented nationally in countries such as France.[46]

Economically, workplace mental health interventions have demonstrated strong impacts. A 2023 Deloitte UK study found that employers saved £57 billion annually through mental health support programmes, with a return of £4.70 for every £1 invested.[47] This reinforces the argument that mental health at work is not only a social imperative but also a sound economic strategy.

5.3 Analysis

Experts underline that workplace mental health requires a rights-based approach, where psychological wellbeing is treated as an entitlement equivalent to physical safety. This involves binding obligations for employers to conduct psychosocial risk assessments, integrate mental health into occupational safety and health (OSH) management systems, and ensure the confidentiality of employee health data.[48] Without enforceable standards, mental health interventions risk remaining symbolic, voluntary or accessible only to large, well-resourced employers.

Another key emphasis in expert analysis is the role of social dialogue. Effective workplace mental health initiatives are more likely to succeed when designed and implemented through cooperation between trade unions, employers and policymakers. In Northern Europe, collective bargaining agreements increasingly include mental health provisions, embedding psychological wellbeing into the wider framework of labour rights.[49] This reflects a systemic shift towards institutionalising mental health in the workplace.

Structured approaches are also promoted, with models such as the BALANCE framework, offering a comprehensive roadmap. This framework emphasises sector-specific interventions, awareness raising, local resource mobilisation, accommodation of diverse needs, nurturing organisational cultures, confidentiality and the empowerment of workers.[50] Experts stress that such frameworks are essential to ensure that interventions are sustainable, evidence-based and embedded across organisational structures.

5.4 Best practices

Several European initiatives illustrate how the principles of workplace mental health can be translated into practice. In Germany, the non-governmental organisation (NGO) *Irrsinnig Menschlich ha*s pioneered prevention and education programmes that combine professional expertise with the lived experiences of people who have faced mental health challenges. Delivered through interactive workshops, these programmes reduce stigma and encourage early help-seeking among employees. Evaluations indicate increased openness to disclosure and the greater use of support services following participation.[51]

In Finland, the Workplace Well-being Network represents a successful model of social partnership, bringing together employers, trade unions and public health institutions. The network promotes integrated programmes that address both physical and mental wellbeing, recognising their interdependence. Firms engaged in the network reported higher productivity, reduced sickness absence and stronger employee satisfaction, demonstrating that investing in wellbeing yields measurable benefits.[52]

The Netherlands provides another instructive case with its Work & Health Covenants, which are negotiated agreements between government, employers and unions that now explicitly cover psychosocial risks. These covenants, especially in high-stress industries, such as logistics and construction, commit all parties to concrete targets for stress management, reintegration and prevention. They demonstrate how sectoral agreements can adapt the principles of mental health promotion to specific occupational realities.[53]

Corporate examples also highlight innovation. In the UK, several companies have implemented "wellness days", allowing employees to take paid leave specifically to support mental health. Rather than reducing output, these initiatives strengthened employee loyalty and reduced turnover. In France and Germany, the right to disconnect has been institutionalised through national laws and company policies, with some firms configuring email servers to block after-hours messages. Such measures reflect a cultural commitment to protecting boundaries between work and personal life.

New technologies are also emerging as tools for prevention. Artificial intelligence (AI) driven monitoring systems and stress-detection chatbots, trialled in EU-funded projects, can identify early signs of burnout and prompt intervention.[54] In this respect, evaluation and putting into practice promising innovations, when implemented transparently and with appropriate safeguards, represent an area of interest for progressives.

Despite these examples, experts warn that the state of play remains insufficient. Current policies are fragmented, with uneven uptake across member states and significant gaps in enforcement. SMEs in particular lack resources to adopt comprehensive measures, leaving large segments of the workforce vulnerable.[55] Furthermore, there is no binding EU directive mandating psychosocial risk management, meaning that many initiatives remain voluntary. Without stronger legislative frameworks and systematic integration of mental health into employment strategies, progress will remain partial and uneven.

These limitations underline the need for the EU to move beyond pilot projects and voluntary guidelines towards binding commitments that guarantee all workers the right to a psychologically safe workplace. Mental health at work is not simply a question of individual wellbeing; it is a matter of economic sustainability, social justice and democratic resilience.

5.5 Where more evidence is needed

Despite the growing recognition of workplace mental health as a public policy and organisational priority, there remain significant gaps in evidence and data collection. One of the key challenges is the lack of harmonised indicators across member states. While physical occupational health and safety hazards are well monitored, psychosocial risks lack comparable EU-wide data.[56] Surveys such as ESENER provide important snapshots, but coverage is uneven, and many smaller enterprises are underrepresented. Without robust, comparable statistics, it is difficult to assess the scale of the problem or to design targeted policies.

Another gap concerns the long-term evaluation of interventions. While short-term studies frequently demonstrate improvements in awareness or reductions in stress, few longitudinal evaluations assess whether workplace mental health initiatives have durable impacts on worker wellbeing and organisational performance.[57] This is especially problematic in SMEs, where interventions are often resource-constrained and outcomes are less systematically documented.

More evidence is also needed on the intersectionality of workplace mental health and socio-demographic characteristics. Workers experience psychosocial risks differently, depending on age, gender, disability, ethnicity and migration status.[58] Yet, most workplace studies treat the workforce as a homogenous category, overlooking the compounded vulnerabilities of groups such as migrant workers in precarious employment or women balancing care responsibilities with paid work.

There is also an increasing body of evidence showing how digitalisation contributes to technostress, burnout and new forms of occupational insecurity. Many workplaces rely on dozens of different digital systems, creating fragmented workdays, reducing opportunities for deep focus and often shifting IT support onto employees without providing adequate training. Constant connectivity becomes an implicit expectation, blurring boundaries between work and private life; in some sectors, workers must complete IT training in their own time, while in others, unreliable systems force frequent interruptions and restarts. The rapid rise of AI adds another layer of pressure, amplifying overload and uncertainty. At the same time, digitalisation has introduced unresolved questions around remote work, algorithmic management and AI-driven tools, the full mental health impacts of which – such as digital fatigue, surveillance stress, and the consequences of algorithm-based scheduling and performance monitoring – are only beginning to be understood.[59] Together, these dynamics show how digitalisation, if poorly managed, undermines both employee wellbeing and organisational effectiveness. Finally, there is insufficient evidence of the cost-effectiveness at scale. While many case studies show positive returns on investment, robust macroeconomic models of workplace mental health interventions across sectors and countries are rare.[60] Policymakers therefore lack clear evidence to justify large-scale investments and legislative measures, despite mounting anecdotal proof of benefits.

Addressing these gaps requires investment in comparative, interdisciplinary and longitudinal research, supported by EU funding programmes such as Horizon Europe and EU4Health. Without stronger evidence, workplace mental health risks remaining an aspirational priority, rather than an operational policy domain implemented across the economy in all types of employment and workplaces.

5.6 Recommendations

Building on the evidence, expert insights and best practices reviewed, several recommendations emerge for advancing workplace mental health at the EU level. Together, these measures would not only reduce suffering and stigma, but also strengthen Europe's economic resilience, as healthier workplaces translate into higher productivity, lower turnover and greater social cohesion.

Address constant connectivity through enforceable protections

Recognise constant connectivity as a major psychosocial risk that blurs work-life boundaries. The solution lies in adopting an EU Directive to enforce the *Right to Disconnect*, protecting workers from off-hours contact and digital overexposure.[61] Employers must ensure manageable workloads during working hours through adequate staffing, fair task distribution and realistic deadlines, combined with routine workload and psychosocial risk assessments. These protections should be backed by anti-retaliation safeguards, collective bargaining provisions and robust labour inspectorate enforcement.

Develop a binding EU directive on psychosocial risks
Move beyond voluntary measures by harmonising minimum standards for psychosocial risk management across member states.[62] The directive should explicitly include technostress, constant connectivity, lack of IT training and lack of IT support as psychosocial risks. Employers must be required to provide sufficient training and accessible support, rather than shifting IT burdens onto workers.

Promote socially sustainable digitalisation
Make IT training and IT support a core responsibility of employers, ensuring all workers are adequately equipped to use workplace technologies, as 11-20% of employees' computer use time is lost on IT-related issues. Require regular audits of workplace IT ecosystems to identify inefficiencies, risks and sources of technostress. Equip companies with technostress audit tools, risk management frameworks and risk profiles to guide preventive measures and build healthier digital work environments. Provide clear ROI assessments that demonstrate how reducing technostress improves productivity, employee retention and organisational resilience.

Strengthen data collection and harmonised monitoring
Establish a universal, cross-national data collection framework and methodology to capture psychosocial risks across member states. This should be integrated into Eurostat and EU-OSHA surveys and supported by standardised indicators for psychosocial risks, with particular attention to SMEs; precarious workers; and intersectional factors such as gender, age, disability and migration background.[63] Systematic data collection should also track unpaid care burdens and the workplace impacts of digitalisation to ensure comparability and policy coherence across the EU.

Support SMEs through tailored resources and incentives
Provide EU-level toolkits, subsidies and knowledge hubs that enable SMEs to build workplace mental health programmes and implement psychosocial risk management. Sector-specific strategies should include reintegration pathways for workers, confidential care mechanisms and ROI evidence showing the business case for preventive measures.

Facilitate knowledge transfer between research and intervention
Strengthen the translation of research into workplace practice, while ensuring that lessons from interventions inform future studies. Create EU-wide knowledge hubs that allow continuous feedback loops between research, policy and workplace practice, thereby accelerating evidence-based solutions and reducing the implementation gap.

Raise mental health literacy across the workforce
Launch EU-wide training and awareness initiatives to equip both employers and employees with the language and skills to identify distress, reduce stigma and foster psychological safety. Ensure that leadership and management training includes psychosocial risk prevention and mental health promotion.

Create neurodiversity-affirming workplaces
Recognise neurodivergence as natural human variation while addressing co-occurring mental health needs. Employers should implement inclusive hiring, confidential accommodations, predictable routines, sensory-friendly workplaces and assistive technologies. Manager training in neuroinclusive practices should be promoted as part of broader diversity, equity and inclusion (DEI) goals.

Institutionalise trade union cooperation
Embed trade unions as co-creators of workplace strategies to combat psychosocial risks. Encourage social partners and member states to integrate mental health provisions into collective agreements, works councils and sectoral covenants, drawing on effective models from countries like the Netherlands and Finland.

Mainstream digital workplace wellbeing into EU digital policy
Recognise the mental health impacts of digitalisation, including technostress, constant connectivity, lack of IT training and support, algorithmic management, and digital surveillance. EU digital legislation – including the Digital Services Act (DSA) and the AI Act – should incorporate explicit safeguards for worker wellbeing.[64]

Apply the BALANCE framework for comprehensive implementation
Sector-specific strategies should be guided by the BALANCE framework. This structured model ensures access to support, inclusive accommodations, reintegration pathways and confidential mechanisms for all workers.

Promote intergenerational inclusion
Support young workers through fairly paid traineeships, mentorships and mental-health-sensitive onboarding, while also supporting older workers with upskilling opportunities, flexible transitions and dignified recognition. EU-wide awareness campaigns should challenge age stereotypes, promote solidarity and highlight the contributions of all generations.

Tackle the mental health burden of unpaid care work
Deliver on the European care strategy by scaling affordable, high-quality, long-term care and early childhood education. Strengthen the Work-Life Balance Directive with robust carers' leave, flexible work, anti-retaliation provisions and adequate income replacement. Embed carers' mental health into national long-term care plans, with funded respite, counselling and peer support. Protect carers through social protection (e.g., pension credits, income support during intensive-care episodes), while systematically monitoring care burdens across member states.

Invest in longitudinal and intersectional research
Fund EU-level studies to assess long-term mental health outcomes of workplace interventions, with explicit attention to under-researched sectors and diverse worker groups. Intersectionality (gender, migration, disability, age and socio-economic status) should be a guiding principle to ensure equitable outcomes.

Promote culture change through awareness and leadership training
Support EU-wide campaigns to combat stigma and normalise mental health as a workplace priority. Require mandatory leadership training on psychosocial risk management, equipping managers to foster inclusive, supportive and mentally healthy organisational cultures.

6. Digital technologies and mental health

6.1 Context

Digitalisation has profoundly reshaped how Europeans live, work and interact, creating both opportunities and risks for mental health. On one hand, digital technologies have revolutionised access to care; telepsychiatry, mobile mental health apps and online peer-support communities have expanded options for prevention, diagnosis and treatment.[65] However, all-encompassing digital environments, particularly social media and similar digital technologies, have also introduced new risks and vulnerabilities. Social media and gaming platforms with manipulative and addictive architectures amplify stress, depression, anxiety and negative body image issues, particularly among young people.[66] Algorithmic targeting, persuasive design and unregulated neurotechnology raise ethical concerns regarding autonomy and "cognitive integrity" – the right to mental self-determination.[67]

The COVID-19 pandemic further accelerated access to the digital world, with sharp increases in screen time, online learning and teleworking. Although digital tools provided continuity of education and healthcare, they also highlighted inequalities, as digitally excluded populations faced greater risks of isolation and stress.[68]

Mental health challenges in the digital sphere must therefore be approached with a dual lens: recognising digital technologies as enablers of care while addressing their role as risk multipliers. This tension makes the issue central to the EU's ambition to develop a comprehensive mental health strategy.

The EU has recognised the digital-mental health nexus through various initiatives, though often indirectly. The DSA, adopted in 2022, imposes new responsibilities on large platforms to mitigate harmful content, algorithmic manipulation and disinformation.[69] Yet, a paradox remains: while some of the most pervasive harms of digital media are mental health impacts – driven by addictive design and persuasive technologies – the DSA does not directly address them, leaving a critical regulatory gap. Similarly, the AI Act, currently under negotiation, categorises certain AI uses in healthcare as "high-risk" but does not explicitly regulate mental health apps or algorithmic nudging techniques.[70]

The European Commission's comprehensive approach to mental health explicitly acknowledges digital technologies as both opportunities and risks, highlighting the need for cross-sectoral regulation.[71] Yet, concrete legislative instruments remain fragmented, and mental health considerations are rarely mainstreamed into digital policy frameworks.

6.2 Existing evidence

Evidence consistently links problematic digital use to adverse mental health outcomes. A systematic review by the OECD found that excessive screen time, especially on social media, correlated with increased risks of anxiety, depression, poor sleep quality and reduced self-esteem.[72] Among adolescents, cyberbullying and online harassment have been shown to significantly increase risks of self-harm and suicidal ideation.[73] A 2022 Eurostat survey reported that 59% of young Europeans aged 16-24 experienced harmful online content, while 28% reported cyberbullying.[74] Evidence shows gendered patterns: girls face higher mental-health risks from social-media exposure – including cyberbullying, harassment and non-consensual image sharing – while boys face elevated risks related to gaming, online gambling and pornography. Gender-diverse youth also

experience distinct and often overlooked vulnerabilities, including targeted abuse and barriers to affirming support, which policy and research must address explicitly.

The addictive design of digital platforms is central to these harms. Social media feeds are engineered for continuous engagement, often exploiting cognitive biases such as variable reward mechanisms. Such persuasive design strategies blur the boundary between voluntary and coerced digital use, raising ethical and legal concerns.[75] While these mechanisms raise broader societal concerns, they pose particular risks for children and adolescents, who constitute a vulnerable population due to their developing brains, heightened sensitivity to social feedback and limited emotional regulation capacities.

At the same time, selected digital tools offer opportunities for prevention, treatment and peer support. Digital cognitive behavioural therapy has proved to be effective at treating depression and anxiety, with outcomes comparable to face-to-face interventions when adequately supported.[76] Telehealth expanded access during COVID-19, particularly in rural or underserved areas. Applications have demonstrated significant potential in early intervention, although their long-term efficacy depends on regulation and integration into formal health systems.[77] Emerging technologies such as AI-driven mental health diagnostics or digital phenotyping – where smartphone data are analysed to infer mood and behaviour – hold potential for personalised interventions but raise acute privacy concerns. The WHO has called for ethical guidelines to ensure that digital innovation respects human rights and avoids exacerbating inequalities.[78] Moreover, it is important to distinguish these health-focused tools from attention-economy platforms, such as social media or gaming, which are the most widely used but often linked to increased risks for mental health rather than prevention.

6.3 Analysis

Experts have stressed the need to recognise cognitive integrity as a fundamental right. Already embedded in Chile's constitutional amendments and emerging in US states such as Colorado and California, this principle would safeguard individuals against manipulative digital practices and unregulated neurotechnologies. Experts argue that the EU, as a global leader in digital rights (e.g., General Data Protection Regulation (GDPR)), is well-placed to pioneer similar protections.

A second key theme is the precautionary principle. While pharmaceuticals and medical devices must prove safety before market entry, digital mental health apps, and even more importantly, social media or gaming platforms, often bypass such scrutiny. Experts recommend extending regulatory frameworks to require evidence of non-harm before platforms and applications are widely deployed. This aligns with calls for independent regulatory bodies to oversee neurotechnology and persuasive design – domains where commercial incentives often conflict with public health priorities.

Manipulative design features, such as infinite scroll, autoplay and dark patterns, should be restricted or banned in services accessible to minors. Children and adolescents are a high-risk group, as their developing brains and immature impulse control make them unable to resist these engagement-maximising mechanisms. Regulation must therefore target persuasive design itself, ensuring that digital environments for youth support healthy development rather than exploit vulnerability.

In particular, stronger regulation is needed for manipulative design practices in social media and gaming platforms. These environments are deliberately engineered to maximise attention

and engagement, yet children and adolescents – whose impulse inhibition is not yet fully developed – are least able to resist. Addressing this regulatory gap would be a critical step toward protecting youth from exploitative design and its documented mental health harms.

6.4 Best practices

Best practices are emerging at national and local levels. In Finland, public health authorities have piloted digital literacy programmes in schools, equipping young people to better recognise online risks and become more aware of manipulative design and harmful behaviours.[79] However, it is essential to acknowledge that digital literacy alone is insufficient: children and adolescents cannot simply be taught self-regulation when their brains are not yet fully developed. Just as we would not rely on gambling awareness to protect minors from gambling itself, we cannot expect education alone to counter the addictive appeal of persuasive technologies. This is particularly urgent given that studies indicate around 25% of children and adolescents already show signs of problematic or addictive use of social media and screens.

In France, the *Maison des Adolescents* network integrates digital mental health counselling with in-person support, creating hybrid models that are more accessible for young people growing up and spending more time in digital environments, while recognising that their heavy engagement with entertainment platforms does not equate to digital competence.

Civil society initiatives also provide promising models. NGOs such as Reset Australia campaign against manipulative design and advocate for ethical tech standards. Similarly, the EU-funded project Caring for Cognition is experimenting with digital nudges that promote wellbeing, such as reminders to take breaks or engage in offline activities.

These examples underscore that regulation must be complemented by culture change and education. Simply prohibiting harmful design is insufficient; equipping citizens with digital literacy and resilience is equally critical.

6.5 Where more evidence is needed

Despite growing research, significant gaps remain. Firstly, there is a lack of longitudinal studies examining the cumulative impact of digital exposure throughout the life course. Most studies are cross-sectional, making it difficult to disentangle causality from correlation.[80]

Secondly, evidence for the effectiveness of regulation is scarce, not because regulation proves to be ineffective, but because it has barely been implemented or there are regulatory gaps (see above) in the first place. In the absence of robust regulatory frameworks, studies cannot yet assess their impact. And though some policies, such as the right to disconnect, show promise, few robust evaluations exist of their mental health impacts. This creates uncertainty for policymakers considering EU-wide adoption.

Thirdly, more research is needed on the intersection of digital harms and inequalities. Vulnerable groups, including children, low-income families and migrants, may face disproportionate risks, yet most studies focus on general populations.[81] Digital divides in access and literacy exacerbate inequalities, with those most in need often least able to benefit from digital tools.[82]

Finally, there is limited knowledge about neurotechnology and persuasive AI, which are rapidly advancing. Brain-computer interfaces and

emotion-recognition systems present unprecedented ethical dilemmas, but empirical studies on their societal and psychological effects remain scarce. Without anticipatory research, regulation risks lagging behind technological developments.

6.6 Recommendations

To address these challenges and opportunities, the following measures are recommended. By balancing innovation with protection, the EU can position itself as a global leader in ethical digital mental health governance, ensuring that technologies enhance rather than erode wellbeing.

Regulate manipulative and addictive design for minors
Restrict or ban manipulative features such as infinite scroll, autoplay, loot boxes and algorithmic recommendation systems in services accessible to children and adolescents under 18 years of age. As with gambling, minors lack mature impulse control, and it is unrealistic and unethical to expect self-regulation. Parents cannot shoulder this burden alone; corporate accountability is required. In parallel, the EU should train clinicians to recognise digital risks; include digital-behaviour screening in routine mental health assessments; and strengthen capacity to detect emerging harms such as self-harm, eating disorders, depression, post-traumatic stress disorder (PTSD), porn addiction and gaming disorders.

Mandate robust age verification with corporate accountability
Technology companies must be required to implement effective age-verification systems, with strict penalties for non-compliance. Responsibility must rest with providers, not families. Experience from tobacco and alcohol regulation demonstrates that corporate accountability is achievable when supported by political will and enforcement.

Enshrine cognitive integrity as a fundamental right
Embed cognitive integrity in the EU Charter of Fundamental Rights, recognising it as a legal right to mental autonomy and protection from manipulative or harmful influences on one's thinking and decision-making. This would align the EU's digital rights framework with its commitments to human dignity and mental health.

Protect early childhood development
Require health professionals to inform parents during newborn and early child check-ups about the risks of early screen exposure – including delayed language, impaired attention, and the impact of parental screen use on bonding and child development. Early prevention is critical to safeguarding cognitive and emotional health.

Establish regulatory frameworks for mental health technology
Mandate that digital mental health apps, AI-driven diagnostics and other online interventions undergo rigorous safety testing before market entry – comparable to medical devices. Initiatives such as Label2Enable and INTERREG SUPER provide promising models. Maximum protection of users' personal data must be guaranteed.

Implement clear screen policies in schools
Require all schools to adopt evidence-based screen-use policies, including smartphone-free classrooms and the integration of safe, purposeful digital tools that support rather than undermine learning. Schools should actively support parents in establishing joint agreements to delay access to smartphones and social media, reducing peer pressure and promoting healthier digital norms.

Educate technology professionals on digital risks
Integrate mental health and digital risk awareness into curricula for computer science, software

engineering and related disciplines. Require training for professionals responsible for digital procurement and deployment so that potential psychological harms are anticipated and mitigated at the design stage.

Promote digital literacy, offline balance and real-world connection
Fund after-school activities, leisure opportunities and education initiatives that provide non-digital spaces and encourage conscious digital use. Evidence shows that physical activity and real-world social relationships improve mood, reduce depression, strengthen self-esteem, and build resilience among children and adolescents.

Coordinate across sectors with a European task force
Create a cross-sectoral task force linking health, education, digital regulation and child protection. This will ensure coherence across policies and enable early identification of risks at the intersection of mental health, technology and child rights.

Recognise and combat technology-facilitated violence
Acknowledge online harassment, cyberstalking and digital abuse as forms of gender-based violence with profound mental health consequences. EU strategies to combat gender-based violence should explicitly incorporate technology-facilitated violence as a policy priority.

Combat disinformation and protect cognitive health
Support tools such as pre-bunking, critical thinking training and fact-checking to reduce the mental health impacts of online disinformation.[83] Protecting citizens against manipulative narratives strengthens resilience and upholds cognitive integrity as part of public health.

7. Outlook for EU mental health policy

Mental health is no longer a marginal concern in European policy making but has become a defining challenge for the Union's social, economic and political agenda. The COVID-19 pandemic exposed the vulnerabilities of fragmented systems, while rising psychosocial risks in the workplace, the pervasive influence of digital technologies and the growing burden of addictions underscored the need for a cross-sectoral response. Mental health challenges already cost the EU close to 4% of GDP in lost productivity and healthcare expenditure.[84] Beyond these economic losses, poor mental health has great individual and family costs, erodes trust in institutions, weakens democratic resilience, and exacerbates inequality across societies.

The EU has recognised these dynamics in its "A comprehensive approach to mental health", published in 2023, which articulates a whole-of-society vision for promoting wellbeing and preventing harm.[85] Yet, when compared to fields such as climate policy or cancer control, mental health still lacks a unifying mission or binding framework. The outlook for the coming decade will therefore depend on whether the Union can move beyond fragmented initiatives and develop a systemic strategy that mainstreams mental health across all areas of policy.

7.1 Opportunities for leadership

The EU is well positioned to become a global leader in mental health governance. Building on its reputation as a pioneer in digital rights, demonstrated through measures such as the GDPR and the DSA, the EU could extend protections to the realm of mental health by recognising cognitive integrity as a fundamental right. This would allow Europe not only to

regulate manipulative technologies, but also to set international standards for ethical digital mental health innovation.[86]

Similarly, the EU's long-standing focus on occupational health and safety provides a strong foundation for addressing psychosocial risks at work. A directive that establishes binding standards for psychosocial risk management would not only protect employees, but also enhance Europe's economic competitiveness by reducing absenteeism and increasing productivity.[87]

The EU's leadership is also crucial in recognising the gendered nature of mental health. Women have been disproportionately affected by the psychosocial consequences of the pandemic, as they shoulder higher burdens of unpaid care work, are more likely to be employed in frontline sectors and face elevated risks of gender-based violence – all of which are linked to higher rates of anxiety and depression.[88] At the same time, men are less likely to seek help for mental health problems, contributing to elevated suicide rates in several member states. A comprehensive EU strategy must therefore integrate gender-sensitive indicators, policies and funding mechanisms to address these distinct vulnerabilities.

Finally, Europe's social model – rooted in solidarity, equality and universalism – provides a normative strength that few other regions can claim. Championing mental health as a social right, aligned with the EPSR,[89] would situate the EU at the forefront of a rights-based global movement for mental health.

7.2 Remaining gaps and challenges

Despite these opportunities, substantial challenges remain. Mental health continues to fall primarily under national competence, with EU initiatives relying largely on soft law instruments and voluntary coordination.[90] The result is uneven implementation across member states, with significant disparities between Northern and Western Europe, on one hand, and parts of Central and Eastern Europe on the other, where infrastructures and resources are more limited.

Equally problematic is the lack of harmonised data and monitoring. While physical health hazards are routinely measured and reported, psychosocial and digital risks are far less visible in European statistics, making it difficult to build robust evidence-based policies.[91] Gender-disaggregated data, in particular, is scarce, making it challenging to design interventions that address women's and men's distinct needs. This invisibility perpetuates inequalities, as female-specific burdens, such as reproductive health, care responsibilities and gender-based violence, are under-recognised in mental health policy frameworks.

Moreover, stigma and inequality continue to act as barriers to access. Young people, migrants, LGBTQIA+ communities and other marginalised groups are often disproportionately affected but remain underserved in national health systems.[92] Gender interacts with these vulnerabilities, with young women reporting higher levels of body-image-related distress linked to digital exposure, while young men are more prone to gaming-related addictions. These trends illustrate the necessity for intersectional approaches to EU policy making.

At the institutional level, the EU's legislative framework is still fragmented. The DSA, the AI Act and existing occupational safety regulations each address parts of the mental health puzzle but do not integrate well with one another. The absence of a guiding mental health principle across these domains hampers the coherence and effectiveness of European action.

This policy brief has not focused on the issue of the mental health workforce, yet it deserves specific attention at the EU level. Currently, it is extremely difficult for clinical psychologists and psychotherapists to move between member states due to fragmented licensing and recognition systems. This not only limits professional mobility, but also makes the organisation of cross-border or emergency psychological support cumbersome. Creating a more mobile, better coordinated and resilient EU mental health workforce would strengthen preparedness for crises, ease regional disparities in access to care and form a cornerstone of any truly European mental health strategy.

7.3 Outlook and path forward

The Union's credibility in this field will hinge on its ability to advance a comprehensive mental health strategy that parallels its flagship initiatives in climate change, digital policy or cancer control. Such a strategy would need to consolidate existing instruments into a coherent framework and embed mental health into all EU policies, from education and employment to digital governance and justice.

The next step for the EU is not merely to acknowledge mental health but to make it a central pillar of its social and economic vision. This entails establishing minimum standards for workplace protections, advancing rights-based digital governance that safeguards cognitive integrity, expanding addiction policy to cover behavioural forms, and developing harmonised indicators and interoperable data systems that allow real-time monitoring and cross-national comparability. Crucially, the strategy must integrate gender mainstreaming at every stage; ensuring that measures address the specific needs of women, men and non-binary people; and that policies take into account how gender roles, norms and inequalities shape mental health outcomes.

If the EU can succeed in these areas, it will not only reduce inequalities and strengthen societal resilience, but also position itself as a global frontrunner in ethical, rights-based mental health governance. In doing so, Europe would demonstrate that protecting the health of its citizens' minds is inseparable from the pursuit of a stronger, fairer and more cohesive Union.

8. Conclusions

The trajectory of European mental health policy over the past three decades illustrates a gradual but undeniable shift: from fragmented initiatives and soft coordination mechanisms towards an emerging recognition that mental health must stand as a pillar of the Union's social and economic project. The COVID-19 pandemic accelerated this transformation, exposing the fragility of existing systems and creating unprecedented political momentum for action. It revealed that mental health was not only a health concern, but also a determinant of democratic resilience, labour productivity and social cohesion.

Across the three thematic areas explored in this study – the workplace, digital technologies and addictions – a consistent pattern emerges. Firstly, mental health challenges are inseparable from broader socio-economic transformations. In the workplace, precarious employment, digitalisation and psychosocial risks are reshaping the conditions of labour and demanding new protections. In the digital sphere, technological innovation both enables new forms of care and creates new risks to cognitive integrity, particularly among youth. In the realm of addictions, both substance-related and behavioural disorders reflect wider inequalities, social exclusion and regulatory gaps.

Secondly, EU-level engagement has so far been characterised by a patchwork of sectoral measures rather than a unifying framework. Occupational safety directives address physical hazards more effectively than psychosocial ones. Digital regulations such as the DSA mitigate some risks but lack an explicit mental health lens. Addiction policy remains largely confined to drug and tobacco control, with little integration into a comprehensive mental health strategy. The resulting fragmentation reduces the EU's capacity to act as a coherent actor in this domain and leaves member states with uneven protections and resources.

Thirdly, the analysis highlights the importance of embedding rights-based, gender mainstreaming and equality-oriented approaches into mental health governance. Mental health is deeply gendered: women carry disproportionate burdens linked to care work and social inequalities, while men face higher risks of underreporting, stigma and suicide. Youth, migrants and other vulnerable groups experience distinct patterns of digital exposure, workplace stress and addiction risks. Any credible EU mental health strategy must therefore mainstream gender and intersectionality, ensuring that interventions respond to diverse lived realities.

The way forward requires the Union to consolidate fragmented initiatives into a coherent strategic framework. Such a framework should establish binding minimum standards for workplace psychosocial protection, regulate digital technologies through the lens of cognitive integrity and youth wellbeing, and integrate addiction policies into a broader public health paradigm. It should also strengthen data collection and monitoring, particularly gender-disaggregated and cross-sectoral indicators, to inform evidence-based policy making. Finally, a comprehensive strategy must be underpinned by the EU's social model: solidarity; equality; and universality.

If mental health is to become a defining feature of Europe's future, the Union must move beyond rhetorical commitments and implement a strategy that is as ambitious as its climate, digital or cancer policies. Doing so will not only reduce health inequalities and enhance resilience but will also demonstrate that the European project itself is attentive to the dignity, rights and wellbeing of its citizens. "Healthy minds, stronger Europe" is not merely a slogan – it is an imperative for the sustainability of the Union's social and democratic fabric.

Bibliography

Andrews, G., A. Basu, P. Cuijpers et al. (2018) "Computer therapy for the anxiety and depression disorders is effective, acceptable and practical health care: An updated meta-analysis". *Journal of Anxiety Disorders*, 55: 70-78.

Brooks, E. and R. Geyer (2020) "The development of EU health policy and the Covid-19 pandemic: trends and implications". *Journal of European Integration*, 8(42): 1057-1076.

Cebollero-Salinas, A., M. Mauri-Medrano and M. Denoni-Buján (2025) "Deep learning in Spanish university students: The role of digital literacy and critical thinking". *Education Sciences*, 9(15): 1183.

"EU drugs strategy 2021–2025". Council of the European Union, 2020.

"Council Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work". OJ L 183, 29.6.1989.

"Council Resolution of 2 June 1994 on the framework for Community action in the field of public health". OJ C 165/1, 17.6.1994.

"Council Resolution of 18 November 1999 on the promotion of mental health". OJ C 86/1, 24.3.2000.

Dohnány S., Z. Kurth-Nelson, E. Spens et al. (2025) "Technological folie à deux: Feedback loops between AI chatbots and mental illness. DOI: 10.48550/arXiv.2507.19218

Dollard, M., C. Dormann and M. Awang Idris (2019) *Psychosocial Safety Climate: A New Work Stress Theory* (Cham: Springer).

Edquist, K. (2022) "Actor-networking European Union mental health governance, 1999–2018". *Journal of Contemporary European Research*, 1(18): 32-47.

"European drug report 2023: Trends and developments". EMCDDA, 2023.

"Mental health in the EU". European Parliamentary Research Service, 12 July 2023.

"ETUC resolution on specific demands for a European Directive on the prevention of psychosocial risks at work". European Trade Union Confederation, 2024.

"The costs of cardiovascular diseases and depression attributable to psychosocial work exposures in the European Union". European Trade Union Institute, 2025.

Dubois, H. (2025) "Mental health: Risk groups, trends, services and policies". Eurofound, 2 September.

"Green paper: Improving the mental health of the population – towards a strategy on mental health for the European Union". COM(2005)484. European Commission, 14 October 2005.

European Commission (2017) *Mental Health at Work: EU-Level Review* (Brussels: European Commission).

"European Pact for Mental Health and Wellbeing". European Commission, 2008.

"European Pillar of Social Rights". European Commission, 16 November 2017.

"Digital education action plan: policy background". European Commission.

"EU4Health Programme 2021-2027 – a vision for a healthier European Union". European Commission.

"2022 State of the Union Address by President von der Leyen". European Commission, 14 September 2022.

"Tobacco Products Directive – implementation report". European Commission, 2022.

"The Digital Services Act". European Commission, 27 October 2022.

"A comprehensive approach to mental health". European Commission, 7 June 2023.

"Flash Eurobarometer 530". European Commission. 2023

"EU-Compass for Action on Mental Health and Well-being". European Commission. 2016

Eurofound (2023), Right to disconnect: Implementation and impact at company level, Publications Office of the European Union, Luxembourg

"Resolution on the right to disconnect". European Parliament, 21 January 2021.

"Artificial Intelligence Act – draft report". European Parliament, 2023.

"Healthy workplaces campaign 2023–25". EU-OSHA.

"Mental health and related issues statistics". Eurostat.

Shiri R, Nikunlaakso R, Laitinen J. Effectiveness of Workplace Interventions to Improve Health and Well-Being of Health and Social Service Workers: A Narrative Review of Randomised Controlled Trials. Healthcare (Basel). 2023 Jun 17;11(12):1792. doi: 10.3390/healthcare11121792

Floridi, L. (2020) *The Ethics of Artificial Intelligence* (Oxford: Oxford University Press).

"Vulnerabilities, mental health and addictions". Foundation for European Progressive Studies. 2023

Harvey, S. B., S. Joyce, L. Tan et al. (2017) "Developing a mentally healthy workplace: A review of the literature". *Australian & New Zealand Journal of Psychiatry*, 12(51): 108-120.

Henson P, Wisniewski H, Hollis C, Keshavan M, Torous J. Digital mental health apps and the therapeutic alliance: initial review. BJPsych Open. 2019 Jan;5(1):e15. doi: 10.1192/bjo.2018.86. PMID: 30762511

Hervey, T. and A. de Ruijter (2020) *Health Law and Policy in the European Union* (Oxford: Oxford University Press).

Howard, A., R. Antczak and K. Albertsen (2022) "Third European Survey of Enterprises on New and Emerging Risks (ESENER-3)". EU-OSHA, 26 July.

Irastorza, X., M. Milczarek and W. Cockburn (2016) "Second European Survey of Enterprises on New and Emerging Risks (ESENER-2)". EU-OSHA, 30 June.

John A, Glendenning A, Marchant A, Montgomery P, Stewart A, Wood S, Lloyd K, Hawton K. "Self-Harm, Suicidal Behaviours, and Cyberbullying in Children and Young People: Systematic Review" J Med Internet Res 2018;20(4):e129 DOI: 10.2196/jmir.9044

Kingdon, J. W. (1995). Agendas, Alternatives, and Public Policies (2nd Ed.). Longman, MI: The University of Michigan.

Ladi, Stella & Tsarouhas, Dimitris. (2020). EU economic governance and Covid-19: policy learning and windows of opportunity. Journal of European Integration. 42. 1041-1056. 10.1080/07036337.2020.1852231.

"Workplace Wellbeing Index 2025", Laya Healthcare, 2025

Makarevičienė, A., M. Nightingale, G. Skubiejūtė et al. (2023) "Minimum health and safety requirements for the protection of mental health in the workplace". Committee on Employment and Social Affairs, Policy Department for Economic, Scientific and Quality of Life Policies. European Parliament, May.

"Care for Mental Health, Invest in Social Rights". Mental Health Europe. 2025

"Burnout report: Young workers". Mental Health UK, 2025.

"Dialogues on emotional health and wellbeing: a mosaic of perspectives", Merck, 2025

OECD (2021) "Fitter minds, fitter jobs: From awareness to change in integrated mental health, skills and work policies". OECD Publishing. DOI: 10.1787/a0815d0f-en

OECD (2021) "Preventing harmful alcohol use". OECD Publishing. DOI: 10.1787/6e4b4ffb-en

OECD/European Union (2022), Health at a Glance: Europe 2022: State of Health in the EU Cycle, OECD Publishing, Paris, https://doi.org/10.1787/507433b0-en.

OECD (2022), Promoting Health and Well-being at Work: Policy and Practices, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/e179b2a5-en.

OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/6e4b4ffb-en.

"Digital divide in education". OECD. 2021

"The Europe We Want", Party of European Socialists. 2024

Santini, Z. I., L. C. Thygesen and S. Andersen (2025) "Social media addiction predicts compromised mental health as well as perceived and objective social isolation in Denmark: A longitudinal analysis of a nationwide survey linked to register data". *International Journal of Mental Health Addiction*, 23: 3136-3153. DOI: 10.1007/s11469-024-01283-3

Schmidt, Vivien. (2008). Discursive Institutionalism: The Explanatory Power of Ideas and Discourse. Annual Review of Political Science. 11. 10.1146/annurev.polisci.11.060606.135342.

Thiagarajan, T. C., J. J. Newson and S. Swaminathan (2025) "Protecting the developing mind in a digital age: A global policy imperative". *Journal of Human Development and Capabilities*, 3(26): 493-504. DOI: 10.1080/19452829.2025.2518313

Tiihonen J, Lönnqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, Haukka J. No mental health without physical health. Lancet. 2011 Feb 19;377(9766):611. doi: 10.1016/S0140-6736(11)60211-0.

Twenge, J. M. (2019) *iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy* (New York: Atria Books).

"S&D Group's Position Paper: Towards a European Mental Health Strategy". The Progressive Alliance of Socialists and Democrats in the European Parliament. 2022

van der Linden, S., J. Roozenbeek and J. Compton (2020) "Inoculating against fake news about COVID-19". *Frontiers in Psychology*, 11, 23 October. DOI: 10.3389/fpsyg.2020.566790

David W. Vinson and Mihael Arcan and David-Paul Niland and Fionn Delahunty (2024), "Towards Sustainable Workplace Mental Health: A Novel Approach to Early Intervention and Support ". DOI: 10.48550/arXiv.2402.01592

Kristian Wahlbeck, European mental health policy should target everybody, European Journal of Public Health, Volume 21, Issue 5, October 2011, Pages 551–553, https://doi.org/10.1093/eurpub/ckr122

Wallace, J., E. Boers, J. Ouellet et al. (2023) "Screen time, impulsivity, neuropsychological functions and their relationship to growth in adolescent attention-deficit/hyperactivity disorder symptoms". *Scientific Reports*, 1(13): 18108. DOI: 10.1038/s41598-023-44105-7

Winkler, I., M. Richter-Werling and M. C. Angermeyer (2006) "Strategien gegen die Stigmatisierung psychisch kranker Menschen und ihre praktische Umsetzung am Beispiel des Irrsinnig Menschlich e. V. [Strategies against the stigmatisation of mentally ill subjects and their practical realisation in the example of Irrsinnig Menschlich e. V.]". *Gesundheitswesen*, 11(68): 708-713. DOI: 10.1055/s-2006-927256

Wynne, R., I. Houtman, S. Leka et al. (2014) "Promoting mental health in the workplace". European Commission.

"A vision for youth mental wellbeing in Europe". White paper. Z Zurich Foundation, 2024.

"Mental Health Declaration for Europe". WHO. 2005

"Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

Zuboff, S. (2019) *The Age of Surveillance Capitalism* (London: Profile Books).

About the authors

TOMÁŠ PETŘÍČEK

Tomáš Petříček is a senior non-residential fellow at the Centre of Global Political Economy at the Institute of International Relations in Prague. He is also director of Progressive Analytical Centre, the Prague based think-tank. Since 2022 he is member of the Board of Trustees of the Boris Nemtsov Foundation for Freedom.

JANA MICHAILIDU

Jana Michailidu is an expert in addiction policy and public health with a PhD in Biotechnology. She is an Assistant professor at the University of chemistry of technology Prague, serves as an advisor to the Czech Ministry of Justice on evidence-based drug policy and coordinates experts in the Institute for rational addiction policies focusing on harm reduction and rational regulation of addictive substances. She is a member of the national expert committee for evaluating the harmfulness of psychoactive substances and promotes approaches grounded in science, human rights, and social justice. Her work combines scientific expertise with political strategy and systemic advocacy to strengthen prevention services, reduce health inequalities, and support progressive policy reform.

AIDA BIKIC

Dr. Aida Bikic is a clinical psychologist and Associate Professor at the University of Southern Denmark and the Research Unit for Child and Adolescent Psychiatry Southern Denmark. Her research focuses on cognitive development and mental health in children and adolescents, with a particular emphasis on ADHD, digital media use, and non-pharmacological interventions. She also works on developing digital tools such as serious games to support mental health. Her work bridges clinical practice and research, aiming to promote mental health and cognitive development in children through evidence-based, accessible interventions.

SARA BOJARCZUK

Sara Bojarczuk holds a PhD in Sociology from Trinity College Dublin. Her research interests lie within the field of migration, employment and migrants' discrimination, mental health, well-being and social support, in particular social support networks and employment. She currently coordinates the E-Factor project, which examines the employers' interests in the labour migration, where she focuses in particular on the cases of Germany and Poland. Bojarczuk's recent studies on the employer perspective in migration, such as the evolution of the migration industry considering employers' interests, are interdisciplinary and conceptually innovative. Bojarczuk's strong methodological background within the field of migration provides an excellent expertise in the mixed methods approach. She also led the project on Rental Market Discrimination, which employed a field experiment and qualitative component. She is also involved in projects exploring career trajectories of Polish migrants in Ireland, as well as Turks in Poland. In her work, she uses a mixed methods approach, drawing on the benefits offered by both qualitative and quantitative tools. She is also actively involved in advocating for comprehensive migration policies at the EU level, providing expertise around the issues of mental health among migrants as well as solutions for European and African collaboration on sustainable labour migration.

About FEPS

The Foundation for European Progressive Studies (FEPS) is the think tank of the progressive political family at the EU level. Its mission is to develop innovative research, policy advice, training and debates to inspire and inform progressive politics and policies across Europe.

FEPS works in close partnership with its 76 members and other partners – including renowned universities, scholars, policymakers and activists – forging connections among stakeholders from the world of politics, academia and civil society at local, regional, national, European and global levels.

FEPS
FOUNDATION FOR EUROPEAN PROGRESSIVE STUDIES

European Political Foundation - No 4 BE 896.230.213
Avenue des Arts 46, 1000 Brussels (Belgium)
www.feps-europe.eu
@FEPS_Europe

About PAC

Progresivní analytické centrum (PAC) is an independent think tank in the Czech Republic dedicated to understanding and responding to major societal, environmental, economic, and security challenges. It seeks to elevate public debate through critical analysis, promote progressive policy ideas, and facilitate solutions especially around inequalities, climate change, democracy, mental health and technological change. The PAC emphasises open dialogue across social divides, interdisciplinary work, and long-term resilience and sustainable development. Its leadership includes experts from academia, policy, and civil society.

Progresivní analytické centrum (PAC),
Nuselská 262/34
Nusle, 140 00, Praha 4, Czech Republic
www.progresivnicentrum.eu
@ProgresivniC

About IRAP

The Institute for Rational Addiction Policies, established in 2017 by former National Drug Policy Coordinator Jindřich Vobořil, is an independent platform focused on evidence-based addiction policies. In the field of addiction, we advocate for a harm reduction approach (minimising risks and harms) and a regulated market that replaces higher-risk substances with safer alternatives. Our strategy is built on balancing prevention, treatment and a regulated market with low-risk alternatives, emphasizing effective regulation based on risk levels to create a safer environment. Our goal is to develop responsible and sustainable policies grounded in scientific evidence, balancing human rights, societal needs and security considerations.

Hilleho 1842/5
602 00, Brno, Czech Republic
https://addiction-policy.eu/en
@IRAP_ThinkTank

Endnotes

1 "Green paper: Improving the mental health of the population – towards a strategy on mental health for the European Union". COM(2005)484. European Commission, 14 October 2005; "European Pact for Mental Health and Wellbeing". European Commission, 2008

2 "2022 State of the Union Address by President von der Leyen". European Commission, 14 September 2022.

3 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

4 "2022 State of the Union Address by President von der Leyen". European Commission, 14 September 2022.

5 "Mental health and related issues statistics". Eurostat.

6 "Mental health in the EU". European Parliamentary Research Service, 12 July 2023.

7 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.; Dubois, H. (2025) "Mental health: Risk groups, trends, services and policies". Eurofound, 2 September.

8 " Flash Eurobarometer 530". European Commission. 2023

9 "Dialogues on emotional health and wellbeing: a mosaic of perspectives", Merck, 2025

10 "A comprehensive approach to mental health". European Commission, 7 June 2023.

11 "The Europe We Want", Party of European Socialists. 2024

12 Ibid.

13 "A vision for youth mental wellbeing in Europe". White paper. Z Zurich Foundation, 2024.

14 "European Pillar of Social Rights". European Commission, 16 November 2017.

15 "Care for Mental Health, Invest in Social Rights". Mental Health Europe. 2025

16 "S&D Group's Position Paper: Towards a European Mental Health Strategy". The Progressive Alliance of Socialists and Democrats in the European Parliament. 2022

17 "Council Resolution of 2 June 1994 on the framework for Community action in the field of public health". OJ C 165/1, 17.6.1994.

18 "Council Resolution of 18 November 1999 on the promotion of mental health". OJ C 86/1, 24.3.2000.

19 Tiihonen J, Lönnqvist J, Wahlbeck K, Klaukka T, Niskanen L, Tanskanen A, Haukka J. No mental health without physical health. Lancet. 2011 Feb 19;377(9766):611. doi: 10.1016/S0140-6736(11)60211-0.

20 "Mental Health Declaration for Europe". WHO. 2005

21 "Green paper: Improving the mental health of the population – towards a strategy on mental health for the European Union". European Commission.

22 Edquist, K. (2022) "Actor-networking European Union mental health governance, 1999–2018". *Journal of Contemporary European Research*, 1(18): 32-47.

23 Kristian Wahlbeck, European mental health policy should target everybody, European Journal of Public Health, Volume 21, Issue 5, October 2011, Pages 551–553, https://doi.org/10.1093/eurpub/ckr122

24 Hervey, T. and A. de Ruijter (2020) *Health Law and Policy in the European Union* (Oxford: Oxford University Press).

25 "Mental health in the EU". European Parliamentary Research Service.

26 OECD/European Union (2022), Health at a Glance: Europe 2022: State of Health in the EU Cycle, OECD Publishing, Paris, https://doi.org/10.1787/507433b0-en.

27 "EU4Health Programme 2021-2027 – a vision for a healthier European Union". European Commission.

28 "A comprehensive approach to mental health". European Commission.

29 Kingdon, J. W. (1995). Agendas, Alternatives, and Public Policies (2nd Ed.). Longman, MI: The University of Michigan.

30 "Vulnerabilities, mental health and addictions". Foundation for European Progressive Studies. 2023

31 Schmidt, Vivien. (2008). Discursive Institutionalism: The Explanatory Power of Ideas and Discourse. Annual Review of Political Science. 11. 10.1146/annurev.polisci.11.060606.135342.

32 Ladi, Stella & Tsarouhas, Dimitris. (2020). EU economic governance and Covid-19: policy learning and windows of opportunity. Journal of European Integration. 42. 1041-1056. 10.1080/07036337.2020.1852231.

33 Brooks, E. and R. Geyer (2020) "The development of EU health policy and the Covid-19 pandemic: trends and implications". *Journal of European Integration*, 8(42): 1057-1076.

34 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022

35 Ibid.

36 Irastorza, X., M. Milczarek and W. Cockburn (2016) "Second European Survey of Enterprises on New and Emerging Risks (ESENER-2)". EU-OSHA, 30 June.

37 "Burnout report: Young workers". Mental Health UK, 2025.

38 "Workplace Wellbeing Index 2025", Laya Healthcare, 2025

39 Pflügner, K., C. Maier, J. B. Thatcher et al. (2024) "Deconstructing technostress: A configurational approach to explaining job burnout and job performance". *MIS Quarterly*, 2(48): 679-698. DOI: 10.25300/MISQ/2023/16978

40 Dollard, M., C. Dormann and M. Awang Idris (2019) *Psychosocial Safety Climate: A New Work Stress Theory* (Cham: Springer).

41 OECD (2022), Promoting Health and Well-being at Work: Policy and Practices, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/e179b2a5-en.

42 Shiri R, Nikunlaakso R, Laitinen J. Effectiveness of Workplace Interventions to Improve Health and Well-Being of Health and Social Service Workers: A Narrative Review of Randomised Controlled Trials. Healthcare (Basel). 2023 Jun 17;11(12):1792. doi: 10.3390/healthcare11121792

43 "Council Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work". OJ L 183, 29.6.1989.

44 Wynne, R., I. Houtman, S. Leka et al. (2014) "Promoting mental health in the workplace". European Commission.

45 Howard, A., R. Antczak and K. Albertsen (2022) "Third European Survey of Enterprises on New and Emerging Risks (ESENER-3)". EU-OSHA, 26 July.

46 "Resolution on the right to disconnect". European Parliament, 2021.

47 "Wellbeing and productivity in the workplace". *Financial Times*.

48 Makarevičienė, A., M. Nightingale, G. Skubiejūtė et al. (2023) "Minimum health and safety requirements for the protection of mental health in the workplace". Committee on Employment and Social Affairs, Policy Department for Economic, Scientific and Quality of Life Policies. European Parliament, May.

49 "Cost of work-related depression in the EU". European Trade Union Institute, 2025.

50 Makarevičienė, A., M. Nightingale, G. Skubiejūtė et al. (2023) "Minimum health and safety requirements for the protection of mental health in the workplace".

51 Winkler, I., M. Richter-Werling and M. C. Angermeyer (2006) "Strategien gegen die Stigmatisierung psychisch kranker Menschen und ihre praktische Umsetzung am Beispiel des Irrsinnig Menschlich e. V. [Strategies against the stigmatisation of mentally ill subjects and their practical realisation in the example of Irrsinnig Menschlich e. V.]". *Gesundheitswesen*, 11(68): 708-713. DOI: 10.1055/s-2006-927256

52 European Commission (2017) *Mental Health at Work: EU-Level Review* (Brussels: European Commission).

53 "EU-Compass for Action on Mental Health and Well-being". European Commission. 2016

54 David W. Vinson and Mihael Arcan and David-Paul Niland and Fionn Delahunty (2024), "Towards Sustainable Workplace Mental Health: A Novel Approach to Early Intervention and Support ". DOI: 10.48550/arXiv.2402.01592

55 "Healthy workplaces campaign 2023–25". EU-OSHA.

56 Ibid.

57 Harvey, S. B., S. Joyce, L. Tan et al. (2017) "Developing a mentally healthy workplace: A review of the literature". *Australian & New Zealand Journal of Psychiatry*, 12(51): 108-120.

58 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

59 "Digitalisation and the future of work: Mental health dimensions". International Labour Organization, 2021.

60 OECD (2021) "Fitter minds, fitter jobs: From awareness to change in integrated mental health, skills and work policies". OECD Publishing. DOI: 10.1787/a0815d0f-en

61 Eurofound (2023), Right to disconnect: Implementation and impact at company level, Publications Office of the European Union, Luxembourg

62 "ETUC resolution on specific demands for a European Directive on the prevention of psychosocial risks at work". European Trade Union Confederation, 2024.

63 "Healthy workplaces campaign 2023–25". EU-OSHA.

64 "The Digital Services Act". European Commission, 27 October 2022.

65 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

66 Twenge, J. M. (2019) *iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy* (New York: Atria Books).

67 Floridi, L. (2020) *The Ethics of Artificial Intelligence* (Oxford: Oxford University Press).

68 "Digital education action plan: policy background". European Commission.

69 "The Digital Services Act". European Commission.

70 "Artificial Intelligence Act – draft report". European Parliament, 2023.

71 "A comprehensive approach to mental health". European Commission.

72 "Digital divide in education". OECD. 2021

73 John A, Glendenning A, Marchant A, Montgomery P, Stewart A, Wood S, Lloyd K, Hawton K. "Self-Harm, Suicidal Behaviours, and Cyberbullying in Children and Young People: Systematic Review" J Med Internet Res 2018;20(4):e129 DOI: 10.2196/jmir.9044

74 "Mental health and related issues statistics". Eurostat.

75 Zuboff, S. (2019) *The Age of Surveillance Capitalism* (London: Profile Books).

76 Andrews, G., A. Basu, P. Cuijpers et al. (2018) "Computer therapy for the anxiety and depression disorders is effective, acceptable and practical health care: An updated meta-analysis". *Journal of Anxiety Disorders*, 55: 70-78.

77 Henson P, Wisniewski H, Hollis C, Keshavan M, Torous J. Digital mental health apps and the therapeutic alliance: initial review. BJPsych Open. 2019 Jan;5(1):e15. doi: 10.1192/bjo.2018.86. PMID: 30762511

78 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

79 Ibid.

80 Cebollero-Salinas, A., M. Mauri-Medrano and M. Denoni-Buján (2025) "Deep learning in Spanish university students: The role of digital literacy and critical thinking". *Education Sciences*, 9(15): 1183; Wallace, J., E. Boers, J. Ouellet et al. (2023) "Screen time, impulsivity, neuropsychological functions and their relationship to growth in adolescent attention-deficit/hyperactivity disorder symptoms". *Scientific Reports*, 1(13): 18108. DOI: 10.1038/s41598-023-44105-7

81 Thiagarajan, T. C., J. J. Newson and S. Swaminathan (2025) "Protecting the developing mind in a digital age: A global policy imperative". *Journal of Human Development and Capabilities*, 3(26): 493-504. DOI: 10.1080/19452829.2025.2518313

82 OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/6e4b4ffb-en.

83 van der Linden, S., J. Roozenbeek and J. Compton (2020) "Inoculating against fake news about COVID-19". *Frontiers in Psychology*, 11, 23 October. DOI: 10.3389/fpsyg.2020.566790

84 "A comprehensive approach to mental health". European Commission.

85 Ibid.

86 Floridi, L. (2020) *The Ethics of Artificial Intelligence*;

87 "Healthy workplaces campaign 2023–25". EU-OSHA.

88 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

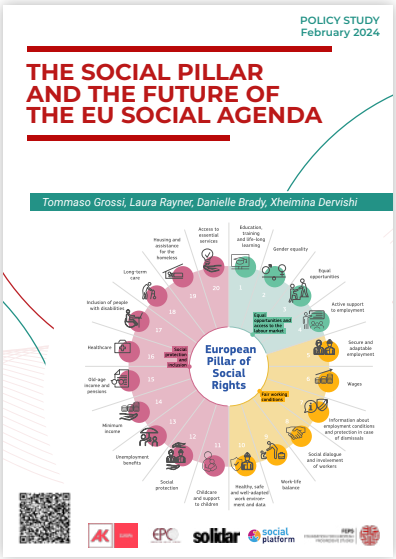
89 "European Pillar of Social Rights". European Commission.

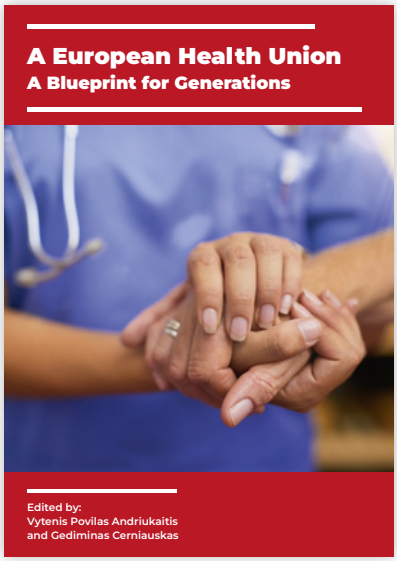
90 Hervey, T. and A. de Ruijter (2020) *Health Law and Policy in the European Union*.

91 "Healthy workplaces campaign 2023–25". EU-OSHA.

92 "Mental health at work: Policy brief". WHO & ILO, 28 September 2022.

ON SIMILAR TOPICS





Healthy minds, stronger Europe:
Progressive solutions for mental health and wellbeing in Europe