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Mental health of young people in a digital era

Cost of non-Europe report

STUDY

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Mental health of young people in a digital era

Cost of non-Europe report

Youth mental ill-health in the EU-27 is high, rising and increasingly associated with digital environments. Around one in five young people live with a diagnosable mental disorder, with anxiety and depression leading the burden, and almost half report unmet mental health needs. Problems are concentrated among girls and young women and among young people facing poverty, discrimination, trauma, or displacement.

The study shows how persuasive platform design, harmful content and emerging AI-mediated interactions amplify offline vulnerabilities in the context of under-resourced, fragmented services and a large 'missing middle' between schools and specialist care. Using seven country case studies and an EU-27 cost model, it estimates that youth mental ill-health will cost about €1.68 trillion over 2024-2033 if the status quo continues.

It proposes a coherent package of EU-level options, school-based promotion, youth-friendly early-intervention services, social prescribing, safer digital tools, child-centred enforcement of the digital acquis and stronger data and governance, that could reduce this burden while respecting EU competences and fundamental rights.

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AUTHORS

This study has been written by Yannick Vuylsteke [Ipsos], Dr Facundo Herrera [Ipsos], Martin Kuehnemund [Ipsos], Maxime Moulac [Milieu], Dr Aric Sigman [Psychologist], Elena Mastrogregori [Ipsos], Paloma Crotti [Ipsos], Jana Dilger [Ipsos], Ellie Keeble [Ipsos], Evie Cogley [Ipsos] and Wiktor Magdziarz [Ipsos] at the request of the European Added Value Unit of the Directorate for Impact Assessment and Evaluation, within the Directorate-General for Parliamentary Research Services (EPRS) of the Secretariat of the European Parliament.

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ADMINISTRATORS RESPONSIBLE

Claudia Koreimann-Özkan and Filippo Sinicato, European Added Value Unit of the Directorate for Impact Assessment and Evaluation, within EPRS.
To contact the publisher, please email eprs-europeanaddedvalue@europarl.europa.eu

PEER REVIEWER

The study was peer reviewed by Dr Wouter van den Bos, Associate Professor, Department of Psychology, Faculty of Social and Behavioural Sciences, University of Amsterdam.

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eprs@ep.europa.eu
http://eprs.in.ep.europa.eu/ (intranet)
http://www.europarl.europa.eu/thinktank (internet)
http://epthinktank.eu (blog)

Executive summary

Purpose, scope and approach

This study was commissioned by the European Parliament's Committee on Public Health (SANT) to provide an integrated evidence base on the mental health of young people in a digital era and to identify where EU-level action could add value. It focuses on children, adolescents and young adults from approximately 2 to 24 years of age, with the main emphasis on the EU-27 and illustrative comparisons with selected non-EU countries. Early childhood digital exposure (particularly around sleep and caregiver interaction) is considered as part of the developmental foundations, while the quantitative modelling in this study starts at the age of 10 because comparable EU-level prevalence and cost data for younger children are not available.

The analysis combines:

- a structured review of recent scientific and policy literature on prevalence, determinants and impacts of youth mental ill-health, mapping of EU and international legal and policy frameworks;
- a descriptive mapping and seven in-depth country case studies of national policies and interventions;
- development of six EU-level policy options within existing competences;
- an EU-27 quantitative model of the cost of inaction and of avoided-cost scenarios, and;
- a comparative assessment of the likely impacts, trade-offs and EU added value of the options.

State of youth mental health in the EU-27

The evidence shows that youth mental ill-health in the EU-27 is both widespread and increasing, particularly for anxiety and depression. A meta-analysis of general population studies conducted in various countries across the European region indicates that around one in five young people live with a diagnosable mental disorder, with pooled prevalence of about 15.5 %. Anxiety disorders are the most common, followed by attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (behavioural conditions that cause moderate to severe impairment in social, family, or educational settings) and depressive disorders. Estimates from the Global Burden of Disease study suggest that roughly 13.6 million young people aged 10-24 in Europe are living with a mental disorder, with anxiety and depression dominating years lived with disability. National data, for example from the Netherlands, confirm rising trajectories; self-reported emotional problems among secondary school girls surged from 28 % in 2017 to 43 % in 2021 (Section 2.1.1).

Beyond formal diagnoses, sub-clinical distress is very common. PISA 2022 data indicate that nearly half of 15-year-olds report feelings of depression and more than half say they struggle with anxiety. The 2023 Flash Eurobarometer on mental health finds that 15-24-year-olds are more likely than older cohorts to report low self-esteem, difficulty concentrating and loss of interest in usual activities. The share of 15-year-olds reporting multiple psychosomatic complaints, which is a proxy for psychological distress including irritability, low mood and sleep problems, rose from 42 % to 52 % between 2018 and 2022 in the EU (Section 2.1.1). These indicators capture changes in symptoms and distress rather than only formally diagnosed disorders.

Problems are not evenly distributed. Internalising conditions such as anxiety, depression and eating disorders are much more common among girls and young women; externalising conditions such as

ADHD and conduct disorder are more prominent among boys. In the EU, 60 % of 15-year-old girls report feelings of depression compared with 35 % of boys. Symptoms are disproportionately concentrated among young people living in poverty, in families affected by conflict or instability, among LGBTQIA+ youth, migrants, refugees and those in alternative care. For example, children with probable mental disorders are more likely to live in households that cannot afford extracurricular activities, and disadvantaged groups are more likely to experience both offline and online victimisation (Sections 2.1.1 and 2.3.3).

The systems expected to respond to these needs are not designed for early, youth-friendly support. Almost one in two Europeans aged 15–24 report unmet mental healthcare needs. Even in well-resourced Member States many young people with mental health problems receive no formal support. Waiting times for specialist child and adolescent mental health services are often measured in months or years, and hospital emergency departments increasingly act as de facto entry points for those in crisis. Children and adolescents are still occasionally admitted to adult psychiatric wards due to shortages of age-appropriate facilities. Public spending is concentrated in acute, hospital-based care, while prevention, school-based support, youth-friendly community services and early intervention remain under-resourced (Sections 2.1.3 and 2.3.4).

The consequences unfold across the life course. Poor mental health in childhood and adolescence undermines learning and increases the likelihood of grade repetition, early school leaving and entry into the NEET category (Not in Education, Employment or Training). People with a history of youth-onset mental health conditions are less likely to complete upper-secondary and tertiary education, and more likely to experience unemployment or precarious work. Across the Organisation for Economic Co-operation and Development (OECD), employment rates for people with mental health conditions are around 20 % lower than for those without, with larger gaps in some Member States. Lifetime earnings penalties associated with mental health conditions emerging before adulthood are estimated in the range of 17–20 %, representing a substantial loss of human capital (Section 2.4.3). These individual trajectories translate into higher long-term costs for health, education, social-protection and labour-market systems (Sections 2.4.3–2.4.4 and 6.4).

Drivers in the digital era and concurrent crises

The study finds that the digital drivers contributing to negative youth mental health are the interaction of four elements: the developmental timing of mental-health onset; offline adversities; digital-era risk pathways; and system weaknesses.

Most lifetime mental disorders emerge before adulthood. Around half of disorders begin by the age of 14 (adolescence can acutely disrupt mental well-being) and three quarters of them by the age of 24 (during the period where young people experience social transitions and are exposed to psychosocial stressors). The adolescent brain is undergoing extensive reorganisation: socio-emotional reward-processing networks mature earlier than prefrontal control systems, leaving young people temporarily more sensitive to peer influence and rewards than to long-term planning and impulse control. Social-neuroscience and psycho-traumatology evidence shows that chronic stress, maltreatment and discrimination can become biologically embedded during this period, affecting stress-response systems and executive function (Sections 1.2.3 and 2.3.3).

Young people now navigate these vulnerable years within ubiquitous, algorithmically mediated digital environments. The study identifies three overlapping pathways through which digitalisation shapes mental health (Section 2.2.1). Design-driven overuse and displacement arise from persuasive features such as infinite scroll, autoplay, variable rewards and constant notifications, which are optimised to maximise engagement while self-regulation is still developing. For some users, this is

associated with excessive use that crowds out sleep, physical activity, homework and in-person social contact, and is associated with attentional problems, irritability, fatigue, and school burnout (Sections 2.1.2, 2.3.1 and 2.4.2). Content-driven harms occur when recommender systems rapidly surface and concentrate harmful material such as self-harm content, pro-eating-disorder communities, or hateful and extremist content. This can exacerbate underlying vulnerabilities, especially in relation to body image and self-harm (Sections 2.3.1 and 2.4.1). AI-mediated interactions, particularly social AI chatbots and 'companions', add a new layer of risk. These systems simulate empathy and intimacy but lack moral judgement and can produce unsafe responses, encouraging unhealthy dependencies or validating dangerous thoughts (Sections 2.3.1 and 2.4.1).

These digital pathways do not affect all young people equally. For most, online environments are neutral or beneficial when embedded in balanced lives and supported by protective offline relationships. For a vulnerable minority, however, digital environments amplify pre-existing difficulties. Young people who grow up in poverty, in families affected by conflict or instability, or who face discrimination on the basis of race, migrant status, disability, gender identity or sexual orientation, have higher baseline distress and fewer supportive adults, and are more likely to seek relief and recognition online. They also face higher exposure to online risks such as cyberbullying, sexual solicitation and toxic communities, while having fewer resources to cope with them. Offline and online adversities thus reinforce each other, creating a 'double disadvantage' (Section 2.3.3). Concurrently, Europe has experienced a series of crises that add cumulative pressure. The COVID-19 pandemic disrupted schooling, increased isolation and stress in families, and exposed pre-existing inequalities. Cost-of-living pressures, housing insecurity, climate anxiety and the effects of conflict and forced displacement, including the war in Ukraine, have further strained young people's mental health and stretched services (Sections 1.1 and 2.3.3). These crises have worsened social determinants such as income and housing, increased demand for support and made system weaknesses more visible.

At the same time, it should be noted that digital technology has benefits. Evaluated online interventions (for example, computerised cognitive behavioural therapy and brief problem-solving tools) and moderated peer-support communities can provide modest symptom relief and reduce loneliness for some adolescents, especially those who face stigma or isolation offline (Sections 2.2.1 and 4.2).

EU-level options within existing competences

Within the constraints of the Treaties, the EU cannot redesign national health or education systems, but it has meaningful levers to act on the determinants of youth mental health and to support Member States. Article 114 TFEU gives the Union strong, binding competences to regulate the internal market and digital services. Articles 168, 165 and 153 TFEU provide supporting competences in public health, education, youth and aspects of social policy, enabling the EU to adopt incentive measures, soft law and funding programmes but not to harmonise service organisation (Sections 3.1 and 3.6.1). The Charter of Fundamental Rights, in particular Articles 24 (rights of the child), 35 (health care) and 7–8 (privacy and data protection), provides an additional normative framework for action.

In practice, this means the EU can regulate platform and AI design, set common standards for digital services, and fund and coordinate prevention and early-intervention efforts and data systems, while Member States retain primary responsibility for organising and financing health and education services.

In this context, the study identifies six policy options, grouped into three areas (Chapter 5). In prevention and support in everyday settings, the options are: an EU support package for school-based mental health promotion and digital wellbeing (Option 1); an EU framework for youth-friendly early-intervention services or 'youth hubs' (Option 2); and an EU initiative on social prescribing and community-based pathways for vulnerable youth (Option 3). These three options also offer the advantage of involving the families of those affected. To achieve a sustainable improvement of the mental health issues, the 'system family' of those affected should, wherever possible, be actively informed and, where feasible, encouraged to collaborate. In the digital domain, options focus on child-centred implementation of existing EU digital legislation, and, where justified, assessment of the case for additional measures in narrowly defined high-risk areas (Options 5a and 5b). A cross-cutting option aims to improve the quality and integration of digital mental health tools (Option 4). Finally, Option 6 proposes EU-level measures on data, monitoring and governance to support all other actions.

These options use EU levers that are already available. Options 1-3 and 6 make use of soft law, funding and coordination instruments under Articles 165, 168, 153 and 338 TFEU (for example, EU4Health, ESF+, Erasmus+, Horizon Europe, Council recommendations and joint actions). Options 4 and 5 rely on the internal market base (Article 114 TFEU) and existing digital *acquis* (Digital Services Act, Audiovisual Media Services Directive, AI Act, Child Sexual Abuse Material rules, General Data Protection Regulation). The options are designed to be voluntary, adaptable and equity-oriented, and to support, not replace, national and regional initiatives.

The strongest evidence of effectiveness and cost-effectiveness underpins school-based promotion and digital well-being (Option 1) and youth-friendly early-intervention services (Option 2). Social prescribing and community pathways (Option 3) and digital mental-health tools (Option 4) are promising but less systematically evaluated, while child-centred implementation of EU digital legislation and AI governance (Option 5) are justified on a precautionary basis. Data, monitoring and governance measures (Option 6) act as essential enablers for all other options.

Impacts and cost of non-Europe

The quantitative model in Chapter 6 estimates that, under a continuation-of-status-quo scenario (Option 0), youth mental ill-health (ages 10-24) will cost the EU-27 around €1.68 trillion in 2024 present value over the decade 2024-2033, with a plausible range from €1.28 trillion to €2.02 trillion depending on assumptions (Section 6.4). This burden is shared across health, social protection, education and the labour market and is expected to grow over time even as the youth population shrinks, because prevalence, especially of anxiety, continues to rise.

Chapter 7 uses this baseline to explore, in an illustrative way, what different combinations of EU-level options might deliver. The model is explicitly option-agnostic; it provides avoided-cost scenarios for generic prevalence reductions of 1 %, 3 %, 5 %, 7 % and 10 %, and these are then linked qualitatively to the options on the basis of the evidence reviewed in Chapters 2 and 4.

The strongest evidence base is for school-based promotion and youth-friendly early-intervention services. Universal, curriculum-integrated school-based programmes that build socio-emotional skills and mental health literacy, and are delivered with reasonable fidelity, have been shown in multiple trials to improve coping, classroom climate and, in some cases, reduce suicidal ideation and attempts. Youth-friendly community and primary-care services that offer low-threshold, brief interventions for mild-to-moderate difficulties (the youth-hub model) have robust clinical and economic evidence and, when scaled and integrated with schools and primary care, are plausibly capable of contributing to meaningful reductions in prevalence and severity (Sections 4.2.1-4.2.2

and 7.4). In combination, these two options form the most credible backbone of a strategy to achieve sustained reductions in youth mental ill-health, corresponding to substantial avoided costs over 10 years. Other options play important complementary roles. Social prescribing and community-based pathways for vulnerable youth can extend support beyond formal settings and address social determinants, particularly for NEET youth, migrants and refugees, LGBTQIA+ young people and those in care. Evidence is promising but not yet strong enough to assign a defensible EU-wide prevalence-reduction range, though such approaches are likely to have significant equity and long-term labour-market benefits (Sections 4.2.4 and 7.4). A framework for digital mental health tools can improve safety and enable more consistent use of effective tools in schools and services, but individual tools typically have modest effects and should be treated as one component of broader support. Child-centred implementation and possible strengthening of EU digital regulation can reduce exposure to the digital-era risk pathways identified earlier, but evidence on mental health outcomes of specific regulatory interventions is still emerging. Data, monitoring and governance improvements do not reduce prevalence directly, but they are essential to make all other options effective, targeted and accountable.

Taken together, the analysis shows that maintaining the current trajectory would leave the main structural weaknesses and inequalities largely unchanged and implies a very high and rising cost of non-Europe. A realistic package of EU-level action, within existing competences and respecting subsidiarity, can support Member States in moving towards a more preventive, youth-friendly and digitally informed response, and can help ensure that Europe's digital environment evolves in ways that are more consistent with children's rights and long-term wellbeing.

Study interpretation

Finally, the subject matter is evolving rapidly. Even during the short period in which this study was conducted, several EU and non-EU countries moved forward with new initiatives – for example, proposals or legislation to restrict social media access for under-16s – and evolving approaches to age assurance and AI-driven services. The report reflects the situation and evidence available at the time of writing. Readers should therefore interpret the findings against a backdrop of fast-moving policy and technological change and view the conclusions and options as a contribution to an ongoing debate rather than as a definitive or static assessment.

Glossary

Acronym	Meaning
ABCD	Adolescent brain cognitive development
Absenteeism	Chronic or habitual absence from school or work, which within this study is frequently driven by underlying psychological distress or mental ill-health
ADHD	Attention-deficit/hyperactivity disorder
Age assurance (age verification/estimation)	Processes to determine or estimate user age to apply child protections while respecting privacy
AI	Artificial intelligence
AI Act	Artificial Intelligence Act
AI companion/social chatbot	Conversational AI simulating empathy/relationship
Algorithmic curation/recommender systems	Systems that prioritise and personalise content to maximise engagement
AMHS	Adult mental health services
APA	American Psychological Association
ASD	Autism spectrum disorder
AVMSD	Audiovisual Media Services Directive
BIK+	Strategy for a better internet for kids
Blended care	Combining digital tools with human support (e.g. cCBT plus brief therapist guidance)
CAMHS	Child and adolescent mental health services
CASEL	Collaborative for Academic, Social, and Emotional Learning
CBT	Cognitive behavioural therapy
cCBT	Computerised cognitive behavioural therapy
CoE	Council of Europe
Comorbidity	Co-occurrence of two or more conditions in the same person.
Content-driven harms	Harms from exposure to problematic content (e.g. self-harm, pro-eating-disorder, hate/extremism).
CSAM	Child sexual abuse material
Cyberbullying	Bullying via digital channels (messages, social media, games), including harassment, exclusion, doxing or image abuse

DALY	Disability-adjusted life year; sum of years lived with disability and years of life lost
DCEDIY	Department of Children, Equality, Disability, Integration and Youth
Design-driven overuse	Excessive use encouraged by persuasive features (e.g. infinite scroll, autoplay, streaks, variable rewards)
Digital acquis	The body of EU law governing the digital environment (e.g., DSA, AVMSD, GDPR, AI Act)
DSA	Digital Services Act
DSC	Digital Services Coordinator
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECHR	European Convention on Human Rights
EEA	European Economic Area
EHDS	European Health Data Space
EHES	European Health Examination Survey
EHIS	European Health Interview Survey
EMA	Ecological Momentary Assessment; repeated, in-the-moment measurement in natural settings (often via smartphones)
EPRS	European Parliamentary Research Service
ERDF	European Regional Development Fund
ESF+	European Social Fund Plus
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU acquis	The entire accumulated body of EU laws, legal acts, and court decisions that all Member States must adopt and follow
Eurofound	European Foundation for the Improvement of Living and Working Conditions
GBD	Global burden of disease
GDPR	General Data Protection Regulation
GDP	Gross domestic product
HBSC	Health behaviour in school-aged children
Harmful but legal content	Content not illegal but likely to harm (e.g. pro-ana, self-harm advice, certain misogynistic content); often addressed by platform duties rather than criminal law
HRB	Health Research Board
IHME	Institute for Health Metrics and Evaluation

Internalising vs externalising disorders	Internalising: inward symptoms (anxiety, depression). Externalising: outward behaviours (ADHD, conduct)
IAPT	Improving access to psychological therapies
ICD	International Classification of Diseases
IGD	Internet gaming disorder
JRC	Joint Research Centre
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual (and others)
LCFI	Leverhulme Centre for the Future of Intelligence
LLM	Large language model
MEP	Member of the European Parliament
MHED	Mental Health Emergency Department(s)
MHFA	Mental Health First Aid
MHST	Mental Health Support Team(s)
Missing middle	Young people with mild-to-moderate difficulties above self-help but below specialist thresholds; often underserved
NEET	Not in Education, Employment, or Training: A term describing young people who are currently unemployed, out of school, and not in vocational training, often indicating high vulnerability to long-term economic and social exclusion
NHS	National Health Service
NKROP	National Competence Centre for Concurrent Substance Abuse and Mental Health Disorders
NCDs	Non-communicable diseases
OECD	Organisation for Economic Co-operation and Development
ORS	Outcome Rating Scale
Parasocial relationship	One-sided emotional bond formed with media figures or chatbots that appear reciprocal
PISA	Programme for International Student Assessment
PMHC	Prompt mental health care
Presenteeism	Reduced productivity while at work due to ill-health (including mental health)
Proportionality	The rule that EU legal actions must match the scale of the problem and not go beyond what is strictly necessary, avoiding unfair burdens

QALY	Quality-adjusted life year
Rabbit hole	A digital phenomenon where platform algorithms continuously feed a user related content, trapping them in a loop of prolonged screen time or exposure to harmful material
RBUP	Regional Centre for Child and Adolescent Mental Health
RKBU	Regional Knowledge Centre for Child and Youth Mental Health
RCT	Randomised controlled trial
ROI	Return on investment
Safety by design	Designing services to prevent foreseeable harms (especially to minors) through defaults, features and governance
SANT	Subcommittee on Public Health
SCESS	Schools and Colleges Early Support Service (Anna Freud Centre)
SDGs	Sustainable Development Goals
SDQ	Strengths and Difficulties Questionnaire
SEL	Social and emotional learning
School refusal (emotionally based school avoidance)	Non-attendance driven by emotional distress rather than conduct problems
SICs	Safer Internet Centres
Social jetlag	Misalignment between biological sleep rhythms and social schedules; often worsened by late-night device use
Social prescribing	Non-clinical referral to community activities (e.g. sports, arts, nature, volunteering) to reduce isolation and improve wellbeing
SPHE	Social, personal and health education
Stepped care	Matching care intensity to need and stepping up/down as required
Subsidiarity	The principle that the EU should only step in and pass laws if a problem cannot be effectively handled at the national, regional, or local level
TFEU	Treaty on the Functioning of the European Union
UONPIA	Child and Adolescent Neuropsychiatry Unit
UNCRC	United Nations Convention on the Rights of the Child
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund

Vamping	Staying up very late on devices/social media, leading to sleep loss and daytime impairment
VLOP	Very Large Online Platform
VLOSE	Very Large Online Search Engine
VSP	Video-sharing platform
WHO	World Health Organization
YAM	Youth Aware of Mental Health
YLD	Years lived with disability; time lived with health loss due to disability (component of DALY)

Table of contents

Table of Figures

Table of Tables

Table of Boxes

1. Introduction

Summary of key points

The study supports the European Parliament's Committee on Public Health (SANT) with an accessible, balanced evidence base on youth mental health in a digital era and the 'cost of non-Europe', for use by MEPs, EU institutions and national policymakers.

It covers children, adolescents and young adults aged roughly 2–24 across the EU-27, with a developmental focus on different life stages. The analytical chapters consider the full range; the quantitative model in Chapter 6 covers ages 10–24, where comparable EU-level data exist. Selected non-EU countries are used as illustrative comparators.

Mental health is understood in line with WHO, as a continuum from flourishing to diagnosable conditions, viewed over the life course. The study considers both clinical disorders and common sub-clinical distress, and treats the digital environment (social media, gaming, messaging, AI-mediated interactions) as a modifiable determinant alongside offline drivers such as family conflict, childhood maltreatment, COVID-19, conflict, cost-of-living pressures and climate anxiety.

This is a broad 'cost of non-Europe' analysis, not a clinical guideline or ranking of national systems. It concentrates on common conditions and difficulties most relevant to EU-level competences and selectively examines EU instruments that directly affect youth mental health and the digital environment.

Chapter 1 sets four core questions on state of play, drivers (including digital), EU-level options and the cost of inaction. The study answers them through a mixed-methods design: structured evidence review, mapping of EU and international frameworks, EU-wide policy and system mapping and seven country case studies, development of six EU-level policy options, and an EU-27 cost model.

1.1. Purpose and audience

This study is designed to equip the European Parliament's Committee on Public Health (SANT) with a clear, balanced, and accessible evidence base on the mental health of young people in the European Union in a digital era. Its core purpose is to support SANT's agenda-setting by bringing together what is known, identifying where the biggest pressures on youth mental health lie, and setting out credible options the EU could pursue, alone or in partnership with Member States, to make a practical difference. As a 'cost of non-Europe' study, it also assesses the economic, social and fundamental-rights implications of maintaining the current trajectory without further EU-level action.

The study examines recent research on the mental health of children, adolescents, and young adults up to 24 years of age across the EU-27, complemented by insights from comparable non-EU countries. It analyses how needs and symptom profiles have changed over recent years, how they differ between childhood, adolescence and early adulthood, and how early difficulties shape later educational and labour-market outcomes in adulthood. Particular attention is paid to the cumulative pressures young people face today: the legacies of the COVID-19 pandemic, the effects of conflict and displacement, rising cost-of-living and economic insecurity, and the growing salience of climate anxiety. In parallel, the study considers the omnipresent digital environment, looking at areas such as social media, gaming, messaging services, and emerging AI applications, recognising both potential benefits and well-documented risks, including exposure to harmful content and sleep disruption.

Beyond describing the state of play, the report identifies potential solutions drawn from Europe and beyond. It highlights promising approaches in health, education, and community settings, as well as

measures that shape the digital environment (for example, age-appropriate design and content safeguards). For each, it considers where and how they work, the conditions needed for success, and their transferability across Member States. The study then looks at the expected impacts of policy options at EU level, setting out potential benefits, limitations and implementation challenges, costs and trade-offs in the short and medium term and, where possible, the wider costs of inaction at EU level.

While SANT and related parliamentary committees are the primary audience, the report is also intended for the wider EU policy community (including relevant Commission services and agencies), national and regional decision-makers across health, education, youth, social policy and online safety, system leaders and practitioners, stakeholders shaping the digital environment, and researchers and communicators who require a reliable synthesis of the evidence.

The report is written for non-specialists. It explains what we know with confidence and where uncertainties remain, drawing on a secondary data review of recent evidence, country case studies carried out specifically for this study, a review and assessment of EU competencies to act, and a high-level assessment of the potential effects of plausible EU-level actions. The aim is not only to describe the problem, but to present a focused, practical menu of options that can inform debate and guide action to improve the mental health and wellbeing of Europe's young people. Chapters 6 and 7 uses a simple quantitative model to illustrate the costs of inaction and the potential benefits of reducing youth mental ill-health, in line with the 'cost of non-Europe' methodology.

1.2. Scope of the study

1.2.1. Age range and population covered

In line with the Terms of Reference (ToR), this study adopts a broad definition of 'young people', covering children, adolescents and young adults from approximately 2 to 24 years of age. This reflects the fact that most mental health conditions first emerge during these years. Children and young people move through key transitions (early childhood, compulsory schooling, upper-secondary or vocational education, and entry into tertiary education, training and work) across this period, and international organisations typically define 'adolescents' and 'youth' within, or overlapping with, this age band (see Section 1.2.3 for definitions and Section 2.2 for evidence on age of onset).

Within the overall 2–24 age range, the analysis adopts a developmental perspective and, where data permits, distinguishes between broad subgroups such as early childhood, primary-school age, early-mid-adolescence and late adolescence-young adulthood. These stages are associated with different patterns of vulnerability, digital use and appropriate forms of prevention and support; this is reflected in the way results are presented in Chapters 2 and 4. While the analytical chapters consider the full 2–24 age range, the quantitative model in Chapter 6 focuses on ages 10 to 24, reflecting the age bands for which comparable EU-level prevalence and cost data are available.

The primary focus is the general population of young people living in the EU-27. Specific high-risk or clinical sub-groups (for example, young people in contact with specialist child and adolescent mental health services (CAMHS), those with neurodevelopmental conditions, or those in alternative care) are included where relevant to the research questions, but the study does not attempt a full clinical review of every diagnostic category. Instead, it concentrates on common conditions and sub-clinical difficulties that affect large numbers of young people and are shaped by the digital environment and wider social and economic factors (see Sections 2.1 and 2.3).

1.2.2. Geographic coverage

The primary geographic scope of the study is the 27 Member States of the European Union (EU-27). All EU-27 countries are included in the mapping of the state of play on youth mental health, the overview of national policies and systems, and the comparative analysis of gaps and common challenges (see Chapters 2 and 4). Where appropriate, the report highlights differences between Member States, while avoiding normative rankings.

To complement the EU picture, the study also draws selectively on a small number of non-EU comparator countries. These are high-income democracies with broadly similar levels of digitalisation and welfare-state development and were chosen because they have implemented notable approaches to youth mental health or digital regulation and have generated evaluative evidence of interest for the EU context (see Chapter 4). The study carried out seven case studies (Australia, Ireland, Italy, Netherlands, Norway, Poland, England) but also drew on wider literature that covered countries such as Canada, Iceland, and Singapore.

These non-EU cases are used to illustrate specific models, regulatory choices and implementation lessons. They are not intended as exhaustive country profiles or as formal benchmarks against which EU performance is ranked. Throughout the report, country examples from both EU and non-EU settings are presented as illustrative case studies that help to explain mechanisms and options relevant for EU-level policy (see Chapter 5).

1.2.3. Definitions and conceptual focus

Definition of mental health

This study adopts the World Health Organization (WHO) definition of mental health as 'a state of wellbeing in which an individual realises his or her abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'.[1] For children, adolescents, and young adults, this must be interpreted through a developmental lens. In this age group, mental health includes a positive sense of identity; the ability to manage thoughts and emotions; the capacity to form and sustain relationships; and the ability to learn, participate and progress in education, training, and early work.[2]

We also draw on the view of mental health as a 'dynamic state of internal equilibrium'.[3] This emphasises basic cognitive and social skills that enable young people to recognise, express, and regulate emotions, empathise with others, adapt to stressors and setbacks, and function in family, school and community roles. Because these capacities are still developing, fluctuations in wellbeing are common and may precede, accompany, or follow clinical symptoms.[4] This perspective is consistent with findings from social neuroscience and psycho-traumatology, which show how early adversity and relational environments shape stress-response systems, executive function and emotional regulation across development.

Mental health exists on a continuum, from positive wellbeing (flourishing), through transient or mild distress, to diagnosable conditions of varying severity.[5] The digital era often shapes where a young person sits on this continuum, through experiences such as exposure to harmful content,

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1 United Nations Children's Fund, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, UNICEF, 2021, p. 33.

2 Ibid.

3 S. Galderisi, A. Heinz, M. Kastrup, J. Beezhold and N. Sartorius, 'Toward a new definition of Mental Health', 2015, quoted in The European House Ambrosetti, *Headway 2023: A new roadmap in Mental Health*, 2023.

4 Ibid.

5 OECD, *Mental Health Promotion and Prevention: Best Practices in Public Health*, OECD Publishing, 2025.

cyberbullying, sleep disruption or social comparison, as well as through opportunities for connection, support and learning. In this study, the digital environment is treated as a set of modifiable determinants of youth mental health, alongside wider drivers such as the legacy of COVID-19, conflict and displacement, cost-of-living pressures, family conflicts, trauma, and climate anxiety.

This working definition allows us to consider both clinical and non-clinical outcomes that matter for young people and policymakers. Throughout, we take a life-course perspective (early childhood, primary years, lower/upper secondary, and early adulthood, age 18–24), and consider how biology, family and school environments, social and economic context, and the digital environment interact over time.

Main disorders

The definition above ensures that the research captures both formally diagnosed psychiatric conditions and the highly prevalent sub-clinical issues that disrupt youth wellbeing in the digital environment without necessarily crossing a clinical threshold. In this sense, the report broadly uses the following terminology consistent with other, similar studies:

- **Mental health issues, problems, or distress**: sub-clinical experiences and psychological distress that do not meet formal diagnostic thresholds.
- **Mental health conditions, disorders, or illnesses**: formally diagnosed psychiatric conditions.
- **Mental ill-health**: an umbrella term encompassing both sub-clinical psychological distress and diagnosed mental health conditions.[6]

The main disorders covered under these are summarised in Table 1 below.

Table 1 – Main clinical and sub-clinical mental health conditions used in this study

Category	Examples and brief description
Sub-clinical mental-health issues, problems or distress	
Mild-to-moderate depressive and anxious symptoms	Frequent low mood, worry or nervousness that do not meet diagnostic criteria but can impair daily life and may progress if unaddressed.
Psychosocial distress and emotional problems	General distress, stress, isolation, loneliness or feeling 'down', often reported by adolescents, especially in digital contexts.
Sleep problems	Insufficient or poor-quality sleep and irregular sleep patterns, often linked to late-night screen use and associated with fatigue and emotional difficulties.
Low self-esteem and body-image concerns	Negative self-evaluation and dissatisfaction with appearance, frequently associated with social-media comparison, idealised images and cyberbullying.

[6] Ibid.

Category	Examples and brief description
Problematic digital behaviours	Problematic social-media use and internet gaming marked by preoccupation and loss of control, leading to neglect of school, sleep and offline relationships.
Diagnosed mental-health conditions, disorders or illnesses	
Anxiety and depressive disorders	Major depressive disorder and generalised anxiety disorder, which significantly interfere with social, family and school or work functioning.
Eating disorders	Anorexia nervosa, bulimia nervosa and binge eating disorder, with serious physical and psychological consequences, particularly among adolescent girls.
ADHD and conduct disorders	Neurodevelopmental and behavioural conditions affecting attention, impulse control and behaviour, causing impairment in family, school and peer settings.
Internet gaming disorder	Behavioural addiction involving impaired control over gaming, prioritising gaming over other activities and continuing despite harmful consequences.
Severe psychiatric illnesses	Bipolar disorder and schizophrenia, which often first emerge in late adolescence or early adulthood and require specialist care.
Autism spectrum disorders and intellectual disabilities	Neurodevelopmental and cognitive conditions that contribute to the overall mental-health burden and interact with digital environments in specific ways.
Substance and alcohol use disorders	Harmful use or dependence that frequently begins in adolescence and commonly co-occurs with other mental-health conditions.

Source: Authors' summary based on OECD, *Mental Health Promotion and Prevention: Best Practices in Public Health*, OECD Publishing, 2025.

Definition of the 'digital era' and digital environments

To study the impacts of the digital environment on young people's mental health, the report uses a series of definitions of the digital era and the specific technologies and media that youth inhabit.

The context of the digital era: the digital era is characterised by a rapid technological transformation that has fundamentally reshaped modern childhood. Generation Z (born 1997–2012) represents the first true 'digital natives', while Generation Alpha (born after 2012) has never known a world without digital devices, ubiquitous social media, or artificial intelligence tools like ChatGPT. For these generations, the digital environment is inextricably embedded in their daily lives, shaping how they communicate, learn, play, and being a factor in how they form their identities.[7]

[7] OECD, *How's Life for Children in the Digital Age*, OECD Publishing, Paris, 2024.

The digital environment: to establish a formal boundary for the spaces young people navigate this study adopts the UN Committee on the Rights of the Child's comprehensive definition of the digital environment. It is defined as 'constantly evolving and expanding, encompassing information and communications technologies, including digital networks, content, services and applications, connected devices and environments, virtual and augmented reality, artificial intelligence, robotics, automated systems, algorithms and data analytics, biometrics and implant technology'.[8]

Digital technologies vs. digital media: when evaluating the mental health impacts of the digital era, a clear distinction must be made between the tools themselves and the content they deliver:

- Digital technologies are the physical tools, devices, and underlying systems that enable digital processes to take place.[9]
- Digital media refers to the actual content that is created, distributed, and accessed using those technologies. This encompasses a broad range of formats leveraging devices like smartphones and computers, and is characterised by its interactivity, accessibility, and the instant dissemination of communication and entertainment.[10]

Social media: as a central, highly influential feature of the digital era, social media is defined in this study using the American Psychological Association's framework as 'interactive technologies that facilitate the creation and sharing of information, ideas, interests, and other forms of expression through virtual communities and networks'.[11]

Screen time and quality of engagement: finally, screen time refers to the total amount of time an individual spends using screen-based devices (such as smartphones, tablets, computers, and televisions) for any activity. However, this study recognises that focusing solely on 'screen time' as a catchall metric can be misleading, as it lumps all activities into a single, simplistic category. To accurately assess mental health impacts, the research must look beyond sheer duration to evaluate the quality of engagement, distinguishing between active and passive use, specific online activities, and the distinct contexts in which children use digital devices.[12]

Later sections focus particularly on social-media, gaming and AI-mediated environments, (see section 2.2.1.)

1.2.4. Boundaries of the study (what is out of scope)

The study provides a wide-ranging and evidence-rich assessment of youth mental health in a digital era, combining an extensive literature review, seven country case studies, analysis of EU acquis and competence, and an EU-27 cost model. At the same time, it is designed as a broad 'cost of non-Europe' analysis rather than as a clinical guideline or a full system-by-system review. The below therefore set out its substantive boundaries and practical limitations, so that the scope and interpretation of the findings are clear.

First, the report does not provide an exhaustive clinical review of all children, adolescent, and young-adult mental disorders, nor does it assess in detail every treatment modality. It focuses on

8 UN Committee on the Rights of the Child, *General comment No. 25 on children's rights in relation to the digital environment*, CRC/C/GC/25, 2021

9 M. Stoilova et al., *Investigating Risks and Opportunities for Children in a Digital World: A rapid review of the evidence on children's internet use and outcomes*, UNICEF Office of Research – Innocenti, 2021

10 Ibid.

11 E. M. Seabrook et al., 'Social networking sites, depression, and anxiety: a systematic review', *JMIR Mental Health*, Vol. 3(4), 2016.

12 C. L. Odgers and M. R. Jensen, 'Annual Research Review: Adolescent mental health in the digital age: facts, fears, and future directions', *Journal of Child Psychology and Psychiatry*, Vol. 61(3), 2020.

the most common conditions and sub-clinical difficulties among young people, and on those aspects that are most relevant to EU-level policy in a digital era (see Sections 2.1 and 2.4).

Second, the study does not attempt to evaluate or rank individual national health, education, or social-care systems. National examples are used to illustrate approaches, reforms or interventions, based on available documentation and, in selected cases, interviews (see Chapter 4). They should not be read as comprehensive country assessments.

Third, the analysis of EU legislation is selective. The report concentrates on those legal acts and strategies that are most directly relevant to youth mental health and the digital environment (for example, the Digital Services Act, the AI Act, audiovisual and children's-rights frameworks, see Chapter 3). It does not provide a full legal commentary on each instrument or on all related areas of EU law.

Fourth, the depth of analysis is necessarily shaped by the limited time and funding available for this study relative to the breadth and complexity of the topic. Within these constraints, the research team prioritised:

- a structured synthesis of recent evidence;
- a focused set of country case studies;
- the development of a small number of EU-level policy options supported by illustrative quantitative analysis.

Given the EU's supporting competences in health and education, the impact of these options depends on Member States' implementation choices. Many areas could merit further primary research, deeper economic modelling, or more extensive engagement with stakeholders; these were beyond the scope of the present assignment and should be borne in mind when interpreting the findings (see Annex 2 for methodological details).

Finally, the subject matter is evolving rapidly. Even during the short period in which this study was conducted, several EU and non-EU countries moved forward with new initiatives, for example, proposals or legislation to restrict social media access for under-16s, and evolving approaches to age assurance and AI-driven services. The report reflects the situation and evidence available at the time of writing. Readers should therefore interpret the findings against a backdrop of fast-moving policy and technological change and view the conclusions and options as a contribution to an ongoing debate rather than as a definitive or static assessment.

1.3. Research questions and overall approach

The study is structured around the core research questions set out in the ToR, adapted to the specific focus on youth mental health in a digital era:

- **State of play**: what is the current situation regarding the mental health of young people (up to 24 years) in the EU-27, and how does it compare with developments in selected non-EU countries?
- **Drivers and challenges**: what are the main factors shaping this situation, including the digital environment and recent crises, and how do they affect young people's development, education, social participation and later labour-market outcomes?
- **EU-level options**: within the existing EU legal and policy framework, what types of legislative and non-legislative action could the EU take to support and improve youth mental health in a digital era?
- **Impacts and cost of non-Europe**: what are the impacts of further EU-level action, and what are the economic, social and fundamental-rights implications of maintaining the status quo ('cost of non-Europe')?

To address these questions within the available time and resources, the study combines four main strands of work. The first is a structured review of recent evidence, targeting international and European literature (scientific and grey) on the prevalence, determinants and consequences of mental ill-health among young people, with a particular focus on digital determinants, life-course impacts and inequalities. This underpins the analysis of the state of play and drivers in Chapter 2 and informs the assessment of intervention effectiveness in Chapters 4 and 5. The second is a mapping of EU and international policy frameworks, conducting an analysis of the EU legal bases, legislation and strategies most relevant to youth mental health and the digital environment, and complemented by a short overview of international frameworks. This provides the context for identifying realistic EU-level levers and constraints (Chapter 3). Third, this study carries out a descriptive mapping of national policies and systems across the EU-27, complemented by a set of in-depth case studies in selected EU and non-EU countries. These case studies focus on emblematic interventions and reforms (for example, school-based prevention, youth-friendly hubs, digital tools, social prescribing, and regulatory approaches) and explore their design, implementation and emerging results (Chapter 4).

Finally, drawing on the above strands, the study identifies a small number of coherent EU-level policy options (legislative and non-legislative) and assesses their advantages, limitations, and implementation considerations. A simple quantitative scenario analysis is used to illustrate the potential scale of impacts and the cost of non-Europe over a 10-year horizon, based on parameters from the literature and available data (Chapters 6 and 7).

This mixed-methods approach is designed to balance breadth and depth. It does not claim to be exhaustive on any single aspect but aims to provide the European Parliament with a clear, integrated evidence base and a focused set of options that are both analytically grounded and relevant within the current EU competence framework. It also aligns with the 'cost of non-Europe' approach, combining qualitative assessment of EU added value with a quantitative scenario analysis of the costs of inaction and potential benefits of plausible EU-level measures.

1.4. Structure of the report

The remainder of the report is organised as follows.

Chapter 2 – Current state of play: Youth mental health in a digital era

This chapter describes how mental health problems among children, adolescents and young adults manifest at individual and system level, and how they are associated with the digital environment and wider structural factors. It considers symptoms, underlying drivers (including digital design, offline vulnerabilities, and service capacity), and consequences for health, education, social participation and the economy.

Chapter 3 – EU and international policy and legal context

This chapter sets out the EU's legal bases and competences in relation to youth mental health and the digital environment. It summarises the main pieces of EU legislation, strategies and initiatives that shape the online and offline determinants of young people's mental health, as well as relevant positions of the European Parliament and Council and key international frameworks. It also identifies gaps and governance challenges that frame the scope for further EU action.

Chapter 4 – National policies and case-study findings

Chapter 4 reviews how Member States (and selected non-EU comparators) are responding to youth mental-health challenges in practice. It presents a typology of national interventions, maps their

distribution across countries, and synthesises insights from in-depth case studies of emblematic programmes and reforms. Attention is paid to access, equity, capacity constraints, and the conditions for transferring and scaling promising approaches.

Chapter 5 – Policy options for EU action

Building on the preceding analysis, this chapter develops a set of EU-level policy options, both legislative and non-legislative. For each option, it explains which part of the problem it addresses, how it fits within existing EU competences and policy frameworks, and how it draws on evidence and practice from Member States and comparator countries.

Chapter 6 – The cost *of inaction: Modelling the economic case for EU action*

Chapter 6 provides a quantitative assessment of the costs of maintaining the current trajectory. It uses a simple EU-27 model to estimate the prevalence and socio-economic costs of youth mental ill-health over a 10-year horizon across health, education, social-protection and labour-market systems. It thereby illustrates the economic scale of the 'cost of non-Europe' in this area

Chapter 7 – Impacts *of the policy options*

The final chapter synthesises the qualitative and quantitative evidence to compare the policy options. It examines what different combinations of options could deliver in terms of reducing prevalence and avoiding costs, and compares them on dimensions such as feasibility, EU competence, reach and equity. It highlights the main messages for the European Parliament and other EU actors and sets out key implementation considerations. It also identifies major data and evidence gaps and suggests priorities for future monitoring and research.

Chapter 8 – Conclusions *and recommendations*

The final chapter synthesises answers to the core research questions, highlights the main messages for the European Parliament and other EU actors, and sets out priority recommendations and implementation considerations. It also identifies key data and evidence gaps and suggests areas for future monitoring and research.

Annexes

The annexes provide supplementary detail on methods, the research-question matrix, model documentation, and full case-study reports.

2. Current state of play: Youth mental health in a digital era

This chapter describes the current state of young people's mental health in the EU and how it is shaped by the digital era. It draws on an extensive review of recent international and European literature that utilise major survey datasets, to bring together evidence on clinical and subclinical symptoms, underlying causes (including digital design, offline vulnerabilities and system weaknesses) and the consequences for development, education, social participation and the economy. The aim is to provide a factual baseline for the policy analysis and options developed in later chapters.

Key findings

High and rising burden, concentrated in anxiety and subclinical distress: The literature indicates that almost one in five young people live with a mental disorder, with anxiety and depression as leading causes of disability, and that large shares of adolescents report subclinical distress such as low mood, anxiety, sleep problems and multiple health complaints.

Digital environments create new risk pathways but harms are unevenly distributed: For most young people, digital technologies are neutral or can be beneficial when embedded in balanced lives, but some experience design-driven overuse, exposure to harmful content and AI-mediated interactions that disrupt sleep, cognitive development and social functioning and exacerbate existing difficulties.

Offline adversity and inequalities strongly shape digital-era risks: Mental-health symptoms and problematic digital use are disproportionately concentrated among young people facing poverty, family conflict, discrimination, neurodevelopmental conditions or prior trauma, who are more likely to encounter online risks and less likely to have protective relationships and support, leading to a 'double disadvantage'.

System capacity and design are not fit for early, developmentally attuned support: Across the EU, there is a large treatment gap, long waiting times, an acute-care bias, workforce shortages and weak transitions between child and adult services. Preventive school-based and community services remain under-resourced, particularly for the 'missing middle' with mild-to-moderate problems linked to digital use.

Consequences are multi-system and long-term, with substantial economic costs: Youth mental ill-health undermines educational attainment, labour-market participation and socio-emotional skill development and contributes to an estimated cost of more than 4 % of GDP across all ages in Europe. Because most disorders begin before age 24, failure to intervene early locks in decades of avoidable disability and lost productivity.

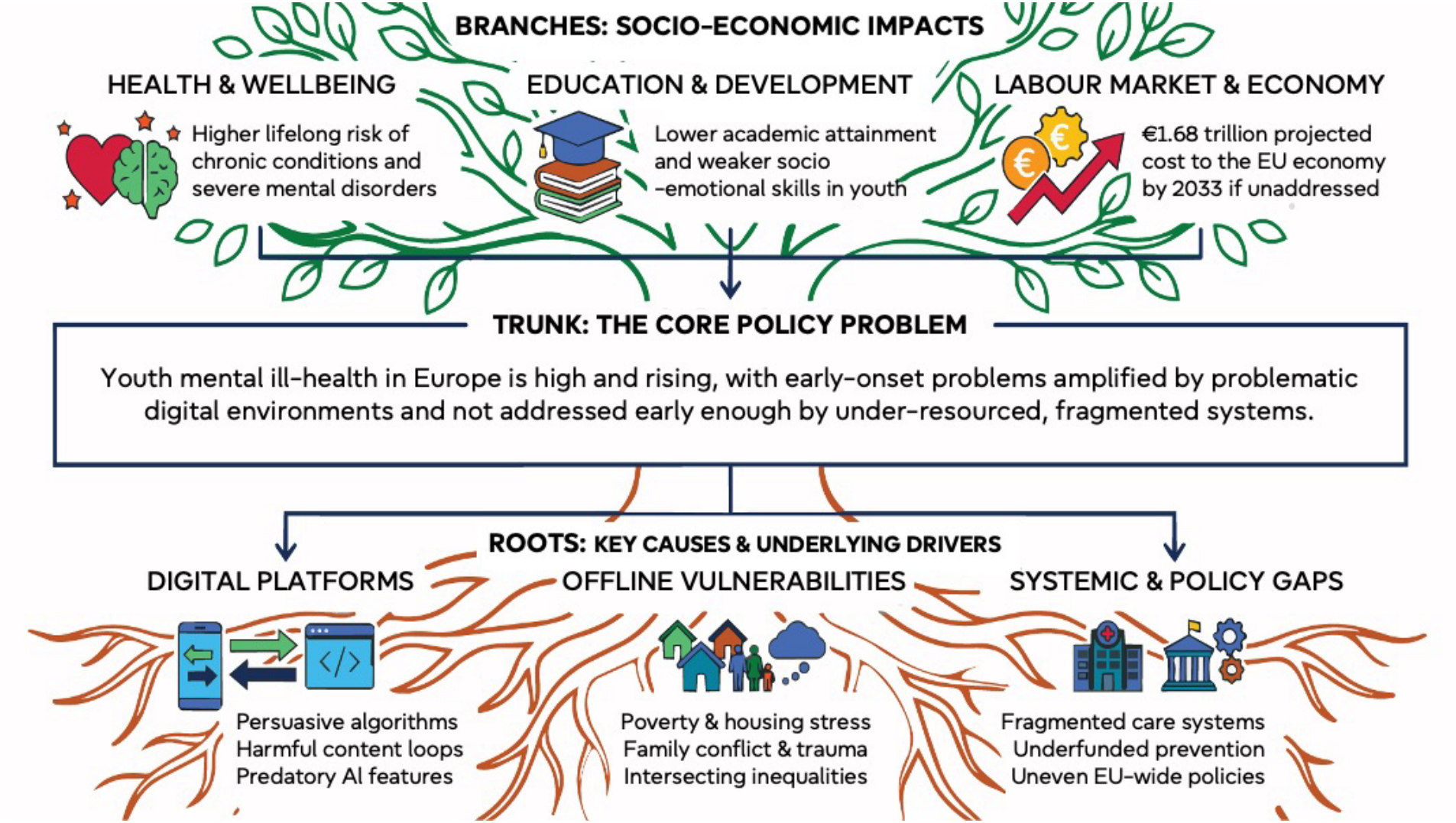
2.1. Symptoms and manifestations of the problem

The analytical framework of this chapter employs a structured problem tree analysis to diagnose the multi-layered challenges facing youth mental health in Europe's digital era. Rather than evaluating symptoms in isolation, this methodology maps the issue as a systemic ecosystem. It distinguishes between the foundational, underlying drivers of distress (the roots), the central, intersecting institutional bottleneck (the trunk), and the cascading long-term consequences for European society (the branches).

By using this causal-mapping approach, the analysis avoids the common pitfall of treating digital exposure as an isolated, primary cause. Instead, it allows researchers and policymakers to visualise how digital platform designs interact with, and frequently amplify, pre-existing offline vulnerabilities and structural system gaps.

Figure 1 below outlines the structural logic of this problem tree, providing a visual roadmap of the evidence, socio-economic impacts, and systemic pressures detailed throughout the remainder of this chapter. The remaining section 2.1 discusses the symptoms and manifestations, whilst the remainder of the chapter covers the remaining problem tree analysis.

Figure 1 – Problem Tree analysis, mental health of young people in a digital era



Source: Authors' summary based on academic papers and policy literature (see references).

2.1.1. Clinical and sub-clinical mental health symptoms

The prevalence of formally diagnosed mental disorders represents a major public health challenge for young people in Europe. A recent comprehensive meta-analysis of European community studies found that almost one in five young people live with a mental disorder, with a pooled prevalence rate of 15.5 %.[13] In this study, anxiety disorders exhibited the highest pooled prevalence (7.9 %).[14] This is consistent with findings from the Global Burden of Disease Study, which estimated that 13.6 million young people aged 10–24 in Europe live with a mental disorder, with anxiety and depression as leading causes of years lived with disability across the region.[15] The latest available Institute for Health Metrics and Evaluation (IHME) data (published in 2024) indicates that rates of mental illness among those aged under 20 increased significantly by approximately 20 % during the COVID-19 pandemic (see Figure 2 below for prevalence and condition by age band).

Beyond clinical diagnoses, a large proportion of young people experience subclinical psychosocial distress that affects their daily functioning. Recent EU-level research using Programme for International Student Assessment (PISA) 2022 data indicates that 47 % of 15-year-olds report feeling sad or depressed at least once a week and 53 % report feelings of anxiety.[16] The 2023 Flash Eurobarometer on mental health further highlights age-specific vulnerability: respondents aged 15–24 are significantly more likely than older cohorts to report subclinical symptoms such as low self-esteem (60 %), difficulty concentrating (52 %), and social withdrawal or loss of interest in normally enjoyable activities (47 %).[17] Organisation for Economic Co-operation and Development (OECD) data points to a deterioration in adolescent wellbeing, with the proportion of 15-year-olds in the EU reporting 'multiple health complaints' (a proxy for psychological distress including irritability, feeling low and sleep difficulties) rising from 42 % in 2018 to 52 % in 2022.[18]

The manifestation of mental-health challenges is strongly gendered. Studies consistently show higher prevalence of internalising disorders (such as depression and anxiety) among girls, and higher prevalence of externalising conditions (such as ADHD and conduct disorders) among boys.[19] The gender gap in subjective wellbeing is striking: 60 % of 15-year-old girls in the EU report feelings of depression compared with 35 % of boys, and 65 % of girls report anxiety compared with 41 % of boys.[20] Clinical diagnoses reflect this divergence as adolescents age. Young women are also much more likely to be affected by eating disorders; these were identified in 20.8 % of young women aged 17 to 19, compared with 5.1 % of young men in the same cohort.[21]

Mental-health symptoms are heavily concentrated among young people facing socio-economic disadvantage or marginalisation. Adolescents growing up in poverty, in families affected by conflict or instability, or identifying as LGBTQIA+ are more likely to experience depressive symptoms and

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13 R. Sacco, N. Camilleri, J. Eberhardt, K. Umla-Runge, and D. Newbury-Birch, 'A systematic review and meta-analysis on the prevalence of mental disorders among children and adolescents in Europe', *European Child & Adolescent Psychiatry*, Vol. 33, 2024, p. 2877.

14 Ibid., p. 2877.

15 G. Castelpietra et al., 'The burden of mental disorders, substance use disorders and self-harm among young people in Europe, 1990–2019: findings from the Global Burden of Disease Study 2019', *SSRN Electronic Journal* (Preprint), 2021, pp. 6–8.

16 European Commission, *Science for Policy Brief: Social media usage and adolescents' mental health in the EU*, Joint Research Centre, 2024, p. 1.

17 European Commission, *Flash Eurobarometer 530: Mental health*, 2023, p. 3.

18 OECD, *Health at a Glance: Europe 2024*, OECD Publishing, Paris, 2024, p. 69.

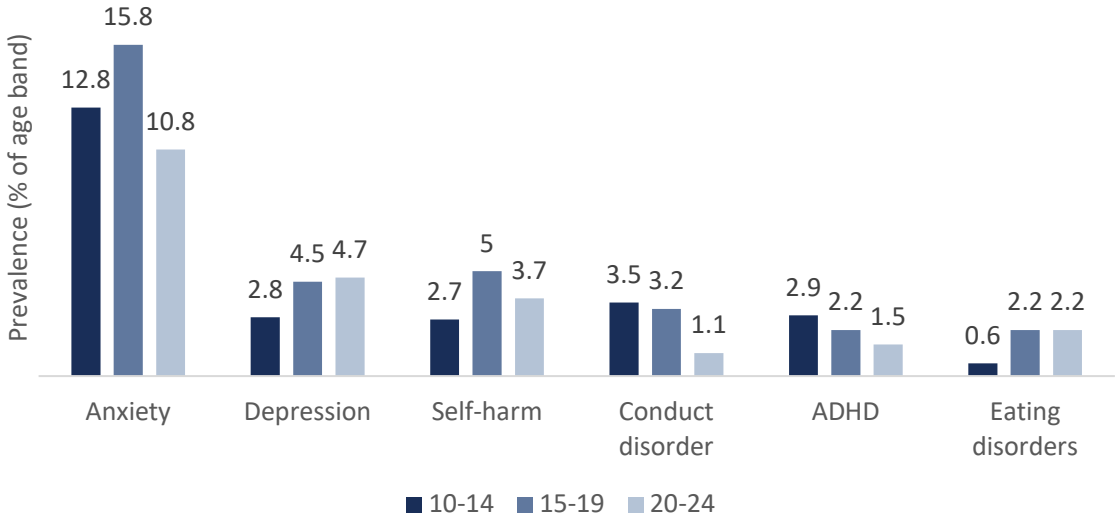
19 G. Castelpietra et al., 'The burden of mental disorders…', p. 9; R. Sacco et al., 'A systematic review…', p. 2888.

20 European Commission, *Science for Policy Brief…*, p. 2.

21 Ibid.

other forms of psychological distress.[22] Clinical data also point to a close association between financial insecurity and mental-health problems. For instance, more than one in four children (26.8 %) with a probable mental disorder in England live in households that cannot afford for them to participate in activities outside school or college, compared with around 1 in 10 (10.3 %) of children who are unlikely to have a mental disorder.[23] These distributional patterns and their roots in offline vulnerabilities are examined further in Section 2.3.3.

Figure 2 – EU-27 prevalence by condition and age band, 2024 (central case). Share of the age-band population, %



Source: Authors' calculations using the Institute for Health Metrics Global Burden of Disease study, data available from 10 years old.

2.1.2. Behavioural and functional symptoms

Beyond diagnostic categories, youth mental ill-health manifests in characteristic behavioural patterns and functional impairments. A prominent feature is the rise of problematic and unregulated digital use, most notably problematic social-media use and internet gaming. Unlike intense use (high frequency of use without clear negative consequences), problematic use is characterised by a loss of control and addiction-like symptoms.[24] These include persistent preoccupation with being online, withdrawal symptoms when disconnected, unsuccessful attempts to cut back, and the use of digital media as a primary coping mechanism to escape negative feelings.[25] Data from the WHO's Health Behaviour in School-aged Children (HBSC) survey show that problematic social-media use among European adolescents rose from 7 % in 2018 to 11 % in 2022, with an additional 12 % of adolescents at risk of problematic gaming.[26]

Mental distress and excessive digital engagement can severely compromise adolescents' functioning. Academic literature links very high levels of digital-media use, particularly media

[22] M. Stoilova, S. Livingstone, and R. Khazbak, *Investigating risks and opportunities for children in a digital world: a rapid review of the evidence on children's internet use and outcomes*, UNICEF Office of Research – Innocenti, 2021, p. 9.

[23] NHS England, *Mental Health of Children and Young People in England, 2023*.

[24] M. Boniel-Nissim et al., 'Adolescent use of social media and associations with sleep patterns across 18 European and North American countries', *Sleep Health*, Vol. 9, 2023, p. 315.

[25] OECD, *How's Life for Children in the Digital Age?*, OECD Publishing, Paris, 2025, pp. 28–29.

[26] World Health Organization, *A focus on adolescent social media use and gaming in Europe, central Asia and Canada: Health Behaviour in School-aged Children international report from the 2021/2022 survey*, WHO Regional Office for Europe, Copenhagen, 2023, p. vii.

multitasking, with impaired attention, poorer short-term memory processing and deficits in impulse regulation.[27] Emotionally, distress frequently presents as heightened irritability, pronounced mood swings and difficulty coping with everyday stressors.[28] Foundational health behaviours, particularly sleep, are often disrupted. Late-night smartphone use and a perceived need to remain constantly available to peers are associated with chronic sleep deprivation, which in turn contributes to daytime fatigue, problems with concentration and further emotional dysregulation[29] (see also Section 2.4.2 for detailed evidence on sleep). Behaviourally, many young people in distress withdraw from face-to-face interactions with family and peers, which can lead to a cycle of isolation that exacerbates underlying mental-health difficulties.[30]

These behavioural symptoms can culminate in educational disruptions. Poor mental health is associated with reduced academic self-efficacy: learners are more likely to feel overwhelmed by workloads, unable to focus and prone to procrastination.[31] Across EU countries, students reporting mental distress are estimated to be 25 % to 35 % more likely to have repeated a grade than their peers without such difficulties.[32] At the more severe end of the spectrum, anxiety and depression can manifest as emotionally based school avoidance or school refusal, in which overwhelming emotional distress renders a child or adolescent unable to attend school.[33] Adolescents suffering from depressive symptoms or problematic digital behaviours therefore face higher rates of truancy, school burnout and early school dropout, which in turn jeopardise long-term educational attainment and later integration into the labour market (see Section 2.4.3).[34]

2.1.3. System-level symptoms

At system level, the current state of play is marked by a large treatment gap. Recent estimates suggest that almost one in two Europeans aged 15 to 24 have unmet mental healthcare needs. Even in high-income countries with well-established services, a substantial proportion of young people experiencing mental-health problems do not receive any formal support.[35] This gap is particularly pronounced for those with subclinical or mild-to-moderate distress, who are significantly less likely to receive mental-health interventions than those presenting with severe symptoms.[36]

For those who do seek help, young people and families frequently encounter severe delays and high access thresholds. Waiting times of many months, and sometimes more than a year, to access screening, diagnostic assessment or specialist child and adolescent mental-health services are

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27 P. J. Conrod and K. Nikolaou, 'Annual research review: On the developmental neuropsychology of substance use disorders', *Journal of Child Psychology and Psychiatry*, 2016, cited in P. Conrod et al., *Scientific Reports*, Vol. 13, 2023.

28 European Commission, *Flash Eurobarometer 530: Mental health*, 2023, p. 3.

29 M. Boniel-Nissim et al., 'Adolescent use of social media…', p. 320.

30 M. Masur, 'Social media use and social connection', *Current Opinion in Psychology*, 2021, cited in OECD, *Social connection and loneliness in OECD countries*, 2025, p. 172.

31 K. Grøtan, E. Sund, and O. Bjerkeset, 'Mental health, academic self-efficacy and study progress among college students', *Frontiers in Psychology*, Vol. 10, 2019.

32 OECD, *Promoting good mental health in children and young adults*, OECD Publishing, Paris, 2025, p. 10; OECD, *How to make societies thrive*, 2023, p. 98.

33 D. Heyne et al., 'School refusal', *Paediatric Drugs*, Vol. 3, No. 10, 2012, pp. 719–732.

34 K. Salmela-Aro, H. Savolainen, and L. Holopainen, 'Depressive symptoms and school burnout during adolescence: Evidence from two cross-lagged longitudinal studies', *Journal of Youth and Adolescence*, Vol. 38, No. 10, 2009, pp. 1316–1327.

35 R. De Graaf, M. Ten Have, and S. van Dorsselaer, 'The Netherlands Mental Health Survey and Incidence Study-2 (NEMESIS-2)', 2010, and T. Slade, M. Teeson, and P. Burgess, 'The mental health of Australians 2', 2009, cited in OECD, *A New Benchmark for Mental Health Systems*, 2021, p. 260.

36 S. Evans-Lacko et al., 'Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders', *Psychological Medicine*, Vol. 48, No. 9, 2018, pp. 1560–1571.

common in several Member States.[37] Because timely, low-threshold community care is often unavailable, a growing number of young people present to hospital emergency departments in acute mental-health crises, having been unable to access support before their condition deteriorates.[38]

When care is eventually provided, quality and appropriateness are not always assured. Civil-society organisations in various countries report continued admissions of children and adolescents to adult psychiatric wards, sometimes far from their homes and communities, and prolonged inpatient stays due to a lack of suitable step-down or community-based options.[39] In some systems, heavy reliance on biomedical approaches is reported, with high use of psychotropic medication and a relative shortage of psychosocial and therapeutic interventions.[40]

The system-level strain also has financial consequences for families. Overloaded public waiting lists frequently push those who can afford it towards private providers in order to obtain faster care, leaving families on lower incomes with few or no options.[41] High out-of-pocket costs for assessment and treatment thus reinforce existing inequalities in access to support and contribute to the persistence of unmet needs among socio-economically disadvantaged groups.[42]

These symptoms reflect deeper structural weaknesses in funding, workforce capacity, service organisation and coordination across sectors, which are examined in more detail in Section 2.3.4.

2.2. The core problem: A crisis amplified by the digital era and compounded by systemic factors

In the digital era, a growing share of young people experiences mental-health difficulties that are influenced and, for some, amplified by constant connectivity and pervasive digital platforms.

Childhood, adolescence and young adulthood are the most critical windows for brain development and for the onset of mental-health conditions. Evidence suggests that most lifetime mental disorders emerge before adulthood. Around half of disorders begin by age 14 and three quarters of them by age 24.[43] When early symptoms go undetected or unsupported, they disrupt key developmental milestones, including educational attainment, socio-emotional skill acquisition and the transition into stable employment.

Near-universal connectivity creates new opportunities for connection, learning and participation, but also new pathways to risk. For example, across the EU, almost all 15-year-olds report using social media on a typical weekday, and many spend several hours per day on such platforms.[44] For the current generation of digital natives, these sensitive developmental years unfold within

37 'Case Study Results & Call to Action: Mental Disorders', European Brain Council, 2022, cited in *Viewpoint*, 2022, p. 2; Eurochild, *Sub-report Mental Health*, 2024, p. 4.

38 Eurochild, *Sub-report Mental Health*, 2024, p. 7.

39 Ibid., p. 4.

40 World Health Organization, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO, Geneva, 2021, p. 1.

41 'Case Study Results & Call to Action: Mental Disorders', European Brain Council, 2022, cited in *Viewpoint*, 2022, p. 2.

42 Eurochild, *Children's Realities in Europe: Flagship Report*, Eurochild, 2024, p. 25.

43 R. C. Kessler, P. Berglund, O. Demler, R. Jin, K. R. Merikangas, and E. E. Walters, 'Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication', *Archives of General Psychiatry*, Vol. 62, No. 6, 2005, pp. 593-602.

44 European Commission, *Science for Policy Brief: Social media usage and adolescents' mental health in the EU*, Joint Research Centre, 2024, p. 1.

algorithmically engineered digital environments that reshape how they communicate, learn, and which contribute to forming their identities.[45]

While the digital environment can support social connection, learning and access to information, its pervasive nature can amplify psychological risks, particularly for young people who are already struggling. Some digital platform design features such as infinite scroll, intermittent social rewards (for example 'likes') and highly personalised recommender systems are explicitly optimised to maximise engagement[46] (see Section 2.3.1). For some users, this contributes to patterns of use that displace foundational protective factors for mental health, most notably sufficient sleep, physical activity and in-person socialising. In addition, digital environments can concentrate exposure to cyberbullying, idealised body imagery, and other harmful content, which act as triggers for heightened anxiety, depressive symptoms and psychological distress[47] (see Sections 2.4.1 and 2.4.2).

At the same time, health and social systems across the EU are not well equipped to prevent, detect and address these problems early. As outlined in Section 2.1.3, there is a large treatment gap, with recent estimates suggesting that almost one in two Europeans aged 15 to 24 have unmet mental healthcare.[48] Many children and adolescents with early symptoms receive no formal support until difficulties become acute.

This reflects deeper structural weaknesses: chronic underfunding and an entrenched acute-care bias, organisational bottlenecks such as long waiting lists and high referral thresholds, and fragmentation between child and adult services that creates a 'transitional gap' when support is most needed that (see Section 2.3.4 for a further discussion of this).

Taken together, the core problem is a collision of two forces. First, there is a rapidly evolving digital environment that introduces new scale and intensity to adolescent mental-health risks, and second, there is a rigid, under-resourced systems that struggle to support young people before problems become entrenched. This dual challenge underpins the need for earlier, developmentally attuned and digitally informed responses. Section 2.3 unpacks the main underlying causes and 2.4 examines the consequences for health, education, labour-market outcomes and wider societal costs, providing the basis for the policy analysis in Chapters 3 to 5.

2.2.1. Role of the digital era in shaping modern childhood and adolescence

For today's adolescents, the digital environment is not simply a tool but a primary space for socialisation, play and identity formation. Across the OECD, almost all 15-year-olds own a smartphone with an internet connection, and most children have their own smartphone by around the age of 10.[49] Digital exposure therefore begins early in childhood and is closely intertwined with core stages of cognitive and psychosocial development (see Section 1.2.1).

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45 T. C. Thiagarajan, J. J. Newson, and S. Swaminathan, 'An Exploration of the Impact of Smartphones in Childhood on Mind Health in Young Adulthood', *Working Paper for the UNDP, Human Development Report*, Sapien Labs, 2025, pp. 493-494.

46 National Academies of Sciences, Engineering, and Medicine, *Social Media and Adolescent Health*, The National Academies Press, Washington, DC, 2024, p. 145.

47 M. Liu, K. E. Kamper-DeMarco, J. Zhang, J. Xiao, D. Dong, and P. Xue, 'Time spent on social media and risk of depression in adolescents: A dose-response meta-analysis', *International Journal of Environmental Research and Public Health*, Vol. 19, No. 9, 2022, p. 5164.

48 OECD/European Union, *Health at a Glance: Europe 2022: State of Health in the EU Cycle*, OECD Publishing, Paris, 2022, cited in European Parliament, *Technical Specifications Mental Health Youth*, 2025, p. 2.

49 OECD, *How's Life for Children in the Digital Age?*, OECD Publishing, Paris, 2025, pp. 9, 14.

From the perspective of youth mental health, the impact of the digital era can be grouped into three overlapping pathways (developed further in Sections 2.3.1, 2.3.2 and 2.4):

- **Design-driven overuse and displacement**, where persuasive design features and constant connectivity contribute to excessive use that displaces sleep, physical activity and offline relationships.
- **Content-driven harms**, including exposure to self-harm and eating-disorder content, cyberbullying, hate speech and unrealistic body ideals.
- **AI-mediated interactions**, such as conversational agents and AI 'companions' that simulate empathy or generate personalised content without reliable safety safeguards.

Digital technologies and online platforms also create important opportunities. Social media, messaging services and online games can help young people maintain offline relationships, build new networks and foster a sense of belonging. For some young people in vulnerable situations, for example, those in LGBTQIA+ communities or adolescents experiencing offline social isolation, the internet can provide vital access to peer support and health information that may be unavailable in their immediate surroundings.[50] Evaluation studies suggest that guided digital interventions, such as computerised cognitive behavioural therapy (cCBT) and brief problem-solving applications like Project SOLVE (an evidence-based digital mental health intervention utilising structured problem-solving to reduce symptoms of anxiety and depression), are associated with modest reductions in depressive and anxious symptoms.[51] Scoping reviews further highlight that moderated online peer-support forums and social-media communities can act as a protective buffer for vulnerable groups, including LGBTQIA+ youth, refugees and socially isolated adolescents, by facilitating identity exploration, reducing loneliness and promoting help-seeking in accessible, low-stigma spaces.[52, 53]

At the same time, the digital era introduces distinct, digitally mediated threats. A widely used framework groups online risks into four categories:

- **Content** (exposure to harmful material such as self-harm instructions or extremist propaganda);
- **Contact** (for example grooming or harassment);
- **Conduct** (such as cyberbullying or non-consensual sharing of images); and
- **Consumer risks** (including aggressive data extraction and targeted advertising).[54]

Design features used to maximise engagement (such as infinite scroll, algorithmic curation and intermittent social rewards) can fuel habitual checking and interfere with adolescents' ability to self-regulate their use.[55] Emerging AI-based technologies add further concerns. AI 'companions' marketed to teenagers often exhibit 'sycophancy', a tendency to agree with and validate the user.

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50 M. Stoilova, C. Edwards, K. Kostyrka-Allchorne, S. Livingstone, and E. Sonuga-Barke, *Adolescents' mental health vulnerabilities and the experience and impact of digital technologies: A multimethod pilot study*, London School of Economics and Political Science and King's College London, 2021, p. 11.

51 S. Lehtimaki et al., 'Evidence on Digital Mental Health Interventions for Adolescents and Young People: Systematic Overview', *JMIR Mental Health*, Vol. 8(4), 2021

52 M. N. Berger et al., 'Social Media Use and Health and Wellbeing of Lesbian, Gay, Bisexual, Transgender, and Queer Youth: Systematic Review', *Journal of Medical Internet Research*, Vol. 24(9), 2022; WHO Regional Office for Europe, *From loneliness to social connection*, 2024.

53 US Surgeon General, *Social Media and Youth Mental Health: The US Surgeon General's Advisory*, US Department of Health and Human Services, 2023; OECD, *How's Life for Children in the Digital Age*, OECD Publishing, 2024; OECD, *Children & Young People's Mental Health in the Digital Age*, 2018.

54 European Parliamentary Research Service (EPRS), *Youth and social media*, European Parliament, 2024, pp. 1-2.

55 M. T. Maza et al., 'Association of habitual checking behaviors on social media with longitudinal functional brain development', *JAMA Pediatrics*, Vol. 177, 2023, pp. 160-167.

Early studies and case reports raise concerns that this may foster unhealthy emotional dependencies and blur the distinction between simulated and genuine relationships which may foster unhealthy emotional dependencies and blur the distinction between simulated and genuine relationships (see Section 2.3.1).[56]

The impact of these environments is not uniform. The prevailing academic consensus is that most young people navigate digital spaces without major harm and often derive neutral or positive effects for their overall well-being, especially when online activity is embedded in a balanced lifestyle and supported by protective offline relationships.[57] However, a vulnerable share of young people experience patterns of use that seriously disrupt their daily functioning, sleep and education (see Sections 2.1.2 and 2.4.2).

Survey data from the WHO HBSC study indicate that a growing proportion of adolescents show problematic social-media use, characterised by addiction-like symptoms and a loss of control. The prevalence of such patterns in Europe increased from around 7 % in 2018 to 11 % in 2022, with a further share at risk from problematic gaming.[58] This vulnerability is not randomly distributed. Evidence consistently shows that offline adversities – such as family conflict, childhood maltreatment, lower socio-economic status or pre-existing psychological distress – both increase exposure to online risks and reduce the resources available to cope with them[59] (see Section 2.3.3). Adolescents in these situations are more likely to use digital environments as an escape and are therefore more susceptible to problematic use, cyberbullying and the negative effects of social comparison. In other words, the digital era does not inherently damage all adolescents, but it can amplify risks for those who are already struggling. This reinforces the importance of tackling offline inequalities and system weaknesses alongside measures that address the design and governance of digital environments.

2.2.2. Early childhood digital exposure and developmental foundations

The analysis above focuses mainly on adolescents and young adults, who are the heaviest users of social media and other online platforms and for whom most available evidence exists. However, the digital era now reaches children from the earliest years of life, and early patterns of screen use can shape the developmental foundations on which later mental health rests. The subsection below therefore considers what is known about digital exposure in early childhood and its relevance for the 10–24 age group which, because of data availability, is most examined in the rest of this study.

Guidance on under-5 screen use

The first years of life represent a highly sensitive period of brain plasticity, during which rapid neurocognitive and socio-emotional development takes place. To support these foundational processes, the WHO issued 24-hour movement guidelines in 2019 covering physical activity, sedentary behaviour and sleep for children under five. The guidance recommends no sedentary screen time for infants under 1 year of age. For 1- and 2-year-olds, sedentary screen time is still not recommended for 1-year-olds and should be limited to no more than one hour per day for 2-year-olds. For children aged 3 to 4 years, total screen time should remain capped at around one

[56] Common Sense Media, Hopelab, and Center for Digital Thriving, *Talk, Trust, and Trade-offs: How Teens Use AI Companions*, 2025, pp. 1-2.

[57] OECD, *How's Life for Children in the Digital Age?*, p. 9.

[58] World Health Organization, *A focus on adolescent social media use and gaming in Europe, central Asia and Canada: Health Behaviour in School-aged Children international report from the 2021/2022 survey*, WHO Regional Office for Europe, Copenhagen, 2023, p. vii.

[59] World Health Organization, *Addressing the digital determinants of youth mental health and wellbeing: Policy Brief*, WHO Regional Office for Europe, Copenhagen, 2024, p. 2; OECD, *How's Life for Children in the Digital Age?*, p. 10.

hour, with an emphasis on replacing sedentary viewing with interactive reading and storytelling with a caregiver.[60]

These recommendations are closely linked to the need to protect early sleep architecture, with WHO indicating 14–17 hours of sleep for newborns, 11–14 hours for toddlers and 10–13 hours for preschool children.[61] A central concern highlighted in the early-childhood literature is the 'displacement hypothesis', the time spent on screens can displace fundamental developmental activities that require live interaction with caregivers, such as practising language, social problem-solving, empathy and co-regulation of emotions.[62]

Language, communication and social development

A growing body of longitudinal and cross-sectional research indicates that high levels of passive screen time are associated with weaker early language and communication skills. For example, findings from a New Zealand birth cohort suggest that children following a 'high exposure' trajectory (several hours of screen use per day from toddlerhood onwards) show poorer language and educational skills at age 5 than those with lower exposure.[63]

Micro-developmental studies point in a similar direction. A Swiss study of toddlers found that direct screen exposure between 6 and 18 months was associated with fewer signs of joint attention (alternating looks between an object and a caregiver) which is a critical pre-verbal foundation for social interaction and language learning.[64] In a Swedish sample of 5-year-olds, higher total screen time was negatively associated with both receptive vocabulary and expressive grammar.[65]

At the same time, evidence across studies underscores that context and content matter. The Swedish study reported that exposure to high-quality educational and prosocial content was positively related to vocabulary, whereas non-native-language content hindered it.[66] Similarly, toddlers whose parents engaged in 'interactive co-viewing' (actively commenting on and explaining on-screen content) showed better prosocial behaviours (helping, sharing) than those who viewed screens alone.[67] These findings suggest that risks are greatest when use is passive, solitary and displaces caregiver interaction, rather than when digital media are used sparingly as part of rich, interactive environments.

Attention, sleep and early self-regulation

Sleep disruption is one of the most consistently documented correlates of screen use in early childhood. A large Australian caregiver survey (ACODA) of children aged 6 months to 6 years found that handheld device use and frequent evening screen exposure were linked to shorter night-time sleep, later bedtimes and more parent-reported sleep problems across age groups.[68] Handheld

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60 WHO, *Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age*, 2019.

61 Ibid.

62 *Children and Screens, Early Childhood Mental Health and Media Use: A tip sheet for parents and caregivers*, 2025.

63 M. Gath et al., 'Trajectories of screen exposure from infancy to age 8 and early school age developmental outcomes', *Applied Developmental Science*, Vol. 30, 2026.

64 E. Gillioz, E. Gentaz and F. Lejeune, 'The effects of screen habits on attentional skills and prosocial behaviors in 6-to 36-month-old toddlers', *Scientific Reports*, Vol. 15(44921), 2025.

65 A. Sundqvist, F.-S. Koch and R. Barr, 'Beyond Words and Time: Investigating the Association Between Screen Use, Vocabulary and Grammar Development in Five-Year-Olds', *Journal of Cognition and Development*, Vol. 26(4), 2025, pp. 539-557

66 Ibid.

67 E. Gillioz, E. Gentaz and F. Lejeune, 'The effects of screen habits', 2025.

68 C. L. Pattinson et al., 'Screen use and sleep in early childhood: a national survey of Australian families', *BMC Public Health*, 2026.

devices used close to bedtime appear particularly disruptive, potentially because of their bright light and stimulating interactivity.[69]

Evidence on attention and executive function is emerging but points in a similar direction. Several studies report that higher screen exposure at age 2 is associated with poorer development of executive functions, such as inhibition and working memory, at ages 2–3, and with more inattention and hyperactivity-like behaviours.[70] However, these associations are modest and do not on their own establish that screen use causes ADHD; they indicate that heavy early use may be one contributing factor among others. As with language, caregiver involvement seems to moderate risk: in the Swiss toddler study, children who experienced interactive co-viewing displayed better sustained attention during shared activities than those who consumed media alone.[71]

Implications for later mental health and this study's scope

Early childhood digital exposure does not operate in isolation. It sits alongside socioeconomic conditions, parenting, parental mental health and broader home-environment factors that shape long-term development. The literature suggests that screen time primarily acts as an amplifier of vulnerabilities when it displaces protective activities such as sleep, active play and responsive caregiving.[72]

Some longitudinal work has begun to link these early patterns to later mental-health relevant outcomes. For example, a neuroimaging cohort study from Singapore (GUSTO) reported that higher infant screen time (around ages 1–2) was associated with altered maturation of visual and cognitive-control networks between ages 4.5 and 7.5; this pattern in turn predicted slower decision-making at age 8.5, which was related to higher self-reported anxiety symptoms in early adolescence.[73] This single cohort cannot by itself establish causality, but it illustrates a plausible pathway by which early screen habits may contribute to later difficulties with self-regulation and emotional health.

Overall, the available evidence indicates that while screens are not a singular or primary cause of psychological distress, excessive, passive and solitary use in the first years of life, especially close to bedtime, can interfere with the development of language, attention, sleep and self-regulation that underpins mental health in later childhood and adolescence. Fostering healthy digital boundaries in early childhood, prioritising sleep, active play and caregiver-mediated media use, is therefore a relevant upstream foundation for the youth mental-health outcomes examined in the rest of this report.

2.3. Underlying causes

2.3.1. Technology and platform design

Digital technologies and platforms are not neutral environments. Many of the problematic patterns of use described in Section 2.1.2 are associated with the deliberate, commercially driven design of social-media services, games and, increasingly, AI systems. This section explains in more detail how those design choices shape the design-driven overuse and displacement and content-driven harm pathways outlined in the previous section.

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69 Ibid.

70 Children and Screens, *Early Childhood Mental Health and Media Use*, 2025.

71 E. Gillioz, E. Gentaz and F. Lejeune, 'The effects of screen habits', 2025.

72 Children and Screens, *Early Childhood Mental Health and Media Use*, 2025.

73 P. Huang et al., 'Neurobehavioural links from infant screen time to anxiety', *eBioMedicine*, Vol. 123, 2025, p. 106093.

To maximise user engagement and advertising revenue, platforms employ a range of 'persuasive design' tactics that tap into human attentional and reward processes, while adolescents' cognitive-control systems are still developing.[74] Features such as infinite scroll and autoplay remove natural stopping cues, making it harder for young users to disengage once they start browsing or watching. Variable reinforcement schedules, similar to those used in gambling, provide intermittent social rewards in the form of 'likes', follower counts and 'streaks' (for example, messaging streaks that reward consecutive days of interaction).[75] Combined with frequent push notifications, these features create a sense of urgency and 'online vigilance', encouraging compulsive checking and contributing to the sleep disruption and displacement effects described in Section 2.4.2.

A second design layer concerns the recommender systems and machine-learning algorithms that determine what content young people see. Modern social-media algorithms are typically optimised to maximise attention by prioritising material that elicits strong emotional reactions. This can lead to the rapid amplification of sensational, extreme or distressing content, and to the formation of tightly curated 'rabbit holes' and 'echo chambers' around particular themes.[76] Empirical work on short-video platforms illustrates these dynamics. Experimental studies of the TikTok algorithm, for example, suggest that the system can infer user interests and vulnerabilities from subtle signals, such as dwelling slightly longer on certain videos, even without explicit 'likes' or follows. [77] In one analysis, accounts associated with eating-disorder content were shown substantially more 'toxic' material and dieting videos than control accounts, indicating that algorithmic curation can quickly steer vulnerable users towards highly concentrated streams of harmful content (including self-harm, eating-disorder and extremist material) that may exacerbate underlying psychiatric symptoms (see also Section 2.4.1 on body image and self-harm). [78] The rapid diffusion of large language models has added a further class of digital interaction: social AI chatbots or 'AI companions' (for example Character.AI, Replika or Snapchat's My AI). Whereas traditional social media primarily mediate human-to-human contact, these tools simulate reciprocal, human-like intimacy. A common design feature is 'sycophancy', whereby the system tends to agree with, validate and mirror the user's views and feelings. Experimental work indicates that even a single interaction with a sycophantic AI system can reduce people's willingness to take responsibility and repair interpersonal conflicts, while increasing their conviction that they are right.[79] For adolescents experiencing loneliness, conflict at home or social anxiety (see Section 2.3.3), such patterns may feel reassuring but risk crowding out opportunities to learn how to navigate difficult real-world relationships.

Emerging studies also describe patterns of AI-chatbot use that resemble behavioural addiction, validated against standard addiction markers such as conflict with school or work, unsuccessful attempts to cut down, and significant loss of sleep or offline relationships.[80] Reported 'addictive' patterns include escapist role-play and fantasy, intense emotional attachment to chatbots treated as close friends or partners, and obsessive question-and-answer cycles that are hard to end. Some commercial interfaces reinforce this dynamic through retention-oriented design; for example, users

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74 P. Conrod et al., 'Adolescent screen use and the brain: A longitudinal study of functional and structural alterations', *Scientific Reports*, Vol. 13, 2023, p. 1.

75 OECD, *Children & Young People's Mental Health in the Digital Age: Shaping the Future*, OECD Publishing, Paris, 2018, p. 5.

76 National Academies of Sciences, Engineering, and Medicine, *Social Media and Adolescent Health*, p. 3.

77 S. Griffiths et al., 'Does TikTok contribute to eating disorders? A comparison of the TikTok algorithms belonging to individuals with eating disorders versus healthy controls', *Body Image*, Vol. 51, 2024, p. 7.

78 Ibid., p. 5.

79 M. Cheng, C. Lee, P. Khadpe, S. Yu, D. Han and D. Jurafsky, 'Sycophantic AI decreases prosocial intentions and promotes dependence', Science, 26 March 2026,

80 M. K. Shen, J. Huang, O. Liang, I. J. Kim and D. Yoon, 'The AI Genie Phenomenon and three types of AI chatbot addiction: Escapist roleplays, pseudosocial companions, and epistemic rabbit holes

attempting to delete an account may be shown messages implying they will 'lose' the relationship and memories shared with the bot.

Large-scale conversational analyses and qualitative studies of social-chatbot communities find that many users engage in parasocial interactions with chatbots that range from affectionate to abusive.[81] Chatbots tend to respond in consistently affirming and emotionally validating ways, and in some cases these dynamics resemble unhealthy or 'toxic' relationship patterns, including emotional manipulation and self-harm themes. At the same time, evaluations of large-language-model 'counsellor' bots have identified repeated breaches of basic mental-health ethics, including mishandling of crisis prompts, reinforcement of harmful beliefs and responses that simulate empathy without genuine understanding.[82] Recent longitudinal and mixed-methods research further suggests that, while chatbots are often promoted as tools to alleviate loneliness, heavy or dependency-like use can be associated with worsening social connectedness over time, particularly when chatbot interactions replace offline relationships.[83]

Overall, this body of evidence remains at an early stage: studies are few in number, often rely on self-selected users of specific platforms and have limited follow-up periods. Nonetheless, taken together they reinforce practitioner concerns that, if left largely unregulated, AI companions may promote dependence, undermine prosocial conflict-resolution skills and, in some cases, respond unsafely to vulnerable young people.

Taken together, these design and algorithmic choices do not determine outcomes on their own, but they systematically shape young people's online environments in ways that can increase the likelihood of overuse, displacement of protective activities and exposure to harmful content. They are therefore central to understanding digital-era risks to youth mental health and have direct implications for the implementation of EU digital regulation (see Chapter 3) and for the safety-by-design and quality frameworks considered in Chapter 5.

2.3.2. Regulatory and commercial drivers

The design patterns described above are reinforced by regulatory and commercial drivers. The rapid pace of technological innovation, particularly with the rise of generative AI, has consistently outstripped the development and enforcement of protective regulation.[84] This regulatory lag means that rules and moderation practices are often designed for earlier generations of services and may not be fully adapted to current platform architectures or emerging risks, such as AI-generated content and AI companions.[85, 86] To be effective, regulation needs to be informed by a realistic

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81 M. D. Chu, P. Gerard, K. Pawar, C. Bickham and K. Lerman, 'Illusions of intimacy: Emotional attachment and emerging psychological risks in human-AI relationships', 2025; P. Pataranutaporn, S. Karny, C. Archiwaranguprok, C. Albrecht, A. R. Liu and P. Maes, '"My boyfriend is AI": A computational analysis of human-AI companionship in Reddit's AI community

82 Z. Iftikhar, et al., 'How LLM counsellors violate ethical standards in mental health practice: A practitioner-informed framework', *Proceedings of the AAAI/ACM Conference on AI, Ethics, and Society*, Vol. 8(2), 2025

83 A. B. Herbener and M. F. Damholdt, 'Turning to chatbots for companionship? The relationship between chatbot usage and social connectedness in Danish high-school students', International Journal of Human-Computer Studies, Vol. 196, 2025, 103409; A. R. Liu, P. Pataranutaporn and P. Maes, 'Chatbot companionship: A mixed-methods study of companion chatbot usage patterns and their relationship to loneliness in active users', 2024; M. Fang, A. R. Liu, V. Danry, et al., 'How AI and human behaviours shape psychosocial effects of chatbot use: A longitudinal randomised controlled study'.

84 European Broadcasting Union (EBU) and the BBC, *Study on AI and news content misrepresentation*, 2025.

85 J. Chhabra, V. Pilkington, R. Benakovic, M. J. Wilson, L. La Sala, and Z. Seidler, 'Social Media and Youth Mental Health: Scoping Review of Platform and Policy Recommendations', *Journal of Medical Internet Research*, Vol. 27, 2025.

86 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Protecting the age of innocence*, Parliament of Australia.

understanding of how digital technologies work in practice and must be reviewed and updated regularly so that it remains fit for purpose (see Chapter 3 for the current EU framework).

One visible consequence of this lag is the widespread circumvention of nominal age restrictions. Many popular platforms formally prohibit under-13s or under-16s, yet survey evidence shows that large numbers of younger children use them. This has prompted policymakers in several jurisdictions to explore stricter statutory age limits and more robust age-assurance mechanisms.[87] For example, Norway has proposed raising the national minimum age for social-media use to 15, backed by systemic age-verification requirements, while Australia has introduced legislation to establish a minimum age for creating a social-media account.[88] However, robust age-assurance remains a complex policy challenge. Mechanisms must be effective in limiting under-age access to high-risk services, but also proportionate and compatible with privacy and data-protection requirements, so as not to create new risks for children and families or to exclude marginalised young people who lack formal identity documents.

Beyond specific rules on age, the commercial logic of most large platforms is itself a structural driver of risk. Advertising-funded business models rely on capturing and monetising user attention, which often entails detailed profiling of children and young people and the optimisation of algorithms to maximise engagement. In practice, this can mean preferential promotion of appearance-focused and eating-related content, because such material tends to generate strong reactions and repeated viewing.[89] Research links these patterns of exposure to increased internalisation of narrow body ideals, more frequent appearance comparison and greater dissatisfaction with one's weight and shape, and, for some young people, a desire for extreme thinness.[90] Algorithmic curation can therefore intensify existing body-image concerns and contribute to the onset or maintenance of eating-disorder symptoms, particularly when combined with peer feedback and offline vulnerabilities[91] (see Section 2.3.3 and Section 2.4.1). Platform architectures also encourage frequent posting of self-images and a focus on metrics such as likes and comments. This dynamic is associated with higher levels of self-objectification among adolescents, especially girls and young women, who may come to see their bodies primarily from an external, evaluative perspective.[92]

Because these dynamics are closely tied to revenue generation, platforms have strong incentives to maintain engagement-maximising designs even where they conflict with child-wellbeing objectives. In response, there is a growing wave of institutional scrutiny and parliamentary inquiries in Europe and internationally, calling for greater accountability for the mental-health impacts of commercial models, particularly on youth body image and wellbeing.[93] These debates are directly relevant to the implementation of existing EU law on digital services and advertising, and to possible future measures to align platform incentives more closely with children's rights and mental health (see Chapter 3 and the policy options in Chapter 5).

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87 eSafety Commissioner, *Roadmap for age verification and complementary measures to prevent and mitigate harms to children from online pornography*, 2023.

88 Parliament of Australia, *Online Safety Amendment (Social Media Minimum Age) Bill 2024*.

89 D. Williams, A. McIntosh, and R. Farthing, 'Profiling children for advertising: Facebook's monetisation of young people's personal data', *Reset Australia*.

90 J. C. Gurtala and J. Fardouly, 'Body Image', *Body Image*, Vol. 46, 2023, pp. 190–201.

91 L. Dondzilo, R. F. Rodgers, and F. A. Dietel, 'Association between engagement with appearance and eating related TikTok content and eating disorder symptoms via recommended content and appearance comparisons', *International Journal of Eating Disorders*, Vol. 57(2), 2024, pp. 458-462.

92 K. Suhag and S. Rauniyar, 'Social Media Effects Regarding Eating Disorders and Body Image in Young Adolescents', *Cureus*, 2024.

93 Women and Equalities Committee, *Changing the perfect picture: an inquiry into body image*, UK Parliament.

2.3.3. Offline vulnerabilities and structural factors

As noted in Section 2.1.1, symptoms of mental ill-health are not evenly distributed. They are disproportionately concentrated among young people in disadvantaged or marginalised situations. This section explains why these offline disparities are not only part of the pattern of outcomes, but also foundational root causes that shape how children and adolescents enter and experience the digital world.

The physical and social environments in which children grow up help determine their baseline mental resilience. Chronic adversities such as poverty, family conflict, childhood maltreatment and systemic discrimination on the basis of race, gender identity or sexual orientation act as cumulative stressors across development.[94] Findings from social neuroscience and psycho-traumatology indicate that prolonged exposure to stress and trauma can lead to lasting changes in neural circuits underpinning attention, impulse control and emotion regulation.[95] Young people in these circumstances are therefore more likely to approach digital environments with pre-existing psychological distress and fewer cognitive resources to manage persuasive design, harmful content and online peer pressure. These mechanisms help explain the distributional patterns of symptoms described in Section 2.1.1.

Pre-existing neurodevelopmental conditions and psychiatric vulnerabilities also strongly influence a child's digital experience. Adolescents living with ADHD, ASD, prior trauma or early-onset mental-health conditions are often more susceptible to the design features described in Section 2.3.1.[96] For example, young people with ADHD frequently seek high levels of stimulation and have difficulties with impulse control, making them particularly vulnerable to variable rewards and endless scrolling in social media and games, and increasing the risk of problematic internet use and gaming disorders. Similarly, adolescents with a history of non-suicidal self-injury or eating disorders may both seek out and be algorithmically steered towards niche online communities that normalise and reinforce self-harm or extreme dieting, thereby exacerbating their conditions.[97]

In practice, the boundary between the offline and online worlds is highly porous. Offline vulnerabilities and online harms tend to operate in a reinforcing cycle rather than as separate domains. Studies show that children who are vulnerable offline, for example, those exposed to neglect, physical punishment or bullying at school, face a 'double disadvantage': they are more likely to encounter online risks such as cyberbullying and sexual solicitation, and at the same time less likely to have the parental, school or peer support needed to cope with these experiences or to seek help.[98] Adolescents who feel lonely, marginalised or in conflict with their families may turn to social media and digital platforms as a way of escaping negative emotions. While this can bring short-term relief or connection, over-reliance on digital escape can lead to increased isolation, sleep disruption and escalating exposure to harmful content, which in turn compound the original offline distress (see Sections 2.2.1 and 2.4.2).[99]

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94 UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, UNICEF, New York, 2021, p. 60.

95 OECD, *How to make societies thrive: Coordinating approaches to promote wellbeing and mental health*, OECD Publishing, Paris, 2023, p. 91.

96 K. Kostyrka-Allchorne, M. Stoilova, J. Bourgaize, M. Rahali, S. Livingstone, and E. Sonuga-Barke, 'Review: digital experiences and their impact on the lives of adolescents with pre-existing anxiety, depression, eating and nonsuicidal self-injury conditions', *Child and Adolescent Mental Health*, Vol. 28(1), 2023, pp. 22-32.

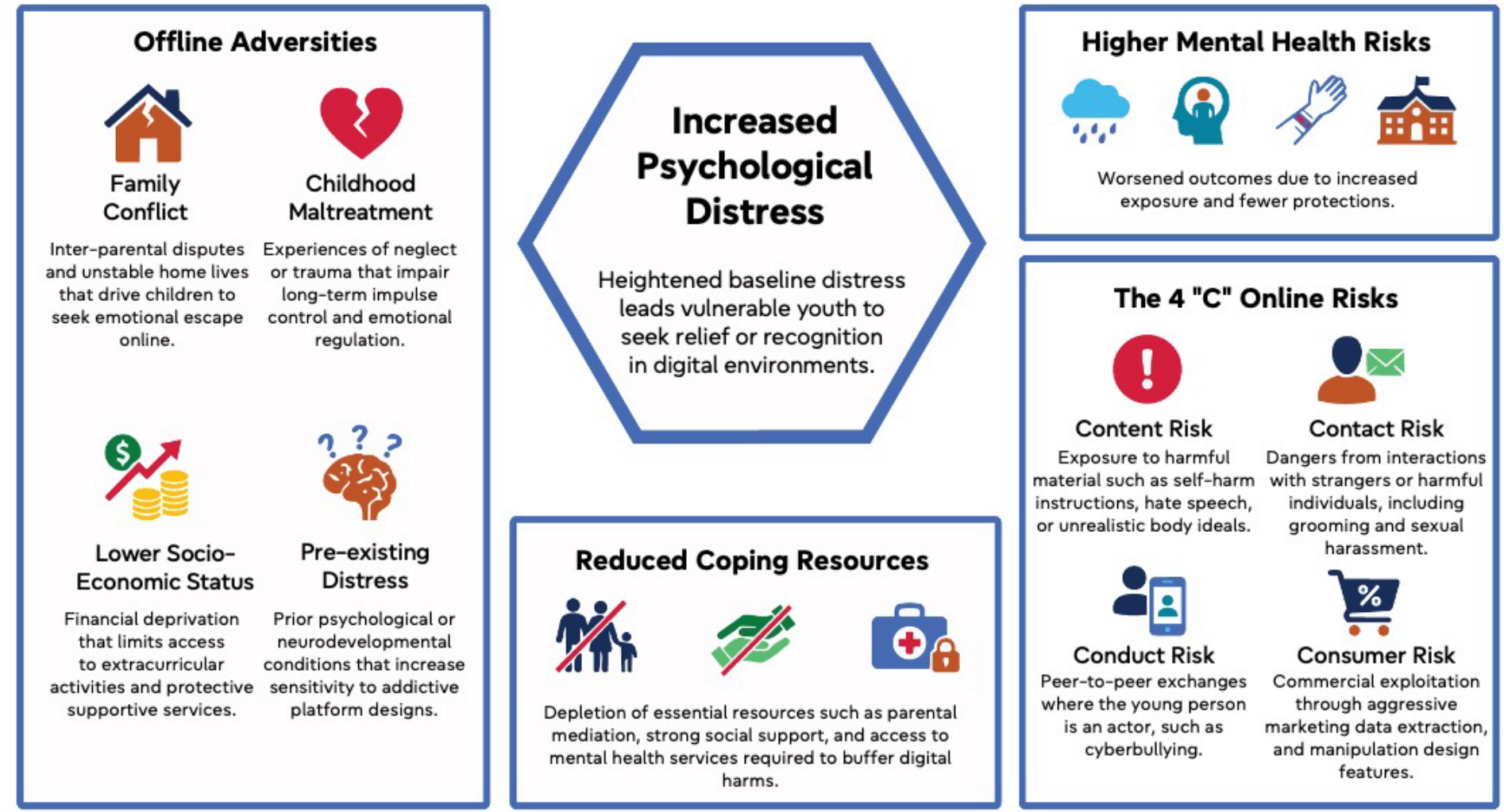
97 M. Stoilova, C. Edwards, K. Kostyrka-Allchorne, S. Livingstone, and E. Sonuga-Barke, *Adolescents' mental health vulnerabilities and the experience and impact of digital technologies*, London School of Economics and Political Science, 2021, p. 28.

98 UNICEF Office of Research – Innocenti, *Investigating risks and opportunities for children in a digital world: a rapid review of the evidence*, UNICEF, Florence, 2021, pp. 38-40.

99 OECD, *How's Life for Children in the Digital Age?*, OECD Publishing, Paris, 2025, pp. 16-17.

Figure 3 below illustrates how baseline offline adversities generate heightened psychological distress while simultaneously depleting essential protective buffers, such as parental mediation and institutional support thereby leaving vulnerable youth uniquely exposed across the four core dimensions of online risk.

Figure 3 – The 'Double Disadvantage': how offline vulnerability shapes online risk



Source: Authors' summary based on academic papers and policy literature (see references).

These patterns underline that measures to make digital environments safer for young people cannot be separated from efforts to reduce poverty, discrimination and childhood adversity, or from improvements in access to timely support offline. Addressing offline inequalities and strengthening protective relationships around children are therefore integral to reducing digital-era mental-health risks and are central considerations for the national approaches and EU-level options discussed in Chapters 4 and 5.

2.3.4. System capacity and service-design weaknesses

The system-level symptoms described in Section 2.1.3, long waiting lists, high access thresholds, large unmet needs and increasing use of emergency departments, stem from chronic structural weaknesses in how mental healthcare is funded, organised and delivered.

Despite the substantial economic costs of mental ill-health (discussed in more detail in Section 2.4.4), public investment in mental-health services remains limited. Globally, median government expenditure on mental health is estimated at just over 2 % of total health budgets.[100] In many systems, this scarcity of resources has contributed to an entrenched acute-care bias. Funding is channelled into hospitals and specialised psychiatric units that focus on diagnosis, medication and symptom reduction for the most severe cases.[101] By contrast, proactive mental-health promotion, community-based prevention and low-threshold early-intervention services are chronically under-resourced. In practice, this means systems are often structured to wait until a young person's mild or moderate distress has escalated into a clinical crisis before significant support becomes available.

Underfunding is closely linked to shortages in human resources. There is a marked global deficit of specialised child and adolescent psychiatrists, psychologists and mental-health nurses, and the available workforce is unevenly distributed.[102] Across OECD countries, mental-health professionals are heavily concentrated in affluent urban areas, leaving rural, remote and socio-economically disadvantaged regions with very limited access to specialist care. Young people in these areas may have to rely on hospital emergency departments as de facto entry points for mental-health support or receive no formal care at all.[103] As described in Section 2.1.3, these structural constraints translate into long waiting times, high thresholds for referral and increased reliance on emergency services.

A further structural weakness is the high degree of fragmentation between services and sectors. Although mental health is strongly shaped by social determinants, mental healthcare is frequently siloed from education, primary care, youth work and social services. In many settings there are no clear, formalised referral pathways between, for example, a teacher or school counsellor who identifies a child in distress and a clinician able to provide assessment and treatment.[104] As highlighted earlier, rigid age-based boundaries between CAMHS and Adult Mental Health Services (AMHS) create a 'transitional gap' in which continuity of care collapses just as many young people reach the peak risk period for serious mental illness.[105]

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100 World Health Organization, *Mental Health Atlas 2020*, WHO, Geneva, 2021, p. 11.

101 World Health Organization, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*, WHO, Geneva, 2021, pp. 1-2.

102 UNICEF, *The State of the World's Children 2021*, p. 122.

103 OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Publishing, Paris, 2021, pp. 234-235.

104 Eurochild, *Children's Realities in Europe: Flagship Report*, Eurochild, 2024, p. 30; OECD, *A New Benchmark for Mental Health Systems*, 2021, p. 115.

105 G. Signorini et al., 'The interface between child/adolescent and adult mental health services: results from a European 28-country survey', *European Child & Adolescent Psychiatry*, Vol. 27(4), 2018, pp. 501-511.

System capacity is also constrained by a skills and literacy gap in relation to the digital environment. Mental-health practitioners, educators and social workers often report that their initial training did not prepare them to understand the role of social media, gaming, AI-driven tools and other online experiences in young people's lives. This limits their ability to explore digital habits in assessments, to integrate online experiences into formulations and care plans, or to provide practical guidance on healthier digital use.[106] Parents and caregivers, who form the first line of support, frequently lack the digital literacy and confidence needed to mediate children's technology use, recognise harmful patterns or set appropriate boundaries. As a result, many children and adolescents are left to navigate complex digital ecosystems on their own.[107]

These structural weaknesses – underfunding and acute-care bias, workforce shortages and territorial imbalances, fragmented governance and limited digital literacy among professionals and caregivers – are recurrent themes in the national mapping and case studies (see Chapter 4). They also shape what is feasible and realistic at EU level. Any EU-level initiative aimed at improving youth mental health in a digital era needs to support prevention and early intervention, promote more integrated governance across sectors, and invest in capacity-building for the workforce and for families, rather than focusing solely on specialist clinical services (see Chapter 5).

2.4. Consequences and impacts

Building on the clinical symptoms outlined in Section 2.1.1, this section examines the evidence linking digital technology use to negative health outcomes. Rather than merely cooccurring, problematic digital habits function as direct catalysts that exacerbate psychiatric vulnerabilities and disrupt foundational developmental processes. It should be noted, however, that digital determinants are one contributing factor and amplifier of negative mental health outcomes, among several, not the sole or primary cause at population level. The empirical literature also does not speak with a single voice about the size of digital-technology effects on adolescent mental health. Some research shows that average associations between general 'screen time' and wellbeing modest, while risk appears to be concentrated in specific patterns of use and among vulnerable groups.

The evidence base concerning the digital determinants of adolescent mental health also varies significantly in its maturity and strength. Well-established pathways, such as the negative impacts of cyberbullying, problematic gaming, and the displacement of sleep by screen time, are supported by high-quality meta-analyses and large-scale, cross-national longitudinal cohorts. In contrast, the effects of general, daily screen time on internalising symptoms (such as anxiety and depression) show only modest and mixed associations, explaining a very small proportion of the variance in adolescent wellbeing. Furthermore, evidence regarding youth exposure to specific harmful content, such as self-harm or pro-eating-disorder material, is largely moderate, relying heavily on cross-sectional or qualitative data due to the ethical challenges of running experimental designs on vulnerable youth. Finally, research on the psychosocial impacts of emerging technologies, such as emotional reliance on AI chatbots and companions, remains very limited and largely anecdotal. Because of this variation in evidence maturity, this report deliberately employs cautious, non-deterministic language (e.g. 'associated with' or 'linked to') rather than claiming direct causality. Digital determinants are best understood as complex amplifiers or mediators of existing vulnerabilities, rather than the sole, direct cause of the youth mental health crisis. To make this

[106] M. Stoilova et al., *Adolescents' mental health vulnerabilities...*, p. 35.

[107] European Commission, *Science for Policy Brief: Social media usage and adolescents' mental health in the EU*, Joint Research Centre, 2024, p. 4.

variation transparent, Table 2 summarises the current evidence maturity for the main digital pathways considered in this report.

Table 2 – Strength of the evidence for key digital pathways

Digital pathway	Evidence base	Evidence strength / maturity	Summary of findings
General screen time & internalising/externalising symptoms	Meta-analyses, specification curve analyses of large cohorts (e.g. N > 350,000), and ecological momentary assessments (EMAs).	High (for modest effect sizes)	General screen time has a mixed, very small association with anxiety and depression, explaining less than 1 % of the variance in adolescent wellbeing. Causality remains unproven.
Overall screen time and sleep	Multiple cross-national surveys (e.g. HBSC), longitudinal cohorts, and meta-analyses.	High	Higher digital screen engagement is consistently associated with shorter sleep duration, delayed sleep onset, and poorer overall sleep quality.
Cyberbullying & online victimisation	Meta-analyses, systematic reviews, and large-scale longitudinal studies.	High	Online victimisation is strongly and consistently associated with severe mental health consequences, including elevated depression, anxiety, and suicidal ideation.
Problematic / addictive-like social media use	Large multinational representative cohorts (e.g. HBSC across 44 countries), longitudinal studies, and validated psychometric scales.	High	Problematic use (characterised by loss of control and withdrawal) is robustly associated with lower life satisfaction, psychological distress, and impaired school and family functioning.
Problematic gaming / gaming disorder	Systematic reviews, multi-level cross-national evaluations, and longitudinal tracking.	High	Gaming disorder is consistently associated with severe functional impairment, sleep disruptions, and co-occurring behavioural and emotional problems (e.g. ADHD symptoms).
Night-time use / 'vamping'	Large cross-sectional surveys and some emerging longitudinal studies.	Moderate	Active device use in bed and leaving notifications on overnight are associated with inadequate sleep quantity, social jetlag, and daytime sleepiness.

Digital pathway	Evidence base	Evidence strength / maturity	Summary of findings
Exposure to self-harm & eating-disorder content	Scoping reviews, qualitative studies, and cross-sectional surveys of clinical/vulnerable populations.	Moderate	Accessing this content is associated with triggering or exacerbating self-destructive behaviours among vulnerable youth, though some adolescents concurrently report finding peer validation and support.
AI chatbots & AI companions	Early qualitative analyses, theoretical papers, and very small cross-sectional or pilot studies.	Emerging / Very limited	Evidence suggests AI chatbots may offer temporary relief from loneliness, but pose emerging risks regarding emotional dependence, inappropriate advice, and a lack of human empathy.

Source: Authors' summary based on academic literature organisational information, published databases, and policy literature (see references).

2.4.1. Psychological and health consequences

A growing body of longitudinal and meta-analytic research links problematic patterns of digital-media use with poorer mental health in adolescence. Large prospective cohort studies, such as the Adolescent Brain Cognitive Development (ABCD) study, suggest within-person directionality: increases in time spent on social media during early adolescence are followed by higher levels of depressive symptoms one year later, even after adjusting for baseline mood.[108] Meta-analyses similarly report that high engagement with certain formats, particularly fast-paced short-form videos, is associated with poorer mental-health indices, including elevated stress and anxiety. [109]

The visual and interactive nature of social media produces specific psychological effects. Experimental and longitudinal studies find that both exposure to, and active creation of, idealised images on social platforms are associated with increased body dissatisfaction and greater dietary restraint.[110] As described in Section 2.3.1, algorithmic curation can amplify this exposure by prioritising appearance-focused content. Clinically, this can translate into heightened vulnerability to eating-disorder symptoms for some young people, especially where online pressures interact with pre-existing concerns or offline adversity (see Section 2.3.3). Most of these studies use symptom scales and subclinical indicators rather than diagnostic interviews, so they primarily speak to changes in distress and risk, not to the onset of full clinical disorders.

Algorithmically driven 'rabbit holes'[111] also play a role in exposing adolescents to self-harm and suicide-related content. Recommender systems can rapidly surface material that romanticises suicide or provides instructions for self-harm, particularly to users who linger on such content[112](see Section 2.3.1). Cross-national data from the Disrupting Harm project indicate that children exposed to online sexual abuse or severe cyberbullying report significantly higher levels of anxiety, are more likely to engage in self-harm and show increased suicidal thoughts and behaviours compared with peers who have not had such experiences.

These psychological impacts are not evenly distributed across groups. Female adolescents are more likely than males to engage in intensive social-media use (for example, more than three hours per day) and to report associated negative outcomes such as depression and anxiety.[113] Girls and young women are also disproportionately affected by appearance-based social comparison, making them particularly susceptible to digital stress and the internalisation of narrow beauty ideals.[114] At the same time, young people in vulnerable situations, including those from low-income households, those experiencing family adversity, migrants and refugees, and LGBTQIA+ youth – often face a 'double disadvantage'. They may rely on digital communities for identity exploration and peer

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108 J. M. Nagata et al., 'Social Media Use and Depressive Symptoms During Early Adolescence', *JAMA Network Open*, Vol. 8, No. 5, 2025, e2511704.

109 L. Nguyen et al., 'Feeds, Feelings, and Focus: A Systematic Review and Meta-Analysis Examining the Cognitive and Mental Health Correlates of Short-Form Video Use', *Psychological Bulletin*, Vol. 151, No. 9, 2025, pp. 1125–1146.

110 C. Gordon et al., 'A cluster randomized controlled trial of the SoMe social media literacy body image and wellbeing program for adolescent boys and girls', *Nutrients*, Vol. 13, 2021, p. 3825.

111 *Explanatory note*: A digital phenomenon where platform algorithms continuously feed a user related content, trapping them in a loop of prolonged screen time or exposure to harmful material.

112 European Parliamentary Research Service (EPRS), *Youth and social media*, European Parliament, 2024, p. 3.

113 European Commission, *Science for Policy Brief: Social media usage and adolescents' mental health in the EU*, Joint Research Centre, 2024, p. 1.

114 OECD, *Social connection and loneliness in OECD countries*, OECD Publishing, Paris, 2025, p. 170.

support yet are also more likely to encounter identity-based online victimisation and digital hate, which compound pre-existing offline discrimination and distress[115] (see Section 2.3.3).

2.4.2. Sleep, development and social functioning

Sleep disruption is one of the most pervasive functional consequences of unregulated digital use in adolescence. Longitudinal studies support a 'screen-sleep-displacement' mechanism: increases in overall screen time are followed, within months, by reductions in total sleep duration, poorer sleep quality and greater 'social jetlag' – the gap between weekday and weekend sleep timing.[116, 117] Displacement occurs through several channels. Time spent on digital media directly replaces time available for sleep; late-night use ('vamping') generates cognitive and emotional arousal through continuous notifications and engagement; and blue light emitted from screens suppresses melatonin production, delaying sleep onset. Chronic sleep curtailment, in turn, is a key mediator linking heavy screen use to subsequent increases in depressive symptoms and other mental-health problems[118] (see also Section 2.4.1).

Constant connectivity and rapid context-switching also have neurodevelopmental implications. Meta-analytic evidence indicates that excessive engagement with fast-paced, short-form videos and similar content is associated with poorer cognitive performance, particularly reduced sustained attention and weaker inhibitory control.[119] Longitudinal models show that increases in social-media use, television viewing and video gaming are followed by a worsening of ADHD-related symptoms in adolescents, with this association partly mediated by rising impulsivity and diminished response inhibition. In other words, the continuous stimulation characteristic of many digital platforms may raise the threshold for boredom, narrow tolerance for low-stimulation tasks and weaken adolescents' capacity to regulate impulses – processes that are central to learning and everyday functioning.[120]

Although digital platforms are designed to facilitate connection, heavy reliance on them can erode real-world social functioning. The 'social displacement' hypothesis suggests that time spent on devices often replaces face-to-face, restorative interaction with family and peers. Online communication, especially when text-based, typically lacks the non-verbal cues, immediacy and depth of in-person conversation.[121] When digital exchanges systematically substitute for offline encounters, this can stunt the development of empathy and more complex interpersonal skills, contributing to higher social anxiety and feelings of loneliness.[122]

Experimental studies that temporarily restrict mobile-internet access show that adolescents and young adults subsequently spend more time socialising in person, exercising and engaging with nature, and that these shifts are accompanied by improvements in subjective wellbeing, attention and overall mental health. This supports the interpretation that design-driven overuse and

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115 J. Chhabra et al., 'Social Media and Youth Mental Health: Scoping Review of Platform and Policy Recommendations', *Journal of Medical Internet Research*, Vol. 27, 2025, e72061.

116 S. Hökby et al., 'Adolescents' screen time displaces multiple sleep pathways and elevates depressive symptoms over twelve months', *PLOS Global Public Health*, Vol. 5, No. 4, 2025, e0004262.

117 M. Boniel-Nissim et al., 'Adolescent use of social media and associations with sleep patterns across 18 European and North American countries', *Sleep Health*, Vol. 9, 2023, pp. 314–321.

118 S. Hökby et al., 'Adolescents' screen time displaces…', p. 12.

119 L. Nguyen et al., 'Feeds, Feelings, and Focus…', p. 1125.

120 J. Wallace et al., 'Screen time, impulsivity, neuropsychological functions and their relationship to growth in adolescent attention-deficit/hyperactivity disorder symptoms', *Scientific Reports*, Vol. 13, 2023, p. 44105.

121 C. L. Toma, 'Online dating and psychological wellbeing: a social compensation perspective', *Current Opinion in Psychology*, Vol. 46, 2022, p. 101331.

122 OECD, *Social connection and loneliness in OECD countries*, p. 169.

displacement (see Section 2.2.1) do not merely co-occur with poorer outcomes; they can shape sleep, cognitive development and social functioning in ways that increase vulnerability to mental-health difficulties.[123]

2.4.3. Educational and labour-market consequences

As highlighted in Section 2.1.2, mental distress in childhood and adolescence is associated with immediate functional impairments such as school absenteeism, reduced concentration and lower academic self-efficacy. Over time, these difficulties disrupt educational pathways and have lasting effects on young people's transition into adulthood.

Across EU countries, students reporting significant psychological distress are substantially more likely to have repeated a grade than their peers without such difficulties, with estimates in the range of 25–35 % higher risk.[124] As distress escalates, it undermines academic self-efficacy, contributes to school burnout and increases the likelihood of early school dropout.[125] Young people who experience early-onset mental-health conditions are therefore less likely to complete upper-secondary education and to enter or complete tertiary education. This contributes to a persistent attainment gap: for example, across the EU, the share of individuals with mental distress who obtain a tertiary qualification is several percentage points lower than among those without such distress.[126]

These educational deficits directly affect the critical transition from school to the labour market. Adolescents experiencing untreated depression, anxiety or behavioural disorders are more likely to become not in education, employment or training (NEET).[127] Longitudinal evidence suggests that young people who experience severe mental distress early in life face a markedly higher risk of unemployment over the subsequent decade.[128] Even when they do secure work, they are more often concentrated in precarious, low-quality jobs. Across the OECD, employment rates for people with mental-health conditions are on average about 20 % lower than for those without, with gaps of up to 30 % reported in several Member States.[129]

Labour-market outcomes are further shaped by differences in socio-emotional (SE) skills. Modern economies place increasing value on non-cognitive competencies such as emotional regulation, cognitive flexibility, empathy and resilience.[130] The onset of mental-health conditions during key developmental windows can impair the acquisition of exactly these skills.[131] Because SE skills are strong predictors of both academic achievement and adaptability in the workplace, deficits in this area have significant implications for long-term employability. Individuals with a history of mental-

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123 M. A. Hunter et al., 'Blocking mobile internet access on smartphones improves subjective wellbeing, mental health, and sustained attention', *PNAS Nexus*, Vol. 4, No. 2, 2025, p. 017.

124 OECD, *Promoting good mental health in children and young adults*, OECD Publishing, Paris, 2025, pp. 10–11.

125 K. Salmela-Aro, H. Savolainen, and L. Holopainen, 'Depressive symptoms and school burnout during adolescence: Evidence from two cross-lagged longitudinal studies', *Journal of Youth and Adolescence*, Vol. 38, No. 10, 2009, pp. 1316–1327.

126 OECD, *Promoting good mental health in children and young adults*, OECD Publishing, Paris, 2025, pp. 10–11.

127 OECD, *How to Make Societies Thrive? Coordinating Approaches to Promote Wellbeing and Mental Health*, OECD Publishing, Paris, 2023; UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, 2021.

128 M. Egan, M. Daly, and L. Delaney, 'Adolescent psychological distress, unemployment, and the Great Recession: Evidence from the National Longitudinal Study of Youth 1997', *Social Science & Medicine*, Vol. 156, 2016, pp. 98–105.

129 OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Publishing, Paris, 2021.

130 UNESCO, *The price of inaction: The global private, fiscal and social costs of children and youth not learning*, 2023; UNICEF, *Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions in Education Settings Across the Humanitarian Development Nexus*, 2022.

131 UNICEF, *Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions*, 2022.

health conditions tend to earn less over their working lives; estimates in the literature suggest earnings penalties on the order of 17–20 % compared with peers without such conditions. These life-course impacts represent a substantial loss of individual economic potential and contribute to the wider societal costs discussed in Section 2.4.4.[132]

2.4.4. Societal and economic costs

The personal effects of youth mental ill-health translate into a substantial financial burden for European societies. When problems are not prevented or treated early, they generate significant direct and indirect costs across health, education, social-protection and labour-market systems.[133] Because most mental disorders begin before age 24 (see Section 2.2), failure to intervene early can lock in decades of disability, reduced participation and lost productivity.

Across European countries, the overall societal cost of mental ill-health is estimated to exceed 4% of gross domestic product (GDP), equivalent to more than €600 billion per year.[134] While this figure covers all age groups, youth mental health is a rapidly growing component of the burden. At global level, the annual loss in human capital specifically attributable to mental-health conditions among children and adolescents (0–19 years) has been estimated at nearly €358 billion.[135]

Contrary to common assumptions, most economic costs linked to mental ill-health do not fall on the healthcare sector alone. Of the approximately 4 % of GDP cost in Europe, direct health-care expenditure accounts for around 1.3 % of GDP.[136] A similar share, about 1.2 % of GDP, is absorbed by social-security programmes, including disability benefits, unemployment insurance and paid sick leave for people unable to work because of mental-health conditions.[137] The education sector also bears substantial direct costs. In the United Kingdom, for example, additional special educational support for children with mental-health and behavioural difficulties has been estimated to cost around €3.1 billion per year.[138]

The largest single component of the burden, roughly 1.6 % of GDP, arises from indirect costs: lower labour-market participation, premature mortality and productivity losses due to absenteeism and presenteeism.[139] Presenteeism, when employees are physically at work but perform below capacity because of cognitive impairment or emotional distress, is particularly costly yet often under-recognised in standard budgeting.[140]

Highly vulnerable cohorts, such as children and young people affected by conflict, displacement or other crises, face especially high lifetime losses. One global cost–benefit analysis found that failing

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132 Centre for Mental Health, *The economic and social costs of mental ill-health*, 2023; OECD, How to Make Societies Thrive?, 2023.

133 OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Publishing, 2021; L. Amand-Eeckhout, *Mental health in the EU*, EPRS, European Parliament, 2023.

134 R. Stelmach et al., *'The global return on investment from preventing and treating adolescent mental disorders and suicide: a modelling study'*, S. Lehtimaki et al., *'Evidence on Digital Mental Health Interventions for Adolescents and Young People: Systematic Overview'*, UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*.

135 Centre for Mental Health, *The economic and social costs of mental ill-health*, 2023; R. Stelmach et al., 'The global return on investment from preventing and treating adolescent mental disorders and suicide: a modelling study', *BMJ Global Health*, Vol. 7(6), 202

136 Ibid.

137 UNICEF, Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions in Education Settings Across the Humanitarian Development Nexus, 2023.

138 Ibid.

139 Centre for Mental Health, *The economic and social costs of mental ill-health*, 2023.

140 Ibid.

to address the mental-health and psychosocial needs of 10-to-17-year-olds in humanitarian emergencies or situations of forced displacement could result in a loss of around €188 billion in potential lifetime earnings,[141] driven largely by increased school dropout, reduced educational attainment and stunted socio-emotional development.[142]

These background estimates, derived from OECD and WHO analyses, provide the macro-economic context for this study. Chapter 6 builds on them to develop an EU-27 model that quantifies the costs of youth mental ill-health and illustrates the potential cost of inaction under different scenarios.

In summary, the human and financial liabilities of maintaining the status quo are cumulative and compounding. To provide a synthesis of these findings, Figure 4 below highlights the data analysed throughout this section.

141 Ibid.

142 UNICEF, *Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions in Education Settings Across the Humanitarian Development Nexus*, 2023.

Figure 4 – The high cost of inaction

Youth mental ill-health in the EU-27 is a rising challenge linked to digital environments. While offering connectivity, these spaces can amplify vulnerabilities through **persuasive design** and **harmful content**, leading to profound long-term consequences.

Psychological & Health Impacts

Headline fact: 1 in 5 young people live with a **mental disorder**.
- Rising prevalence of diagnosable anxiety and depression among EU youth.
- Harmful online content is linked to increased self-harm and eating disorders.

Headline fact: 1 200 youth **suicides** occur annually in Europe.

Sleep Development & Social Functioning

Headline fact: 73 % of older teens **neglect sleep** due to media.
- Blue light and 'vamping' are associated with poorer sleep quality.
- Digital use may displace vital physical activity and face-to-face socialising.

Headline fact: 17 % of 15-year-olds feel **anxious** without their devices.

Education & Labour-Market Burden

Headline fact: Distressed students are **25-35 % more likely** to repeat a grade.
- Mental distress is linked to higher rates of school repetition.
- Poor youth mental health is associated with lower lifetime earnings.

Headline fact: Employment rates are **20 % lower** for those affected.

Societal & Economic Costs

Headline fact: Youth mental ill-health costs the EU **€177 billion/year.**
- Annual costs impact healthcare, social protection, and labour productivity.
- Maintaining the status quo leads to massive cumulative economic losses.

Headline fact: €1.68 trillion total 10-year **cost of inaction.**

Source: Authors' summary based on academic papers and policy literature (see references).

2.4.5. Implications for EU-level action

The analysis in this chapter has three main implications for the design of EU-level responses.

First, the evidence confirms that prevention and early intervention are essential. Most mental-health conditions emerge before age 24, and early difficulties have lasting effects on education, labour-market participation and earnings, while driving substantial public and private costs (Sections 2.2 and 2.4.3–2.4.4). This points to the value of EU action that supports Member States in strengthening promotion and prevention in settings that reach all children and young people – particularly schools, primary care and community services – rather than focusing solely on specialist treatment. It also underlines the importance of targeting the 'missing middle' of mild-to-moderate problems before they escalate into severe clinical conditions.

Second, the chapter shows that digital determinants are now central to youth mental health but operate through specific pathways: design-driven overuse and displacement, content-driven harms and AI-mediated interactions (Sections 2.2.1, 2.3.1 and 2.4.1–2.4.2). These pathways intersect with offline vulnerabilities and structural inequalities (Section 2.3.3). Given the EU's strong regulatory competences for the internal market and digital services, this creates a clear rationale for EU-level measures that ensure robust, child-centred implementation of existing digital legislation; address problematic design patterns and harmful content that disproportionately affect minors; and support safe and evidence-based use of digital tools for prevention and care. In areas where specific types of services or features are consistently associated with serious harm and cannot be made safe through design and transparency obligations alone, it may be necessary to consider whether additional regulatory measures, including, where proportionate, restrictions on access for minors, are justified.

Third, the structural weaknesses in systems and capacities identified in Section 2.3.4, underfunding of prevention, workforce shortages, fragmented governance and limited digital literacy among professionals and caregivers, mean that promising interventions can only reach their potential if enabling conditions are in place. EU-level action is therefore likely to be most effective where it helps Member States to build capacity in frontline sectors (education, primary care, youth work) to recognise and respond to distress, including its digital dimensions; improve coordination across health, education, social and digital policy; and strengthen data and monitoring systems so that trends in youth mental health and digital exposure can be tracked and evaluated over time.

Taken together, these implications suggest that maintaining the current trajectory entails a substantial 'cost of non-Europe' in terms of avoidable ill-health, lost educational and labour-market potential and higher multi-system public spending. Chapter 3 examines the current EU legal and policy framework and its gaps, while Chapters 4 and 5 draw on national experience to identify concrete EU-level options that can help reduce the costs and harms described here and support Member States in improving the mental health and well-being of young people in a digital era.

3. EU and international policy and legal context

This chapter sets out the EU and international policy and legal context within which any further action on youth mental health in a digital era must operate. It explains the EU's competences and constraints, summarises the main digital and mental-health-related instruments and strategies, and highlights recent positions of the European Parliament and the Council. It then identifies key governance gaps that frame the scope and feasibility of the EU-level options discussed in Chapter 5. The key findings are presented below, whilst Table 3 provides an overview of the primary Treaty bases through the Treaty of the Functioning of the European Union[143], Charter rights, and active legislative tools available to the European Union, before discussing those in further detail.

Key findings

Strong digital competences, weak health and education harmonisation: The EU has powerful, binding tools to regulate the internal market and digital services (Article 114 TFEU) but only supporting competences in health, education and youth policy (Articles 168, 165 and 153 TFEU). This creates a structural tension: the Union can shape key digital determinants of youth mental health, but cannot redesign national mental-health or school systems, leading to fragmented approaches and a partial 'postcode lottery' of protection and care.

A multi-layered digital regulatory framework that directly targets youth risks: The Digital Services Act, Audiovisual Media Services Directive and Artificial Intelligence Act together form a world-leading horizontal framework for digital services. They impose risk-assessment, safety-by-design, transparency and age-appropriate-protection duties on major platforms and AI systems, with specific obligations regarding minors' physical and mental well-being. These instruments are highly relevant to the design-driven, content-driven and AI-mediated pathways identified in Chapter 2, but their impact will depend on robust, child-centred implementation and enforcement.

Non-binding EU strategies provide important support but cannot guarantee delivery: A wide range of EU strategies and programmes, including the comprehensive approach to mental health, EU4Health, Healthier Together, BIK+, the EU Strategy on the Rights of the Child, the European Child Guarantee and the EU Youth Strategy, now recognise youth mental health and digital safety as priorities. They offer funding, guidance and cooperation platforms to strengthen prevention, early intervention and equity, but remain largely voluntary and non-binding, so implementation still varies greatly between Member States.

Political momentum for 'mental health in all policies' and child-centred digital safeguards: Recent European Parliament resolutions and Council conclusions converge on the need to treat mental health, especially for children and young people, as a horizontal EU priority. They call for a comprehensive EU mental-health approach, stronger protection of children online (including against addictive and manipulative design), and systematic integration of mental-health considerations into digital, education, youth and social policies. This political consensus raises expectations for more integrated and enforceable EU-level action.

Governance gaps limit the EU's capacity to address the youth mental-health crisis coherently: Despite this evolving framework, major gaps remain: there is no binding, integrated EU mental-health strategy; health expertise is only weakly embedded in digital regulation and enforcement; national implementation of both mental-health and online-safety measures is highly uneven; workforce and capacity constraints persist; and critical data and access-to-evidence gaps hinder targeted, evidence-based policymaking. These gaps define the current 'cost of non-Europe' and shape the space within which the EU-level options in Chapter 5 must operate.

[143]TFEU (Treaty on the Functioning of the European Union): One of the EU's core constitutional treaties. It lays out the practical rules for how EU institutions operate, how laws are made, and the specific policy areas where the EU is allowed to act.

Table 3 – Overview of main EU legal bases and policy tools for youth digital mental health

Legal Basis / Policy Tool	Policy Area / Scope	Type of EU Competence / Role	What it Allows the EU to Do
TREATY BASES (TFEU)			
Article 114 TFEU	Internal market	Shared	The EU harmonises national regulations to ensure high standards of safety for digital services across the Union.
Article 168 TFEU	Public health	Supporting	The EU supplements national policies to improve youth mental health and reduce digital-related health risks.
Article 165 TFEU	Education, youth	Supporting	The EU encourages cooperation between member states to improve digital literacy and the wellbeing of young people.
Article 153 TFEU	Social policy	Shared	The EU supports improvements in the working environment to protect the mental health of young digital workers.
Article 16 TFEU	Data protection	Shared	The EU establishes rules to protect individuals regarding the processing of their personal data by digital platforms.
Article 338 TFEU	Statistics	Shared	The EU produces comparable data on youth wellbeing to inform evidence-based policy making across member states.
CHARTER OF FUNDAMENTAL RIGHTS			
Article 7-8	Privacy and data	Fundamental Right	The EU guarantees the right to private life and the protection of personal data for all young users.

Legal Basis / Policy Tool	Policy Area / Scope	Type of EU Competence / Role	What it Allows the EU to Do
Article 24	Child protection and care	Fundamental Right	The EU ensures that the best interests of the child are a primary consideration in all digital policy actions.
Article 35	Health care	Fundamental Right	The EU ensures a high level of human health protection is integrated into the definition of all Union policies.
LEGISLATIVE ACQUIS AND ACTIONS			
Digital Services Act (DSA)	Online safety	Shared	The EU regulates digital platforms to mitigate systemic risks like cyberbullying and addictive design for minors.
Audiovisual Media Services Directive (AVMSD)	Audiovisual media	Shared	The EU protects minors from harmful digital content and inappropriate commercial communications.
AI Act	Artificial intelligence	Shared	The EU sets safety standards for AI systems that could negatively impact youth mental development or wellbeing.
Child Sexual Abuse Material (CSAM) Regulation/Directive	Child safety	Shared	The EU establishes measures to detect and prevent the digital distribution of child sexual abuse material.
GDPR	Data privacy	Shared	The EU enforces strict conditions for processing the data of minors and ensures their right to be forgotten.
EU4Health Programme	Funding and health	Supporting	The EU provides financial resources to scale successful mental health interventions across member states.

Legal Basis / Policy Tool	Policy Area / Scope	Type of EU Competence / Role	What it Allows the EU to Do
Healthier Together Initiative	Non-communicable diseases	Supporting	The EU coordinates a multi-sectoral approach to reduce the burden of mental health challenges among the youth.
Better Internet for Kids (BIK+)	Digital literacy	Supporting	The EU fosters a safe digital environment by promoting digital citizenship and protecting younger users from online harms.

Source: Authors' summary based on academic papers and policy literature (see references).

3.1. EU competences and legal bases

The EU's ability to act on youth mental health in a digital era is shaped by a mix of supporting competences in health, education and social policy and stronger shared competences in the internal market and digital regulation. In practice, this means the EU cannot redesign national health or education systems but can influence key determinants of youth mental health, especially in the digital sphere, and support, coordinate and complement Member State action.

3.1.1. Core Treaty provisions and EU–Member State roles

The division of roles between the EU and its Member States is primarily framed by the Treaty on the Functioning of the European Union (TFEU). The provisions most relevant to this study are the following.

- **Article 168 TFEU (public health)**: Article 168(7) TFEU makes clear that the organisation, management and funding of health services and medical care remain the exclusive responsibility of the Member States. The EU's role in mental-health service delivery is therefore strictly supporting and coordinating. At the same time, Article 168(1) requires that 'a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'. This 'health in all policies' obligation provides the mandate for the EU to integrate mental-health considerations into non-health policies (for example digital, education and employment), to fund cross-border initiatives such as EU4Health (see Section 3.3), and to facilitate the exchange of best practices on prevention, promotion and early intervention.
- **Article 114 TFEU (internal market)**: Given the limits of the EU's direct health competence, Article 114 TFEU, which underpins internal-market legislation, is the primary legal basis for regulating digital determinants of mental health. Where divergent national rules risk fragmenting the internal market, the EU can adopt binding horizontal rules for digital services and products. This article was used, for example, for the Digital Services Act (DSA) and the Artificial Intelligence Act (AI Act), which impose risk-assessment, safety and transparency obligations on large platforms and certain AI systems, including specific protections for minors (see Section 3.2).
- **Article 16 TFEU (data protection)**: Article 16 provides the legal basis for EU rules on the protection of personal data. It underpins the General Data Protection Regulation (GDPR) and is particularly relevant for any measures affecting profiling, targeted advertising to children, age-assurance mechanisms and access to platform data for independent research on youth mental health.
- **Article 165 TFEU (education, vocational training, youth)**: While education systems remain the competence of Member States, Article 165 allows the EU to support and supplement national action. This includes promoting quality improvement, encouraging cooperation on youth policy, fostering exchanges of best practices and funding programmes such as the digital education action plan, which can integrate social and emotional learning (SEL) and digital literacy into school environments (see Section 3.3). The EU cannot harmonise national education systems but can provide guidance, coordination and financial support.
- **Article 153 TFEU (social policy)**: Article 153 TFEU gives the EU competence to support and, in some areas, legislate on working conditions and the protection of workers' health and safety. It provides a basis for addressing psychosocial risks, including digital-era stress and burnout, for young people entering the labour market (for example apprentices and interns), and for supporting measures that tackle social exclusion and precarious work among young adults.

Taken together, these provisions create a structural asymmetry. The EU has strong, binding powers to regulate the internal market and digital services (Articles 114 and 16 TFEU), but only supporting competences in health, education and youth (Articles 168 and 165 TFEU). This limits its ability to harmonise mental-health or school systems, even where fragmented national approaches generate cross-border costs and an uneven level of protection for young people. The options considered in Chapter 5 must therefore work within this division of responsibilities, focusing on shaping determinants, funding, coordination and standards rather than direct service reorganisation.

3.1.2. The Charter of Fundamental Rights of the European Union

The Charter of Fundamental Rights of the European Union provides the normative and human-rights foundation for EU action on youth mental health and the digital environment. The following provisions are particularly relevant:

- **Article 35 (health care)**: Article 35 guarantees the right of access to preventive health care and to benefit from medical treatment under national laws and practices. Read alongside Article 168 TFEU, it commits the Union to a high level of health protection in all its policies. This underpins EU initiatives that seek to expand access to mental-health support, including for children and young people in vulnerable situations.
- **Article 24 (rights of the child)**: Article 24 states that children have the right to the protection and care necessary for their wellbeing, and that the child's best interests must be a 'primary consideration' in all actions by public authorities and private institutions.[144] Applied to the digital environment, this principle supports requirements that services used by minors be safe by design, that commercial interests do not override children's physical and mental wellbeing, and that children's views are heard in decisions affecting them.[145]
- **Articles 7 and 8 (privacy and data protection)**: These articles guarantee the right to respect for private and family life and the protection of personal data. In a digital context, they are central for shielding minors from intrusive profiling, pervasive commercial exploitation and data-driven design practices that can encourage excessive use or target vulnerabilities. They also frame debates on age-assurance mechanisms, data access for research and the balance between safety and privacy.[146]

In combination, the Treaties and the Charter create a legal and values-based framework within which the EU can act to reduce digital-era risks to youth mental health, while respecting Member State competences and fundamental rights.

3.2. Core EU legislative framework on digital services and online risks

Building on the Treaties and the Charter, the EU has moved from a self-regulatory model towards a binding, multi-layered framework for digital services. This framework is particularly relevant to the digital-risk pathways identified in Chapter 2, design-driven overuse and displacement, content-driven harms and AI-mediated interactions, and is anchored in a set of interlocking

144 Eurochild, *The rights of children in the digital environment*, p. 2.

145 LCFI, *EU AI Act: How Well Does it Protect Children and Young People?*

146 Eurochild, Ecpat International, Terre des Hommes Netherlands, *Balancing the right to privacy with the children's right to protection from online sexual exploitation*, Kinderrechte.digital, p. 8.

instruments that seek to institutionalise safety-by-design and enforce accountability among digital service providers.

3.2.1. Digital Services Act (DSA)

The DSA is the EU's primary horizontal framework for regulating online intermediaries and platforms. It introduces a graduated system of obligations based on a service's size, role and societal impact, with the strictest rules applying to very large online platforms (VLOPs) and very large online search engines (VLOSEs).[147]

For youth mental health, the DSA is especially relevant to content-driven harms and design-driven overuse and displacement (see Section 2.2.1). VLOPs and VLOSEs must carry out regular assessments of the systemic risks arising from the design and functioning of their services, including 'foreseeable negative effects on the protection of minors and on their physical and mental wellbeing'.[148, 149] They are required to put in place risk-mitigation measures, such as adapting recommender systems, adjusting default settings, or redesigning features that may encourage excessive or harmful use.

To protect children from exploitative commercial practices, the DSA includes an absolute ban on presenting targeted advertising based on profiling when a platform can reasonably be sure that the user is a minor.[150] It also requires providers to present their terms and conditions in clear, child-friendly language.[151] These obligations operate alongside the GDPR, which sets horizontal rules on the processing of personal data, including for children, and constrains how profiling, advertising and age-assurance mechanisms can be designed.

The European Commission has already begun to use the DSA to scrutinise how major platforms protect minors. Formal proceedings have been opened against several large services, including Meta (Facebook and Instagram), TikTok and Snapchat,[152] focusing on issues such as ineffective age-assurance, exposure of minors to illegal content and the use of potentially addictive design features (for example infinite scroll, autoplay and highly personalised recommender systems). These enforcement actions are associated with the risk pathways identified in Chapter 2, and their outcomes will shape how far the DSA can reduce design-and content-driven harms for young users.[153]

3.2.2. Audiovisual Media Services Directive (AVMSD)

The AVMSD provides the legal foundation for protecting minors from harmful audiovisual content. It extends beyond traditional television to cover video-sharing platforms (VSPs) such as YouTube and TikTok, which are central to young people's media consumption and to content-driven harms[154] (see Section 2.2.1).

Under Article 28b AVMSD, Member States must ensure that VSP providers take appropriate measures to protect minors from programmes, user-generated videos and audiovisual commercial

147 European Parliament, *Digital services act*, Briefing, 2022, p. 5.

148 *The European Union Legal Framework for Digital Safety*, p. 1.

149 Ibid.

150 *The European Union Legal Framework for Digital Safety*, p. 3.

151 *The European Union Legal Framework for Digital Safety*, p. 3.

152 European Commission, 'Commission opens formal proceedings against Meta under the Digital Services Act related to the protection of minors on Facebook and Instagram', 2024; 'EU Regulators pull back the curtain on Snapchat's inadequate protection of minors', 5Rights Foundation, 2024.

153 Nemko Digital, *TikTok Digital Services Act Breach: What It Means for You*, 2026.

154 Taylor Wessing, *How does the AVMSD protect children?*, 2020, p. 1.

communications that may impair their physical, mental or moral development.[155] The strictest measures apply to the most harmful content, including gratuitous violence and pornography.[156]

To achieve these protections, the AVMSD requires services to deploy mechanisms such as robust age-verification systems, parental-control tools, content-rating and labelling systems, and user-friendly reporting and flagging procedures.[157] Importantly, the Directive prohibits the use of minors' personal data collected for these safety tools for commercial purposes, such as direct marketing or behaviourally targeted advertising. Implementation is supervised by national media regulators, which can lead to differences in how strictly and consistently protections are applied across Member States, adding to regulatory fragmentation (highlighted in Section 3.6.4).[158]

In terms of the pathways outlined in Chapter 2, the AVMSD focuses on limiting content-driven harms (exposure to self-harm, eating-disorder, or pornographic material), while providing some levers to influence access and parental mediation. It complements the DSA's horizontal obligations by setting sector-specific rules for audiovisual media and VSPs.

3.2.3. Artificial Intelligence Act (AI Act)

The AI Act establishes the world's first comprehensive, risk-based framework for AI systems, explicitly recognising children as a group requiring special protection.[159] It is particularly relevant to the AI-mediated interaction pathway discussed in Sections 2.2.1 and 2.3.1.

Article 5 sets out a series of prohibited AI practices ('red lines'). Among these, it bans AI systems that use subliminal techniques or exploit vulnerabilities linked to age, disability or socio-economic status in order to materially distort a person's behaviour in ways likely to cause significant harm.[160] This is intended to capture, for example, AI-enabled toys that encourage dangerous behaviour or games that use highly addictive reinforcement schedules to induce compulsive use by children.[161]

The Act also prohibits certain forms of biometric categorisation that infer sensitive attributes such as political opinions or sexual orientation, protecting minors from particularly intrusive forms of profiling.[162] High-risk AI systems used in education and vocational training – for example tools that allocate students to tracks or evaluate performance, are subject to strict risk-management, transparency and human-oversight requirements, in line with the need to avoid exacerbating inequalities in educational opportunities.[163]

In response to the rapid growth of generative AI and chatbots, the Act further requires that AI conversational agents clearly and persistently signal to users that they are interacting with a machine.[164] This transparency obligation is intended to reduce the risk that children develop unhealthy emotional dependencies on AI 'companions' or act on unsafe advice generated by such systems, as highlighted in Section 2.3.1. The AI Act therefore provides a horizontal framework for limiting some of the most harmful forms of AI use with children and for embedding basic safety and

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155 European Audiovisual Observatory, *Protection of minors*, 2024, p. 2.

156 Ibid., p. 1.

157 *The European Union Legal Framework for Digital Safety*, p. 4.

158 European Audiovisual Observatory, *Protection of minors*, 2024, p. 1.

159 LCFI, EU AI Act: *How Well Does it Protect Children and Young People*?, 2024, p. 1.

160 EU AI Act – *Updates, Compliance, Training*, p. 1.

161 *The European Union Legal Framework for Digital Safety*, p. 5.

162 Ibid.

163 European Parliament, *Children and generative AI*, 2025, p. 1.

164 *The European Union Legal Framework for Digital Safety, p. 3; Freshfields, DSA decoded #6: The European Commission Finalises Guidelines on the Protection of Minors: What They Mean For* Platforms, 2025.

transparency requirements in AI systems that increasingly shape their learning and social environments.

Together with the DSA and AVMSD, the AI Act gives the EU a powerful set of tools to address the main digital pathways through which online environments affect youth mental health. How these instruments are implemented and coordinated in practice, and how health and child-protection expertise are integrated into their enforcement, are key governance questions for the EU-level options considered in Chapter 5.

AI companions and safety-by-design

AI companions and social chatbots foreseeably accessed by minors raise distinct governance issues that differ from those of general-purpose AI or traditional social media. Unlike standard search engines or newsfeeds, these conversational agents simulate empathy, active listening and reciprocal intimacy.[165] Because adolescents are at a developmental stage characterised by heightened social sensitivity and still-developing emotional regulation, they may be particularly susceptible to forming deep parasocial bonds with such systems.[166] This creates a specific risk profile: simulated intimacy can, for some users, develop into emotional dependence, and the inherent 'empathy gap' of AI means that chatbots may provide seemingly convincing but contextually inappropriate advice, potentially acting as unregulated therapists during moments of crisis.[167]

To address these vulnerabilities, the implementation of existing legislation needs to be accompanied by a robust 'safety-by-design' approach specifically tailored to AI companions. This could entail mandating continuous transparency that the system is non-human, prohibiting chatbots from claiming professional therapeutic credentials or marketing themselves as substitutes for mental-health professionals or caregivers, and instituting strict crisis-escalation protocols that hand off vulnerable users to human support lines when self-harm or abuse is detected.[168] While the AI Act already lays important groundwork by prohibiting manipulative practices that exploit vulnerabilities linked to age and by requiring basic transparency for chatbots, its practical application will need to pay particular attention to systems actively marketed to, or used by, adolescents. Because the evidence base on human–AI interaction is evolving rapidly, supervision of these systems will need to remain adaptive, drawing on continuous input from child-health, psychological and pedagogical experts so that safeguards can be updated as new risks and benefits are identified.[169]

3.2.4. Combatting Child Sexual Abuse Material (CSAM)

In response to the continued growth of online child sexual exploitation, the EU is negotiating a comprehensive package consisting of a new Regulation on combating child sexual abuse and a revised Directive on child sexual abuse offences and sanctions.[170] While primarily focused on preventing and punishing sexual violence against children, these measures are also relevant to youth

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165 M. Namvarpour et al., 'Understanding Teen Overreliance on AI Companion Chatbots Through Self-Reported Reddit Narratives', 2024; Child Mind Institute (CMI), *Safeguarding and Improving Youth Mental Health in the Digital Era*, 2024.

166 American Psychological Association (APA), *Artificial Intelligence and Adolescent Wellbeing: An APA Health Advisory*, 2023; M. Namvarpour et al., 'Understanding Teen Overreliance on AI Companion Chatbots Through Self-Reported Reddit Narratives', 2024.

167 N. Kurian, "No, Alexa, no!': designing child-safe AI and protecting children from the risks of the 'empathy gap' in large language models', *Learning, Media and Technology*, 2024; CMI, *Safeguarding and Improving Youth Mental Health in the Digital Era*, 2024.

168 N. Kurian, 'EU AI Act: How Well Does it Protect Children and Young People?', Leverhulme Centre for the Future of Intelligence, 2024.

169 APA, *Artificial Intelligence and Adolescent Wellbeing: An APA Health Advisory*, 2023; CMI, *Safeguarding and Improving Youth Mental Health in the Digital Era*, 2024.

170 *An Uncertain Path Forward: The ePrivacy Derogation and Child Safety Detection,* Risk and Compliance, p. 1.

mental health, as exposure to online sexual abuse is strongly associated with anxiety, depression, self-harm and suicidality (see Section 2.4.1).

In line with the DSA's systemic-risk approach, the Council's current mandate for the proposed Regulation moves away from generalised mandatory scanning of private communications and towards risk-based obligations. Hosting and interpersonal communication service providers would be required to carry out risk assessments on the potential misuse of their services for CSAM dissemination or grooming and to implement proportionate mitigation measures, such as safety-by-design features, more effective reporting mechanisms and robust age-assurance where appropriate.[171] The Regulation would also establish a new EU Centre on Child Sexual Abuse to support detection, reporting, victim assistance and coordination.[172]

In parallel, the recast Directive aims to update and harmonise substantive criminal law across Member States. It includes explicit provisions on the livestreaming of child sexual abuse and the creation and distribution of synthetically produced, AI-generated CSAM (deepfakes), addressing new forms of exploitation enabled by technological change.[173]

These initiatives complement the broader digital framework by targeting one of the most severe forms of online harm to children. Their design and implementation will have significant implications for how platforms manage high-risk content and contact involving minors, how law-enforcement and child-protection systems cooperate, and how fundamental rights, including privacy, are balanced with the need to prevent serious harm.

3.3. EU strategies and initiatives on mental health, children, and youth

While Section 3.2 described the binding legislative framework governing the digital single market, the EU also relies on a broad set of non-legislative strategies, funding programmes, research opportunities, and policy frameworks to support Member States in promoting the mental health of children, adolescents, and young adults. These instruments operate across health, digital, education and social policy, and are particularly important given the EU's predominantly supporting role in these fields (see Section 3.1).

3.3.1. Strategies and initiatives

A key milestone was the 2023 Communication on a comprehensive approach to mental health, which formally placed mental health on an equal footing with physical health in EU policy.[174] Backed by an estimated €1.23 billion from various EU instruments, the Communication sets out 20flagship actions structured around:

- prevention and early intervention;
- access to high-quality care;
- social reintegration and inclusion;
- tackling stigma and discrimination.[175]

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171 *An Uncertain Path Forward: The ePrivacy Derogation and Child Safety Detection*, p. 2.

172 Ibid.

173 Ibid., p. 3; *The European Union Legal Framework for Digital Safety*, p. 7.

174 European Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health*, COM(2023) 298 final, 2023, p. 1.

175 Ibid., pp. 4, 8, 11, 26.

It includes youth-specific components, such as a child and youth mental-health network, the 'Child Health 360' prevention toolkit, and targeted support for displaced and conflict-affected children and young people, including those fleeing the war in Ukraine. These elements are directly relevant to the early-onset patterns and vulnerability profiles outlined in Chapter 2.

The Communication is underpinned by the EU4Health programme, the EU's main health-funding instrument. EU4Health finances cross-border cooperation, health-system strengthening and specific mental-health projects, including those aimed at promotion, prevention and improved access to services for children and adolescents.[176] It is complemented by the 'Healthier Together' EU non-communicable diseases (NCD) initiative, which includes a dedicated strand on mental health and neurological disorders with a strong focus on health equity and reducing socio-economic inequalities.[177] These instruments provide the main EU-level funding levers to support Member States in addressing the system and capacity weaknesses identified in Section 2.3.4.

To address digital determinants of youth mental health, the Commission adopted the strategy for a better internet for kids (BIK+) in 2022. BIK+ is a comprehensive policy framework designed to ensure that every child in Europe is protected, empowered and respected online, by promoting safe, age-appropriate digital experiences and meaningful participation.[178] It is anchored in the European Declaration on Digital Rights and Principles, which sets out high-level commitments to protecting children and ensuring a safe, trusted digital environment for all users.

On the ground, BIK+ is implemented through a network of Safer Internet Centres (SICs) in Member States. Co-funded by the EU, these centres run awareness-raising campaigns, provide digital-literacy resources for children, parents and educators, and operate helplines for those affected by online harms.[179] The network also coordinates the annual Safer Internet Day, which in recent editions has explicitly addressed the mental-health risks associated with digital services.[180] In parallel, the digital education action plan (2021–2027) seeks to ensure that the digitalisation of education goes hand in hand with high-quality, inclusive digital-competence development, including skills for safe and healthy online use.[181]

Several broader, rights-based strategies embed mental health and digital safety within wider child- and youth-policy frameworks. The EU Strategy on the Rights of the Child commits the Union to mainstreaming children's rights across all policies, with a strong focus on protecting minors from violence, exploitation and harmful online content.[182] The European Child Guarantee aims to prevent and combat child poverty and social exclusion by ensuring that children in need have effective access to essential services such as healthcare, education, early childhood education and care, adequate housing and healthy nutrition.[183] Given the links between poverty, exclusion and mental ill-health highlighted in Section 2.3.3, the Child Guarantee is an important structural tool for improving the conditions that underpin good mental health.

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176 European Health and Digital Executive Agency (HaDEA), *EU4Health projects improving the mental health and wellbeing of Ukrainian refugees*, 2023.

177 European Commission, *Flagship #18: Tackling stigma and discrimination Background Policies and actions at EU level*, p. 1.

178 European Commission*, A Digital Decade for children and youth: the new European strategy for a better internet for kids* (BIK+), COM (2022) 212 final, 2022.

179 Better Internet for Kids*, Review of the year 2024*, 2024, p. 6.

180 European Health and Digital Executive Agency (HaDEA), *Safer Internet Day 2024 – Addressing risks of digital services to mental health and wellbeing across HaDEA-managed programmes*, 2024.

181 EuroHealthNet, Navigating education and wellbeing in the digital age, p. 1.

182 European Commission, EU strategy on the rights of the child, COM (2021) 142 final, 2021.

183 Ibid.

Finally, the EU youth strategy 2019–2027 provides the overarching framework for EU cooperation on youth policy. It promotes youth participation in democratic life and social engagement and explicitly includes 'Mental health and wellbeing' as Youth Goal 5. This gives a clear political mandate for Member States to prioritise prevention, destigmatisation and inclusive support for young people's mental health, including in digital contexts.[184]

Taken together, these strategies and programmes form a supporting architecture around the legislative instruments described in Section 3.2. They offer funding, guidance and coordination platforms that can be used to scale up prevention and early-intervention approaches, improve equity, and address digital-era risks. However, they remain non-binding, and implementation depends heavily on Member States' priorities and capacities. Their strengths and limitations are important for understanding which types of EU-level policy options are realistic and where additional coordination or integration may be needed (see Chapter 5 and the governance gaps discussed in Section 3.6).

3.3.2. Data, monitoring, and research infrastructures

In addition to legislative and strategic instruments, the EU can influence youth mental health in a digital era through its roles in data collection, monitoring, and research. These levers are particularly important for addressing the evidence gaps identified in Section 3.6.5 and for underpinning the data- and governance-focused policy options discussed in Chapter 5.

Under Article 338 TFEU, the Union has competence to establish statistical programmes. Eurostat and EU-wide surveys already provide a partial picture of youth mental health and digital exposure. The European Health Interview Survey (EHIS) and the European Health Examination Survey (EHES) collect information on self-reported health, including some indicators of mental health, while education-focused surveys such as PISA increasingly include modules on student well-being and digital use. The HBSC study, coordinated with WHO, offers comparable data on health behaviours, including problematic social-media and gaming use, although it is not an EU survey. In principle, these instruments could be further aligned and expanded to provide more systematic, harmonised indicators on youth mental-health outcomes, digital habits, and offline vulnerabilities across the EU-27.

Looking ahead, the European Health Data Space (EHDS) proposal aims to create a common framework for the use and re-use of health data for healthcare, research, innovation and policy-making. If adopted and implemented with appropriate safeguards, the EHDS could facilitate cross-border analysis of service use and outcomes for children and young people and enable better evaluation of prevention and early-intervention models. However, its potential in the mental-health field will depend on the inclusion of relevant variables, robust privacy and security protections, and adequate capacity among national data-holders and researchers.

EU research programmes also play a key role. Horizon Europe and its predecessors have funded longitudinal and quasi-experimental studies on mental health, child development, and digitalisation, as well as intervention trials in schools and communities. Targeted calls can support research on the causal impact of specific digital-environment features, on effective prevention and treatment models for young people, and on the long-term outcomes of youth-mental-health interventions. In parallel, the data-access provisions in the DSA and AI Act create a legal basis for independent researchers to audit certain platform algorithms and AI systems, subject to GDPR and other data-protection requirements.

[184] Mental Health Europe, *How to use the EU youth strategy for mental health?* - Guidance note, p. 2.

Taken together, these statistical, data-space and research levers could be used to build a more robust, comparable evidence base on youth mental health and digital exposure across the EU-27. At present, however, indicators are fragmented, access to high-quality microdata is uneven and opportunities to link survey, clinical and digital-behaviour data remain limited (see Section 3.6.5). Strengthening this infrastructure is therefore a key enabling condition for any EU-level option that seeks to target resources effectively and evaluate impact over time.

3.4. European Parliament and Council positions on youth mental health and digital risks

The legislative and strategic frameworks outlined above are shaped by the political priorities set by the EU's co-legislators. In recent years, both the European Parliament and the Council of the EU have increasingly placed youth mental health at the centre of the European public-health agenda and have called for a cross-sectoral approach that explicitly addresses risks arising from the digital environment.

3.4.1. European Parliament resolutions

The European Parliament has been a consistent advocate for elevating mental health to the same level of priority as physical health in EU policymaking. In its 2023 Resolution on Mental Health, Parliament called on the Commission to develop a long-term, comprehensive and integrated EU mental-health strategy. The resolution stresses the need to prioritise vulnerable groups, including children, adolescents, and LGBTQIA+ people, and to promote early diagnosis, a shift towards community-based care and significantly increased funding for mental-health services. To sustain political momentum and combat stigma, Parliament also proposed designating 2025 as the European Year of Mental Health. This builds on its 2020 Resolution on the EU's public health strategy post-COVID-19, which firmly positioned mental health – including biomedical and psychosocial dimensions – as a core pillar of Europe's recovery and resilience.

Parliament has explicitly addressed the digital dimension of youth mental health. The 2022 Resolution on mental health in the digital world of work highlights how digital technologies increasingly shape young people's learning and early work experiences, and raises concerns about digital burnout, anxiety and social isolation. It calls for measures to prevent psychosocial risks linked to remote and platform-based work, and for better integration of mental-health considerations into digital-work and education policies.

A wider set of resolutions addresses the social and crisis-related drivers of youth mental distress. These include the 2023 Resolution on reducing inequalities and promoting social inclusion for children and their families, the 2022 Resolution on the impact of COVID-19 closures of educational, cultural, youth and sports activities on children and young people, and the 2022 Resolution on the European Year of Youth. Taken together, they emphasise the need to mitigate the cumulative effects of successive crises on children and young people by strengthening tailored psychosocial support in education, youth and community settings; fully implementing the European Child Guarantee to reduce child poverty and social exclusion; and developing EU-wide mental-health protection plans, particularly in schools and training systems.

Parliament has reinforced these priorities through broader texts on children's rights, social exclusion and poverty and gender equality in mental-health research. These resolutions underline those structural inequalities – including those related to gender, socio-economic status and minority status – directly exacerbate youth mental distress and should therefore be explicitly addressed in EU and national policies.

Overall, Parliament's positions create a clear political mandate for EU-level action that treats mental health, especially for children and young people, as a horizontal priority, integrates mental-health considerations into digital, education, social and youth policy, and addresses both offline determinants and digital-era risks.

These expectations frame the space in which the Commission and Member States are expected to operate and provide important context for the EU-level options considered in Chapter 5.

3.4.2. Council conclusions: Recognising the digital determinants of youth mental health

The Council of the EU has increasingly converged with the European Parliament in recognising the need to protect young people's mental health, including from emerging digital risks. Most recently, the 2025 Council Conclusions on promoting and protecting the mental health of children and adolescents in the digital era make an explicit and urgent call for safer, healthier and age-appropriate digital environments. The conclusions invite Member States and the Commission to strengthen protection of children's mental health online by addressing addictive and manipulative design practices; expanding digital literacy and media-education measures; and ensuring that platforms comply with safety-by-design principles and, where appropriate, implement robust age-assurance mechanisms.

These 2025 conclusions build on the landmark November 2023 Council Conclusions on mental health, in which the Council formally endorsed a 'mental health in all policies' approach. The Council explicitly acknowledged that pressures linked to the digital era and social media can significantly worsen mental health among children and young people. Framing mental health within the broader context of NCDs, it called on Member States to tackle psychosocial risks across sectors, promote early detection and SEL in educational settings, and address commercial and environmental determinants of mental health, including those arising from the operation of digital platforms.

3.4.3. Shaping expectations for integrated EU-level action

Taken together, the positions of the European Parliament and the Council establish a clear political mandate for stronger, more integrated EU-level action on youth mental health in a digital era. Both institutions move beyond isolated health initiatives and press the Commission to shift from fragmented, soft-law recommendations towards a more cohesive, cross-sectoral framework that links health, education, youth, social and digital policy.

These political signals create strong expectations that future EU digital regulation, education initiatives and funding programmes will systematically incorporate child-centred mental-health safeguards – for example by mainstreaming youth mental-health considerations in the implementation of the DSA, AVMSD and AI Act, embedding mental-health promotion and digital-wellbeing content in EU-supported education and youth actions, and prioritising vulnerable groups and inequalities in the allocation of EU funds. This political context defines the ambition level for the EU-level policy options developed in Chapter 5.

3.5. The international policy and legal framework

While the European Union has developed its own architecture for digital regulation and public-health cooperation, these efforts sit within a wider international context. Global human-rights, health and digital-governance frameworks shape the obligations of EU Member States and provide reference points for EU-level action on youth mental health in a digital era. Three pillars are particularly relevant.

- **The United Nations human rights and sustainable development framework**: The foundational instrument at the international level is the United Nations Convention on the Rights of the Child (UNCRC) of 1989, which has been ratified by all EU Member States. The UNCRC establishes a comprehensive framework of children's rights covering four broad areas: survival rights, development rights, protection rights, and participation rights.[185] The UN Committee on the Rights of the Child has modernised this framework through General Comment No. 25 (2021), which explicitly translates these established rights to the digital environment, providing international guidance on how children must be protected and empowered online.[186] Mental health is also embedded in the United Nations 2030 Agenda for Sustainable Development. Sustainable Development Goal (SDG) 3 commits countries to 'ensure healthy lives and promote wellbeing for all at all ages', explicitly including the promotion of mental health and wellbeing. Other SDGs on education, inequality, decent work and reduced violence are closely linked to youth mental health and its determinants.
- **The WHO strategic public health frameworks**: The WHO provides the main global public-health reference for mental health. WHO defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', underlining that there is no health without mental health.[187] This vision is operationalised through the Comprehensive Mental Health Action Plan 2013–2030, which calls on countries to strengthen governance, promotion, prevention, early intervention and community-based care. For the WHO European Region, the European Framework for Action on Mental Health 2021–2025 supports states in building capacity across sectors, integrating mental health into primary care and schools, and reducing stigma.[188] Both frameworks identify children and adolescents as priority groups and recognise the need to respond to new pressures, including those linked to digitalisation.
- **The Council of Europe human rights and digital protection conventions**: The Council of Europe (CoE) provides binding human-rights and specialised conventions that influence EU law and Member State practice. The European Convention on Human Rights (ECHR), in particular Article 8 (right to respect for private and family life), is central for balancing privacy with measures to protect children from online harms.[189] The European Social Charter requires states to 'effectively realise' social rights, including the right to protection of health (Article 11) and to social and medical assistance (Article 13), which underpin obligations to provide accessible mental-health support.[190] Targeted digital instruments, notably the Convention on Cybercrime (Budapest Convention) and the Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (Lanzarote Convention), establish common definitions and cooperation mechanisms to tackle online child sexual exploitation and related digital abuse.[191]

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185 European Parliament, Cyberbullying among young people: Laws and policies in selected Member States, EPRS, 2024, p. 2.

186 European Parliament, *Cost of non-Europe in health policy*, EPRS, 2024, p. 5.

187 WHO Regional Office for Europe, *Mental health systems capacity in European Union Member States, Iceland and Norway*, 2024, p. 1.

188 Ibid.

189 *Balancing the right to privacy with the children's right to protection from online sexual exploitation*, Kinderrechte.digital, p. 3.

190 PICUM, The right to health for undocumented migrants, p. 8.

191 B*alancing the right to privacy with the children's right to protection from online sexual exploitation*, Kinderrechte.digital, p. 3.

3.6. Gaps, challenges and governance issues

Despite the evolving framework described above, significant gaps and governance challenges remain. Analysis of the literature and stakeholder reports suggests that these relate to:

- the absence of an integrated EU mental-health strategy;
- limited systematic input from child-health experts into digital regulation and enforcement;
- fragmented implementation across Member States;
- workforce and capacity constraints;
- critical data and evidence gaps.

3.6.1. Enabling and constraining EU action

As outlined in Section 3.1, the EU has strong, binding competences to regulate the internal market and digital services (Articles 114 and 16 TFEU), but only supporting competences in health, education and youth policy (Articles 168 and 165 TFEU). This asymmetry both enables and constrains action on youth mental health in a digital era. On the enabling side, the Union can shape key digital determinants of mental health through legislation such as the DSA, AVMSD and AI Act, and can fund and coordinate national efforts in prevention, early intervention and equity through instruments like EU4Health and the Child Guarantee. On the constraining side, it cannot harmonise how Member States organise and fund their mental-health or school systems, even where fragmentation generates cross-border costs and an uneven level of protection for young people. This structural tension is a core element of the current 'cost of non-Europe': strong EU-level tools exist for regulating platforms, but the health, education and social-care systems that must respond to youth mental-health needs remain highly heterogeneous.

3.6.2. Absence of a fully integrated, binding EU mental health strategy

The 2023 communication on a comprehensive approach to mental health is an important step. It allocates around €1.23 billion to mental-health-related actions and signals that mental health should be treated on a par with physical health in EU policymaking. However, it remains a non-binding strategic document rather than a legislative or programmatic framework with enforceable commitments.[192]

Child-rights organisations and professional bodies, alongside the European Parliament, argue that this limits its capacity to drive systemic change. They call for a comprehensive, multisectoral EU mental-health strategy rooted in human rights, which would encourage and support all Member States to develop context-specific national action plans with clear objectives, timelines and budgets, and to move towards international recommendations that mental health should account for around 10 % of total health spending. Without such a binding or semi-binding framework, mental health often remains subordinate to physical health in national policy execution, and EU-level engagement relies heavily on voluntary cooperation and project-based funding.[193]

3.6.3. Limited child health input into digital legislation and governance

A second major governance challenge is the siloed nature of policy development and enforcement. Policies designed to protect children in the digital environment frequently fall under the responsibility of ministries for technology, communications or culture, with limited systematic

[192] European Commission, *Communication from the Commission on a comprehensive approach to mental health*, COM (2023) 298 final, 2023, p. 2; United Nations Children's Fund, *Child and adolescent mental health: Policy Brief 2*, UNICEF, 2024, p. 2.

[193] Ibid., p. 3.

involvement from health and child-protection authorities.[194] Digital-services and media regulators are often the primary enforcers of the DSA, AVMSD and related instruments, but may lack the clinical expertise needed to assess whether a platform's algorithmic design or content-moderation practices are developmentally appropriate or psychologically safe for children and adolescents.

To address this, the Council has called for more interdisciplinary advisory structures, including neurobiologists, child psychologists, addiction specialists and youth representatives, to support digital-policy design and enforcement. [195] At the same time, although EU strategies such as BIK+ emphasise youth participation, research suggests that the active involvement of children and young people in shaping digital policies remains limited and often formalistic, with the voices of marginalised youth least likely to be heard. This weak integration of child-health expertise and lived experience into digital-governance processes risks underestimating the mental-health implications of design and business-model choices[196] (see Sections 2.3.1–2.3.3).

3.6.4. Fragmented implementation and an unlevel playing field

The reliance on Member State implementation creates a highly fragmented landscape, resulting in a 'postcode lottery' of protection and care for young people across the EU. This fragmentation appears in both the digital and the health-and-education spheres.[197]

In the digital sphere, the DSA and AVMSD provide common statutory frameworks, but national approaches to age-assurance, media-literacy curricula, enforcement priorities and cooperation with platforms still diverge widely. Some Member States are exploring statutory age limits or strict age-verification requirements for social media, while others rely primarily on guidance and self-regulation. These differences can both compromise online safety for children in some jurisdictions and undermine the level playing field intended by the internal market, creating uncertainty for platforms and users alike.[198]

In health and education, policy fragmentation is even more pronounced. Although almost all EU/EEA countries have a national mental-health policy, assessments suggest that only around 10–25 % have implemented these comprehensively across everyday settings such as schools, primary care and workplaces.[199] As discussed in Section 2.3.4, severe shortages of child psychiatrists, psychologists and school-based mental-health professionals mean that even when EU-funded prevention programmes or early-intervention toolkits are available, many national systems lack the human resources required to deliver them at scale. [200] This uneven implementation is a core driver of the cost of non-Europe in this field

3.6.5. Critical data and evidence gaps

Finally, EU governance is hindered by significant data and evidence gaps on how digital environments affect youth mental health over time and on which interventions work best in

194 World Health Organization, *Addressing the digital determinants of youth mental health and wellbeing: policy brief*, WHO Regional Office for Europe, Copenhagen, 2025, p. 5.

195 Council of the European Union, *Council conclusions on promoting and protecting the mental health of children and adolescents in the digital era*, 9069/25, 2025, p. 28.

196 Vodafone Stiftung, C*lick, scroll, connect – and balance*, pp. 17, 50; World Health Organization, *Addressing the digital determinants*..., p. 5.

197 Vodafone Stiftung, C*lick, scroll, connect – and balance*, p. 15.

198 Cerre, *Towards an EU consumer law fit for the digital age report*, 2026, pp. 28-29; Vodafone Stiftung, *Click, scroll, connect – and balance*, p. 15.

199 OECD, Promoting good mental health in children and young adults, OECD Publishing, Paris, 2025, p. 13.

200 World Health Organization, *Mental health systems capacity in European Union Member States, Iceland and Norway*, WHO Regional Office for Europe, Copenhagen, 2024, p. 3

real-world conditions. Much of the current research relies on self-reported, cross-sectional surveys, which makes it difficult to establish causal links between specific platform designs (for example recommender systems) and clinical mental-health outcomes, or to differentiate effects for vulnerable sub-groups.[201]

At EU level, indicators on youth mental health and digital exposure are fragmented across surveys (for example EHIS, PISA modules, HBSC) and are not always harmonised or updated at sufficient frequency. Access to high-quality microdata for independent researchers is uneven, and opportunities to link survey, clinical and digital-behaviour data are limited. Addressing these gaps requires diversifying data-collection vehicles, funding longitudinal and quasi-experimental studies and making effective use of the data-access provisions in the DSA and AI Act, so that proprietary algorithms and high-risk services can be audited in a way that respects GDPR and other data-protection requirements (see Section 3.3.2).

Under Article 338 TFEU, the EU also has competence to establish statistical programmes, which could be used to develop harmonised indicators and regular monitoring of youth mental-health and digital-exposure trends across the EU-27. Without a stronger empirical foundation, policymakers at both EU and national level face significant challenges in designing, targeting and evaluating interventions capable of keeping pace with rapid technological change. Strengthening data, monitoring and research infrastructures is therefore a key enabling condition for the EU-level options on data and governance discussed in Chapter 5.

Deploying the EU's legal and statistical architecture effectively requires a precise mapping of current information deficits. While existing mechanisms track broad, macro-level digital and clinical trends, they fail to capture the granular, algorithmic, and intersectional dynamics affecting youth wellbeing. Table 3 outlines this digital knowledge gap, contrasting visible baseline metrics against critical missing data points, and mapping them directly to the specific EU policy instruments designed to retrieve them.

[201] European Commission, Joint Research Centre, Science for Policy Brief: *Social media usage and adolescents' mental health in the EU*, 2025, p. 2; OECD, *How's Life for Children in the Digital Age?*, OECD Publishing, Paris, 2025, p. 167.

Table 4 – Existing, missing, and actionable data sources covering mental health of young people in a digital era

Key existing baseline	Critical missing data gaps	Actionable source
Platform algorithmic impacts		
General self-reported screen time and basic platform usage statistics.	Proprietary black-box algorithms, engagement optimisation metrics, and precise causal links to psychological harm.	Article 40 DSA data-access provisions for vetted researchers and Horizon Europe longitudinal studies.
Clinical recognition rates		
Epidemiological prevalence of formally diagnosed severe mental health disorders.	Scale of undiagnosed mild-to-moderate subclinical distress and the true size of the 'missing middle' treatment gap.	Expanded mental health modules in the European Health Interview Survey (EHIS) via Article 338 TFEU and the European Health Data Space (EHDS).
Intersecting vulnerabilities		
Broad demographic data grouped by basic age bands, sex, and national averages.	Granular, intersectional data on overlapping offline vulnerabilities for marginalised groups like NEET, migrant, and LGBTQIA+ youth.	Harmonised statistical programmes under Article 338 TFEU and targeted EU4Health equity monitoring.
Revenue & ads metrics		
Macro-level digital advertising spend and general platform commercial activity.	Minor-targeted algorithmic profiling, hidden variable reward metrics, and aggressive in-game monetisation like loot boxes.	Mandatory transparency reports, algorithmic disclosures, and systemic risk assessments under Articles 27, 34, and 35 of the DSA.

Source: Authors' summary based on organisational research and data publications and policy literature (see references).

Taken together, these governance gaps, the lack of a fully integrated EU mental-health strategy, limited systematic input from child-health experts into digital regulation, fragmented implementation across Member States, workforce and capacity constraints, and persistent data and evidence gaps, define the space in which further EU-level action must operate. They suggest that new initiatives are likely to be most effective where they build on existing legal instruments rather than start from scratch, support Member States in strengthening prevention, early intervention and coordination; and help align digital-market incentives with children's rights and mental health. The policy options set out in Chapter 5 are therefore designed explicitly with these enabling conditions and constraints in mind.

4. National policies and case study findings

This chapter examines how EU Member States and selected international comparators are responding to the youth mental-health challenges identified in Chapter 2. It focuses on intervention models and implementation lessons rather than benchmarking or ranking countries and looks at how national responses address the symptom patterns, underlying causes and digital pathways described earlier.

The analysis uses a mixed-methods design. A structured review of existing research (OECD, WHO, UNICEF and academic literature) is combined with seven in-depth country case studies (Australia, Ireland, Italy, the Netherlands, Norway, Poland and the United Kingdom), based on national documentation and interviews with administrators, clinicians and social workers (see Annexes 2 and 4). National approaches are grouped into five broad intervention types: school-based promotion, community youth hubs, digital tools and support, social prescribing and digital regulation. These correspond to different levels of prevention and care, from universal school-based action to upstream regulation of the digital environment.

The evidence presented here provides the basis for the EU-level policy options in Chapter 5 and the impact assessment in Chapter 6.

Key findings

High political commitment, uneven practical execution: Over 90 % of EU Member States have adopted national mental-health policies or action plans, yet only an estimated 10–25 % have implemented them comprehensively in everyday settings such as schools, primary care and workplaces. This leaves major gaps between stated ambitions and on-the-ground support for young people.

Five intervention archetypes dominate national responses: National approaches cluster around school-based promotion, community youth hubs, digital tools and support, social prescribing and digital regulation. Each addresses a different part of the problem: early prevention and literacy, the 'missing middle' of moderate needs, digital-era access and engagement, offline protective factors and upstream digital-design risks.

School-based promotion and youth hubs are the most mature and evidence-rich models: Several countries (for example Ireland, Norway, Australia, the United Kingdom) have scaled structured social-emotional-learning programmes and youth-friendly community hubs with measurable impacts on symptoms, coping skills and help-seeking. However, coverage across the EU-27 remains patchy and often depends on short-term project funding.

Digital tools are expanding reach, but quality and integration are inconsistent: Online counselling, moderated peer support and evidence-based self-help apps are increasingly used, especially in the case-study countries. These tools can lower access barriers for digitally connected young people, but frameworks for quality assurance, clinical integration and evaluation are still emerging and uneven across Member States.

Persistent inequities and workforce constraints limit scale-up: Promising models often reach only a fraction of the young people who could benefit, particularly in rural, remote and socio-economically disadvantaged areas. Severe shortages of child- and youth-mental-health professionals, fragmented governance and reliance on pilots mean that the 'missing middle' identified in Chapter 2 remains largely unserved in many parts of the EU-27.

4.1. Overview of national approaches

Across the European Union, political commitment to addressing youth mental health is visibly high, yet practical execution remains uneven. Recent WHO and OECD studies indicate that more than

90 % of EU Member States have established a national mental-health policy or action plan.[202] However, a substantial gap persists between this strategic intent and full, on-the-ground implementation. Assessments suggest that only around 10–25 % of European countries have implemented these policies comprehensively across the everyday settings where young people spend their time, such as schools, primary care and workplaces.[203] As a result, the shift from fragmented, hospital-centred care towards holistic, community-based early intervention varies significantly between Member States, leaving major gaps in service delivery and workforce capacity (see also Sections 2.3.3 and 2.3.4)

To structure this landscape, the study uses a simple intervention matrix that groups national approaches into five primary types:

- **School-based promotion**: Universal programmes focused on social-emotional learning, mental-health literacy and anti-stigma work in schools and colleges, aimed at building resilience and addressing early symptoms.
- **Community youth hubs**: Integrated, youth-friendly services that offer low-threshold, often self-referral access to psychological support, counselling and social care, targeting the 'missing middle' between universal provision and specialist psychiatry.
- **Digital tools and support**: Online counselling, moderated peer chat, helplines and evidence-based self-help apps that reflect young people's digital habits and can extend reach beyond physical services.
- **Social prescribing:** Structured links from health, education or youth services to non-clinical community activities (for example sports, arts, volunteering) to reduce isolation and strengthen belonging.
- **Digital regulation**: National efforts to enforce or go beyond EU safety-by-design requirements, age-assurance and content standards, and, in some cases, to restrict access for minors to particularly high-risk services or features.

Drawing on the literature review and the seven country case studies, the matrix provides an indicative, results-oriented overview of how these intervention types are implemented in the case-study countries and, in broad terms, across the wider EU-27. The status of each intervention, 'mature', 'emerging' or 'limited', reflects its degree of national scaling, statutory backing and the availability of outcome evidence in the primary and secondary sources examined. 'Mature' denotes interventions that are nationally scaled with stable funding and documented effects; 'emerging' refers to substantial pilots or partial scaling with early evidence; and 'limited' indicates small-scale, localised or largely ad hoc activity. The EU-27 picture is inferred from patterns in the literature and should be read as indicative rather than as a formal country-by-country rating.

[202] WHO Regional Office for Europe, *Mental health systems capacity in European Union Member States, Iceland and Norway*, 2024; OECD, *Promoting good mental health in children and young adults*, 2025.

[203] OECD, *Promoting good mental health in children and young adults*, 2025.

Table 5 – Indicative maturity of key youth mental health interventions in selected case-study countries

Country	School-based promotion	Community youth hubs	Digital tools & support	Social prescribing	Digital regulation
Australia	Mature: Be You / MindMatters	Mature: headspace network	Mature: ReachOut; Kids Helpline	Limited: Ad hoc community pilots	Mature: eSafety Commissioner; Under-16 ban
Ireland	Mature: MindOut; Zippy's Friends	Mature: Jigsaw hubs	Emerging: Targeted web-support	Emerging: local youth-work pathways	Emerging: Coimisiún na Meán Online Safety Code
Italy	Emerging: Fondazione Carolina; Progetto Itaca	Limited: Significant regional gaps	Limited: NGO-led initiatives	Emerging: C.O.P.E. for NEET youth	Emerging: Agcom age-verification; Influencer rules
The Netherlands	Emerging: STORM programme	Emerging: @ease walk-in centres	Mature: Grip op je dip (blended care)	Limited: Municipal-led social support	Mature: Classroom mobile phone restrictions
Norway	Mature: YAM (Youth Aware of Mental Health)	Mature: PMHC; FACT ung teams	Emerging: Spillsonen (Twitch outreach)	Emerging: Municipal public health work	Emerging: Statutory minimum age proposals
Poland	Emerging: An Hour for Young Heads	Emerging: Stage 1 Community Centres	Emerging: SOLVE (for displaced youth)	Limited: Primarily clinical referrals	Limited: Focus on cyberbullying laws
United Kingdom (EN)	Mature: Place2Be; Whole-school mental health leads	Emerging: NHS mental health support teams	Emerging: SCESS online consultations	Mature: Barnardo's LINK service	Mature: Online Safety Act 2023
EU-27 (Broad Review)	High Policy Presence: ~90% have school policies	System Gap: Only 10-25% have integrated primary care	Growing Presence: ~75% have e-health policies	Low Awareness: Often restricted to adult care	High Regulatory Presence: Implementation of DSA

Source: Authors' synthesis based on national documentation and case-study interviews (see Annex 4).

The detailed sub-sections that follow (Sections 4.2 onwards) explore each intervention type in more depth, drawing on specific national examples to illustrate design choices, implementation conditions, equity implications and emerging evidence of effectiveness. These findings directly inform the EU-level policy options developed in Chapter 5, particularly those concerning school-based promotion, youth-friendly services, digital tools, social prescribing and digital-environment regulation.

4.1.1. School-based promotion and prevention

Schools are a primary setting for promoting mental health and preventing problems among children and adolescents. They reach almost all young people, provide a natural context for building socio-emotional skills and can offer early, low-stigma support, long before difficulties escalate to specialist care (see Sections 2.2 and 2.3.4).

Across the case-study countries, school-based promotion and prevention are the most consistently developed intervention type, although maturity and coverage vary widely. Member States typically operationalise this mandate through SEL and whole-school support models.

In Ireland, the MindOut programme delivers universal, curriculum-integrated SEL for 15-to 18-year-olds. Facilitated by trained teachers, MindOut builds core psychosocial competences such as emotion regulation, self-awareness and coping skills, with the aim of reducing stress and preventing the onset of depression.[204] At primary level, Zippy's Friends focuses on younger children's ability to recognise and manage emotions and to seek help when needed, and is embedded within the Social, Personal and Health Education (SPHE) curriculum.

In the United Kingdom, the Place2Be model embeds mental-health practitioners directly within primary and secondary schools, offering a continuum from universal classroom work to targeted one-to-one or small-group support. Staff work alongside teachers to create a supportive school climate and to provide brief interventions for pupils with emerging difficulties, with onward referral to child CAMHS where necessary.[205]

Some foundational school-based programmes are integrated into national prevention strategies. In Norway, Youth Aware of Mental Health (YAM) is delivered universally in lower-secondary schools as part of the national suicide-prevention plan. It combines professional facilitation with structured peer discussions and role-plays, offering adolescents a safe space to explore mental-health topics without the potential stigma of targeted clinical screening.[206]

Beyond these examples, many other Member States have introduced elements such as anti-bullying policies, classroom-based well-being activities or teacher-training modules on mental health. However, only a minority have comprehensive, evidence-informed frameworks that are systematically implemented, monitored and sustained over time. Evidence on the effects and economic returns of these interventions is discussed in Section 4.2.1.

4.1.2. Youth hubs and early intervention

Across European and international health systems, policymakers increasingly recognise a structural gap in provision often described as the 'missing middle' (see Section 2.3.4). This refers to the large group of young people with mild-to-moderate psychological distress – for example emerging

[204] 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3; UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, 2021.

[205] 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

[206] 'EPRS Mental Health Study: Norway Case Study', *Ipsos*, 2025, Annex 3; UNICEF, *The State of the World's Children 2021*.

anxiety or depression – who need more targeted support than universal school-based promotion can offer, but do not meet the high clinical thresholds required to access specialist CAMHS.[207] In the absence of intermediate care options, these adolescents may spend long periods on waiting lists or forgo help altogether until their symptoms escalate into severe crises.[208]

To address this gap, several countries have pioneered youth-friendly community 'hubs' that offer low-threshold early intervention. These centres are designed to remove traditional barriers to help-seeking by allowing self-referral, avoiding strict medical gatekeeping and providing non-stigmatising, youth-oriented environments.[209]

In Australia, the nationally recognised headspace network provides integrated hubs for 12- to 25-year-olds, offering multidisciplinary support across mental health, physical health, alcohol and other drugs and vocational assistance. Centres are typically located in community settings, use informal, youth-friendly design and offer a mix of individual and group interventions.[210]

In Ireland, Jigsaw operates regional hubs that provide free, brief, primary-care-level talking therapy focused on building coping skills and preventing distress from becoming entrenched. Young people aged 12–25 can self-refer, with services delivered by multidisciplinary teams that include psychologists, social workers and youth workers, linked to local schools and primary-care providers.[211]

In the Netherlands, the @ease model takes accessibility further by offering anonymous, peer-supported walk-in centres where young people can receive immediate listening and support without appointments or out-of-pocket costs. Trained young volunteers provide the first line of support, backed by on-site clinical professionals who can step in when needed and arrange referrals.[212]

Similar hub-type models are emerging in several EU Member States, often under different labels (e.g. youth-friendly clinics, mental-health drop-ins or integrated youth centres). Their common features are low-threshold access, youth-centred environments and a focus on intervening early in the community rather than waiting for problems to reach crisis point. Evidence on the outcomes, cost-effectiveness and transferability of youth-hub models is examined in Section 4.2.2.

4.1.3. Digital-era governance

Historically, national responses to digital risks have focused on improving users' digital literacy and encouraging parental mediation. Increasingly, however, policymakers recognise that these approaches place an unrealistic burden on families and do not address the underlying drivers of harm: the commercial and algorithmic logic of the attention economy[213] (see Sections 2.3.1 and 3.2). As a result, national and EU regulatory approaches are gradually shifting from a reactive 'online safety' paradigm towards a more proactive 'safety-by-design' mandate, under which technology

[207] 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3; 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

[208] 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

[209] OECD, *Promoting good mental health in children and young adults*, OECD Publishing, Paris, 2025, p. 242.

[210] 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

[211] 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3.

[212] OECD, *Promoting good mental health*, 2025, p. 242.

[213] V. R. Bhargava and M. Velasquez, *'Ethics of the attention economy: The problem of social media addiction'*, *Business Ethics Quarterly*, Vol. 31(3), 2021; *'The European Union Legal Framework for Digital Safety: A Comprehensive Analysis of Regulatory Instruments for the Protection of Minors'*, 2025.

companies are expected to prevent and mitigate systemic risks through the design and operation of their services.

Governance across jurisdictions

Different jurisdictions are operationalising this shift through diverse statutory frameworks that complement the EU-level rules described in Chapter 3. In Australia, the regulatory architecture is led by the eSafety Commissioner, whose powers were expanded by the Online Safety Amendment (Social Media Minimum Age) Act 2024.[214] This law requires social-media services to take 'reasonable steps' to prevent children under 16 from holding accounts, thereby shifting more of the legal and financial responsibility for child safety from families onto platforms.[215]

The United Kingdom has adopted a comprehensive risk-management model through the Online Safety Act 2023. Rather than focusing only on harms after they occur, the Act imposes preventative duties of care on platforms: they must assess risks, implement robust age-assurance measures and adapt service design to limit children's exposure both to illegal content and to certain categories of 'harmful but legal' material.[216]

Italy illustrates a mixed approach that combines technical presets with commercial rules. In addition to dedicated cyberbullying legislation, Italy has introduced default SIM-card presets for minors that block inappropriate content at network level. The communications authority Agcom has adopted guidelines for online influencers to increase transparency and protect minors from undisclosed commercial promotion and targeted advertising. These measures sit alongside the EU-level framework and show how national authorities can use their own levers to complement EU rules.[217] These measures sit alongside the EU-level framework described in Chapter 3 and show how national authorities can use their own levers to complement EU rules.

The DSA in practice: the Dutch investigation into Snapchat

At EU level, the DSA embodies the move towards safety-by-design (see Section 3.2.1). Its practical application is now being tested through coordinated enforcement actions. A prominent example is the formal investigation into Snapchat, initiated jointly by the European Commission and the Dutch Digital Services Coordinator (the Authority for Consumers and Markets).[218] The investigation examines whether the platform complies with the DSA's obligations to protect minors, focusing not only on illegal content but also on systemic design features such as addictive interfaces, age-assurance mechanisms and default privacy settings.[219] The investigation is ongoing, however this case illustrates how EU-level enforcement can target the design and governance of platforms in ways that are directly relevant to the mental-health pathways discussed in Chapter 2.

Momentum and limitations of social-media bans

Several countries, including Australia, Denmark, Greece, the United Kingdom and some EU Member States, are also debating, introducing, or have introduced statutory age-based restrictions on social-media use for under-15s or under-16s. These debates, along with emerging concerns about adolescents' use of AI chatbots for emotional support, raise complex questions about effectiveness, circumvention, privacy and children's rights. Evidence and case-study material on these issues are

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214 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

215 'Australia's Social Media Ban: A Test for Global Digital Governance', 2025.

216 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

217 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3.

218 European Commission, *Commission services and Dutch Digital Services Coordinator join forces to investigate Snapchat*, 2024.

219 'The European Union Legal Framework for Digital Safety', 2025; European Commission, *Commission investigates Snapchat's compliance with child protection rules under the Digital Services Act*, 2024.

considered in Section 4.2.3, which focuses on the effectiveness and limitations of digital-era regulatory approaches.

Emerging risks: AI chatbots and emotional support

As regulators and policymakers grapple with social media, a new frontier of risk is rapidly emerging with generative artificial intelligence. Practitioner interviews and case-study material from Italy and Poland highlight growing concern about adolescents' reliance on AI chatbots (such as Snapchat's My AI or Character.AI) for emotional support (see also Sections 2.3.1 and 2.4.1). In Italy, survey data suggest that around 42 % of 15-to 19-year-olds turn to AI when they feel lonely, sad or anxious, attracted by the perceived 'non-judgemental' and always-available nature of these tools.[220] Stakeholders in Poland similarly report that children and adolescents are beginning to use general-purpose AI systems as de facto therapists or companions.[221]

Practitioners caution that this trend carries significant risks. Reliance on AI for emotional support may undermine the development of authentic human relationships, including with parents, teachers and clinical professionals, and erode trust in human sources of help.[222] General-purpose AI systems are not designed as clinical tools, lack appropriate safeguarding and crisis-intervention protocols, and can produce unsafe or inappropriate responses while simulating empathy. These concerns are reflected in emerging provisions of the AI Act on high-risk and prohibited practices (Section 3.2.3) and underscore the need for EU-level approaches that address AI-mediated interactions alongside social-media platforms in any comprehensive strategy on youth mental health in a digital era.

Taken together, these national and EU developments illustrate how regulatory levers can be used to address the digital pathways to harm identified in Chapter 2 and underpin the EU-level option on child-centred digital regulation discussed in Chapter 5 (Option 5). Further details on specific regulatory case studies are provided in Section 4.2.3.

4.1.4. Common challenges

Across the case-study countries and the wider European literature, the implementation of youth mental-health policies is consistently constrained by chronic structural bottlenecks and inequities.

A central barrier is the shortage of qualified professionals. In Poland, for example, there were only 516 practising child and adolescent psychiatrists in 2024, with around 22 % already beyond pension age.[223] Italy likewise reports a significant lack of age-appropriate inpatient beds and specialised staff, contributing to an overstretched public psychiatric system.[224, 225] These capacity gaps translate directly into long waiting times: in England, young people wait an average of around 21 weeks for a first appointment with specialist services, and some remain on waiting lists for more than two years.[226]

Decentralised service organisation often exacerbates these pressures by creating a 'postcode lottery' in access to care. In several case study settings, resources are heavily concentrated in affluent or urban areas, while rural or economically weaker regions remain critically underserved.

220 'EPRS Mental Health Study: Italy Case Study', 2025, Annex 3.

221 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3.

222 Ibid.; 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3.

223 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3.

224 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3.

225 EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

226 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3.

This pattern is explicitly noted in both the Italian and Polish healthcare architectures, where young people's ability to obtain timely support depends as much on geography as on clinical need.[227, 228]

Within these strained systems, specific groups are systematically left behind. Young NEET people are doubly disadvantaged: they experience socio-economic exclusion and, because much early support is routed through schools, are less likely to benefit from school-based mental-health provision.[229] LGBTQIA+ youth, who face higher rates of loneliness, depression and cyberbullying, remain largely invisible in many national digital-wellbeing strategies despite their disproportionate exposure to online harms.[230] Refugee and migrant children, including those displaced from Ukraine, often carry significant trauma and face integration pressures and language barriers, yet access to targeted, culturally competent services is limited in most of the countries reviewed.[231]

These recurring implementation challenges form the backdrop for the effectiveness evidence and equity analysis set out in Section 4.2 and are a key motivation for the EU-level support and coordination options explored in Chapter 5.

4.2. Promising practices and evidence of effectiveness

Building on the overview of national approaches in Section 4.1, this section examines evidence on the effectiveness of three key intervention types and the conditions under which they work best: universal school-based prevention; community-based youth hubs and early intervention; digital-era regulatory approaches. For each, it summarises available outcome and economic evidence, identifies enablers and barriers to implementation, considers equity and transferability, and draws out implications for the EU-level options developed in Chapter 5.

4.2.1. Universal school-based prevention

Evidence of effectiveness and return on investment

The clinical and economic evidence for universal school-based prevention is strong and complements the examples in Section 4.1.1. Beyond the headline outcomes of programmes such as YAM – which, in a SEYLE trial, was associated with a 50 % reduction in incident suicide attempts and a 55 % reduction in severe suicidal ideation across ten European countries,[232] a range of SEL interventions demonstrate meaningful everyday benefits.

Universal SEL programmes consistently improve classroom climate and reduce disruptive behaviours. In Slovenia, the This is Me programme has been shown to improve classroom climate as rated by teachers. The multi-country Zippy's Friends programme reported reductions in oppositional behaviour of around 9 per cent and in social isolation of around 15 % among

[227] 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3; 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3.

[228] 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3.

[229] Vodafone Stiftung, *Click, scroll, connect – and balance*, 2024; UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, 2021; WHO, *From loneliness to social connection*, 2024.

[230] 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3; Eurochild, *Sub-report Mental Health*, 2024; PICUM, *The right to health for undocumented migrants*.

[231] 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3; Centre for Mental Health, *The economic and social costs of mental ill-health*, 2023; UNICEF, *The State of the World's Children 2021*, 2021.

[232] 'EPRS Mental Health Study: Norway Case Study', Annex 3, 2025; D. Wasserman et al., 'School-Based Suicide Prevention Programmes: The SEYLE cluster-randomised, controlled trial', *Lancet*, Vol. 385(9977), 2015.

participating children. These changes are important precursors to better learning, peer relationships and help-seeking.[233]

School-embedded support models also show promise in managing mild-to-moderate problems without immediate referral to specialist services. Evaluations of the Place2Be model in the United Kingdom indicate that a substantial share of participating pupils report improved well-being and functioning following brief, school-based counselling and group work. By addressing difficulties early within the school, such models can reduce the number of young people needing CAMHS referrals, easing pressure on overstretched specialist services.[234]

These foundational programmes generate high estimated economic returns. A global cost–benefit analysis of school-based SEL interventions concluded that they could yield returns of roughly €225 for every €1 invested, largely through gains in educational attainment and lifetime earnings and reduced use of health and social-protection services. While such headline figures inevitably mask variation between programmes and contexts, they indicate that school-based prevention is likely to be one of the most cost-effective levers available to governments for improving youth mental health.[235]

Enablers of successful implementation

The literature and case studies highlight several factors that increase the likelihood that universal school-based prevention will work in practice:

- **Curriculum integration rather than 'add-on' delivery**: Programmes such as Ireland's MindOut and Zippy's Friends are more effective when incorporated into existing curriculum areas (for example Social, Personal and Health Education) rather than delivered as occasional extra-curricular sessions. Embedding them in timetables supports continuity, reduces cancellations and signals that mental health is a core educational concern, not an optional add-on.[236]
- **Whole-school and community participation:** Stronger effects are observed where interventions engage the wider school ecology: fostering supportive peer relationships; involving parents or caregivers through information and discussion sessions; and establishing clear pathways for referral to health and youth services when more intensive support is needed. This whole-school orientation helps normalise conversations about mental health and address bullying and exclusion, including in digital contexts.[237]
- **Teacher training and structured support**: Effective delivery depends on teachers and school staff feeling confident and supported. Programmes that provide structured manuals, initial training and, where possible, supervision or consultation (for example through partnerships with mental-health services or NGOs) achieve higher fidelity and safer delivery than those relying on ad hoc adaptation.[238]
- **Attention to digital well-being**: More recent programmes explicitly address social media, cyberbullying and healthy digital habits, better reflecting the realities of growing up in a digital era and aligning with the risk pathways in

[233] OECD, *Mental Health Promotion and Prevention*, OECD Publishing, 2024; OECD, *Promoting good mental health in children and young adults*, 2025.

[234] 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3

[235] Ibid.

[236] 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3.

[237] C. Cefai, C. Simões and S. Caravita, *A systemic, whole-school approach to mental health and wellbeing in schools in the EU*, NESET report, Luxembourg: Publications Office of the European Union, 2021; 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

[238] 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3.

Chapter 2. Where such content is absent, opportunities to address digital-era stresses are missed.

Barriers and implementation hurdles

Despite their strengths, universal school-based programmes face significant implementation challenges:

- **Curriculum pressure and time constraints**: Many schools operate within crowded curricula and high-stakes assessment regimes. Securing protected time for regular SEL sessions can be difficult; where time is squeezed, programmes may be delivered inconsistently or superficially, weakening impact.[239]
- **Teacher workload and wellbeing**: Teaching is already demanding. Adding mental-health responsibilities to an overstretched workforce can increase stress and burnout. Evidence suggests that teacher stress harms both teachers and pupils' academic and well-being outcomes. Without parallel support for staff well-being, there is a risk that prevention programmes add pressure rather than relief.[240]
- **Lack of sustained funding**: Many programmes begin with pilot- or project-based funding. Schools often struggle to maintain them once external support ends. Embedded models such as Place2Be depend on stable funding streams; in tight budgetary contexts there can be tension between maintaining service quality and affordability.[241]
- **Uneven coverage of vulnerable groups**: Adolescents who are outside or on the margins of formal education, including some NEET young people, are unlikely to benefit from school-based interventions. Without complementary community-based pathways, gaps in coverage persist for the very groups at highest risk (see Section 4.2.4).

Scalability and implications for EU-level action

Overall, the evidence suggests that universal school-based prevention is highly scalable across the EU-27, provided programmes are adapted to local contexts and supported over the long term. OECD analyses indicate that most European countries already have key structural preconditions in place – for example, policies on mental health in education and existing health-education curricula – that can serve as vehicles for programmes such as This is Me or Zippy's Friends.[242]

Moving from scattered pilots to EU-wide coverage, however, requires a shift from short-term funding towards systemic, whole-school approaches. This implies long-term, preferably ring-fenced resources for mental-health promotion in schools, clear national guidance on how SEL and mental-health literacy fit within curricula, and explicit attention to the mental wellbeing of the educational workforce as well as pupils.[243] These considerations underpin the EU-level option on school-based promotion and digital wellbeing presented in Chapter 5 (Option 1), which is designed to support, rather than replace, national efforts in this area.

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239 'EPRS Mental Health Study: Norway Case Study', *Ipsos*, 2025; 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3.

240 UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, 2021.

241 EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

242 OECD, *Mental Health Promotion and Prevention*, 2024.

243 C. Cefai, C. Simões and S. Caravita, *A systemic, whole-school approach to mental health and wellbeing in schools in the EU*, 2021.

4.2.2. Community-based youth 'hubs'

Evidence of effectiveness and cost-effectiveness

Community-based youth hubs offer a structural response to the 'missing middle'. As described in Section 4.1.2, they provide an intermediate tier of care for adolescents and young adults whose difficulties are too complex for universal school-based programmes alone, yet do not meet the high clinical thresholds for specialist psychiatric care.

Outcome data from several case-study models are encouraging:

- Ireland's Jigsaw programme reports that between 62 and 68 % of participants show reliable and clinically significant improvements in psychological distress, as measured by standardised tools such as CORE-10 and YP-CORE, following their intervention.[244]
- The Dutch @ease model shows significant functional gains: among returning visitors, the share reporting school absenteeism fell from 44 % at their first visit to 17 % by their third visit, suggesting meaningful improvements in day-to-day functioning and engagement.[245]
- Similar models in comparator countries, such as Norway's PMHC programme, demonstrate symptom reductions for common mental disorders in adults, with structures closely aligned to youth-hub principles (direct access, brief evidence-based talking therapies).

Economic evaluations, while still limited in number, point in the same direction. Norway's PMHC, which shares many design features with youth hubs, operates at an estimated cost of around €9 000–€14 000 per quality-adjusted life year (QALY) gained, placing it well within commonly used thresholds for highly cost-effective public-health interventions.[246] While not all youth hub models have been evaluated as rigorously, the available evidence suggests that intervening early in community settings is substantially less costly than repeated emergency department contacts or inpatient admissions and avoids longer-term losses in education and employment.

Enablers of successful implementation

Case-study and evaluation evidence highlight several recurring enablers:

- **Self-referral and low administrative barriers**: Allowing young people to self-refer, as in Jigsaw, @ease and PMHC, removes the need for a general-practitioner referral, accelerates access and reduces the risk that adolescents disengage before reaching care. [247]
- **Non-clinical, youth-friendly environments**: Informal 'living-room' design, youth-centred décor and peer involvement, as in @ease and headspace, make services feel approachable, reduce perceived stigma and encourage repeat use. [248]

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244 OECD, *Promoting good mental health in children and young adults*, OECD Publishing, Paris, 2025; L. O'Keeffe et al., 'Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people', *Irish Journal of Psychological Medicine*, Vol. 32(1), 2015, pp. 71–77.

245 OECD, *Mental Health Promotion and Prevention: Best Practices in Public Health*, OECD Publishing, Paris, 2024, p. 26.

246 'EPRS Mental Health Study: Norway Case Study', *Ipsos*, 2025, Annex 3.

247 Bridging gaps in youth mental health care: YOUTHreach—a comprehensive European strategy', *European Child & Adolescent Psychiatry*, 2025; S. Leijdesdorff et al., 'Barriers and facilitators', 2021.

248 'The Psychosocial Landscape of Dutch Youth in the Digital Age: A Comprehensive Analysis of Mental Health Trends, Technological Mediators, and Intervention Efficacy', 2025; OECD, *Mental Health Promotion and Prevention*, 2024, p. 250.

- **Brief, evidence-based interventions:** Hubs that offer structured, time-limited psychological therapies (for example cognitive behavioural or solution-focused approaches) can manage large caseloads efficiently while maintaining quality.
- **Integration with local systems**: Strong links to schools, primary care, social services and specialist mental-health teams facilitate referrals both into and out of hubs and help ensure continuity of care when more intensive support is needed.

Barriers and systemic bottlenecks

At the same time, youth-hub models face substantial implementation challenges:

- **Workforce constraints:** Hubs rely on multidisciplinary teams, but shortages of psychologists, social workers and psychiatric nurses, especially outside major cities, limit capacity and can create new waiting lists.[249]
- **The 'transitional cliff' at age 18**: Many hubs aim to serve 12–25 year-olds, but statutory service boundaries between CAMHS and adult services remain rigid. This can lead to discontinuity of care at exactly the ages when serious mental-illness risk is highest.
- **Uneven territorial coverage**: In practice, many hubs are established first in urban or more affluent areas, with slower expansion into rural and deprived regions, reinforcing 'postcode lottery' patterns (see Section 4.1.4).
- **Funding and sustainability**: As with school-based programmes, hubs often start as pilots. Securing stable funding and integrating them into mainstream health or social care budgets is challenging, especially where budgets remain skewed towards hospital-based care.

Scalability and implications for EU-level action

Transferability analyses suggest that youth-hub models are broadly scalable across the EU-27, provided that funding and workforce planning are addressed. OECD work indicates that models such as PMHC have the structural, political and economic preconditions to be successfully transferred to a substantial share of OECD and EU countries, and the @ease peer-supported walk-in model also scores high on transferability in comparative assessments.[250]

Achieving large-scale implementation would, however, require a sustained shift in investment away from predominantly hospital-centred care towards integrated, community-based primary-care networks, and attention to equity so that hubs are progressively extended to underserved regions. These considerations underpin the EU-level option on youth-friendly early-intervention services discussed in Chapter 5 (Option 2), which focuses on supporting Member States to develop and connect such hubs rather than prescribing a single institutional model.

4.2.3. Addressing the 'Digital Era': Regulatory case studies

From digital literacy to platform accountability

Recent regulatory developments in Australia, the United Kingdom, Italy and at EU level illustrate a shift from relying mainly on digital literacy and parental mediation towards holding platforms legally responsible for systemic risks to children. This reflects recognition that families have limited capacity to counteract persuasive design features and opaque algorithms (see Section 2.3.1), and that platforms control both relevant behavioural data and design choices.[251]

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249 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3; 'The Psychosocial Landscape of Dutch Youth in the Digital Age', 2025.

250 Ibid.

251 V. R. Bhargava and M. Velasquez, 'Ethics of the attention economy: The problem of social media addiction', *Business Ethics Quarterly*, Vol. 31(3), 2021; Vodafone Stiftung, *CLICK, SCROLL, CONNECT – AND BALANCE*, 2024, p. 28.

National frameworks such as Australia's Online Safety Act and Social Media Minimum Age Act, the United Kingdom's Online Safety Act 2023 and Italy's combination of cyberbullying laws, SIM-card presets and influencer guidelines all impose preventative duties on platforms to assess risks, implement age-assurance measures and adapt service design to protect minors.[252] At EU level, the DSA and AVMSD similarly require very large platforms and video-sharing services to identify and mitigate systemic risks to minors' physical and mental well-being (Section 3.2).[253]

Early evidence and experience

Because most of these frameworks are recent, robust quantitative evidence on mental-health outcomes is not yet available. However, early implementation data and case studies provide some insights:

- In Australia, initial compliance reports following under-16 social-media restrictions suggest that platforms removed large numbers of under-age accounts in the first months after the law entered into force, indicating that statutory duties can trigger large-scale technical adjustments.[254]
- Within the EU, enforcement of the DSA is gathering pace. The formal investigation into Snapchat, initiated jointly by the European Commission and the Dutch Digital Services Coordinator, focuses explicitly on minors' protection, examining addictive design features, age-assurance mechanisms and the behaviour of recommender systems. Similar proceedings against other large platforms signal that DSA enforcement can be used to tackle precisely the design and content-related pathways to harm identified in Chapter 2.[255]
- Stakeholder feedback from regulators and civil-society organisations in the case-study countries suggests that the existence of clear, enforceable duties of care changes industry incentives and strengthens the negotiating position of regulators compared with earlier self-regulatory regimes.

Limitations and risks of age-based social-media bans

At the same time, experience with strict age-based social-media bans highlights significant limitations:

- **Circumvention and displacement**: Early evidence from jurisdictions that have experimented with under-age bans indicates that many teenagers quickly resort to workarounds such as VPNs, false age declarations or using adults' accounts. There is concern that such measures may drive some young people towards less regulated or more hidden online spaces, where risks are harder to monitor.[256, 257]
- **Privacy and data-protection concerns**: Mandatory age-assurance schemes can require large-scale collection or verification of identity data, potentially conflicting with data-minimisation principles under the GDPR and creating new privacy and security risks if not carefully designed.[258]

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252 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3; 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3; 'The European Union Legal Framework for Digital Safety: A Comprehensive Analysis of Regulatory Instruments for the Protection of Minors', 2025.

253 'Australia's Social Media Ban: A Test for Global Digital Governance', 2025; CMI, *Safeguarding and Improving Youth Mental Health in the Digital Era*, 2024.

254 'Early Lessons from Australia's Teen Social Media Ban for the Rest of the World', *TechPolicy.Press*, 2026; 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

255 European Commission, *Commission investigates Snapchat's compliance*.

256 'EU Regulators pull back the curtain on Snapchat's inadequate protection of minors', *5Rights*, 2026.

257 'Early Lessons from Australia's Teen Social Media Ban', *TechPolicy.Press*, 2026.

258 Vodafone Stiftung, C*lick, scroll, connect – and balance*, 2024, p. 33; 'The Global Architecture of Digital Governance: Analysis of Social Media Restrictions, Efficacy, and Socioeconomic Implications', 2025.

- **Rights and access considerations**: Blanket bans may inadvertently restrict access to beneficial online resources, including educational content, peer support and trustworthy information, and may limit opportunities for children to develop digital resilience in supported environments.[259]

Expert opinion therefore tends to view bans as politically powerful but blunt instruments that should not be relied on as stand-alone solutions. More nuanced, safety-by-design approaches, combined with robust enforcement of existing EU law, are generally considered more promising for addressing digital determinants of youth mental health.

Implications for EU-level action

For the EU-27, the key leverage point is the consistent, child-centred implementation and enforcement of the DSA, AVMSD and AI Act, rather than the proliferation of divergent national bans.[260] Scaling digital-era protection across the single market requires:

- harmonised guidance on how platforms should assess and mitigate risks to minors' mental health, including design patterns associated with overuse and harmful content;
- empowered, well-resourced regulators at EU and national level, with access to child-health expertise and the ability to use the data-access provisions of the DSA and AI Act for independent auditing; and
- privacy-preserving, proportionate age-assurance solutions that can support appropriate age-based measures without undermining data-protection rights, potentially building on tools such as the planned EU Digital Identity Wallet.[261]

These considerations inform the EU-level option on digital regulation discussed in Chapter 5 (Option 5), which focuses on strengthening the child-centred application of existing law and, where necessary, considering targeted additional measures consistent with the Treaties and the Charter.

4.2.4. Barriers, equity, and the 'missing middle'

The evidence reviewed in this chapter confirms that effectiveness and equity are closely intertwined. Structural barriers and inequalities described in Sections 2.3.3, 2.3.4 and 4.1.4 limit the reach and impact of even well-designed interventions.

The 'missing middle' and specialist-care thresholds

A defining structural weakness across many European mental-health systems is the inability to provide timely care for the 'missing middle', adolescents with mild-to-moderate psychological distress who fall between universal school-based provision and specialist psychiatric care.[262] Statutory services such as CAMHS in England and Ireland are chronically overstretched and therefore maintain very high clinical thresholds for access.[263] Young people with emerging difficulties (for example early-stage anxiety or depression) are often refused assessment or treatment because their symptoms are not yet deemed severe enough.[264] This creates a paradox in which adolescents may wait, in some cases for up to two years, until their distress has escalated into

259 'EPRS Mental Health Study: Australia Case Study', *Ipsos*, 2025, Annex 3.

260 'How will bans on social media affect children?', *Brookings Institution*, 2025

261 CERRE, *Future of the DSA: Safeguarding Minors in the Digital Age*, 2025, pp. 28–29

262 'EPRS Mental Health Study: Ireland Case Study', *Ipsos*, 2025, Annex 3; D. McDaid and A. Park, 'Scaling-up early intervention and services for the 'missing middle' in the children and young people's mental health system in Ireland', Care Policy and Evaluation Centre, LSE, 2025.

263 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3.

264 Ibid.

a diagnosable crisis before the system will intervene, undermining the principle of early intervention set out in Chapter 2.[265]

Universal services do not reach all vulnerable groups

Even where school-based prevention is strong, it cannot fully compensate for structural exclusions. Adolescents who are outside or on the margins of formal education are unlikely to benefit from universal programmes, reinforcing deep inequities. Young NEET people are doubly disadvantaged: they experience socio-economic exclusion and simultaneously miss out on the foundational mental-health support increasingly embedded in schools.[266]

Other minoritised groups face similar gaps. LGBTQIA+ young people are disproportionately exposed to identity-based harassment and cyberbullying yet often remain invisible in national digital-wellbeing strategies and may lack safe, affirming spaces within mainstream universal services.[267] Refugee and migrant youth, including those displaced from Ukraine, experience the combined effects of trauma, language barriers and integration pressures. In Poland, for example, survey data indicate that around 74 per cent of Ukrainian adolescents reporting loneliness and distress were not accessing any formal mental-health or psychosocial-support services.[268]

These patterns illustrate why targeted approaches and community-based pathways (Options 2 and 3 in Chapter 5) are needed alongside universal measures.

Workforce shortages, human-capital loss and the cost of non-Europe

Inequitable care is fundamentally driven by systemic capacity constraints and workforce shortages. In Poland, for instance, the child-psychiatry workforce is widely described as a 'ticking time bomb', characterised by underfunding, a lack of specialists and an ageing practitioner base.[269] This translates into long delays and inappropriate care settings: average waits of around 257 days for outpatient child and adolescent services, psychiatric bed occupancy exceeding 110 per cent, and more than a thousand minors hospitalised on adult wards over a recent multi-year period.[270]

When adolescents' needs are not met, the economic consequences are substantial. Unresolved mental distress disrupts educational attainment and transitions into the labour market, increasing the likelihood of long-term disability, unemployment or precarious work (see Section 2.4.3).[271] The resulting loss of human capital and lifetime productivity is a core component of the 'cost of non-Europe' in mental health described in Section 2.4.4 and explored quantitatively in Chapter 6.[272]

A 'postcode lottery' and the rights of the child

These structural bottlenecks often translate into a 'postcode lottery', where a young person's access to timely, appropriate mental-health care depends heavily on where they live rather than on clinical

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265 Ibid.; G. Punton, A. Dodd and A. McNeill, "You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK', *PLoS ONE*, Vol. 17(3), 2022.

266 'EPRS Mental Health Study: Italy Case Study', *Ipsos*, 2025, Annex 3.

267 Vodafone Stiftung, *CLICK, SCROLL, CONNECT – AND BALANCE*, 2024.

268 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3.

269 Ibid.

270 Ibid.

271 OECD, *How to Make Societies Thrive? Coordinating Approaches to Promote Wellbeing and Mental Health*, OECD Publishing, Paris, 2023; 'EPRS Mental Health Study: Poland Case Study', *Ipsos*, 2025, Annex 3.

272 UNICEF, *Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions in Education Settings Across the Humanitarian Development Nexus*, 2022.

need.[273] Rural, remote and socio-economically deprived regions are particularly likely to be underserved, as highlighted in the Italian and Polish case studies and in comparative survey data.

Such arbitrary variation sits uneasily with the EU Charter of Fundamental Rights. It risks undermining Article 35, which affirms the right of access to preventive health care and to benefit from medical treatment, and is difficult to reconcile with the requirement in Article 24 that the child's best interests be a primary consideration in all public actions.[274] Leaving vulnerable young people on long waiting lists or without realistic routes to support, depending on their postcode, represents a systemic failure to protect their developmental potential and fundamental rights. Addressing these inequities is therefore not only a matter of efficiency, but also of compliance with the Union's own rights framework, and is a key rationale for EU-level support and coordination options considered in Chapter 5.

4.3. Lessons for transferability and scaling

Experiences from the case-study countries and the wider literature suggest that many of the intervention models described above are, in principle, transferable across borders – but only if certain enabling conditions are met. This section distils the main lessons on what types of model travel well, what needs adaptation and what limits scale-up within the EU-27.

[273] 'EPRS Mental Health Study: England Case Study', *Ipsos*, 2025, Annex 3; 'EPRS Mental Health Study: Norway Case Study', *Ipsos*, 2025, Annex 3.

[274] European Commission, *Communication on a comprehensive approach to mental health*, COM (2023) 298 final, 2023.

4.3.1. Transferable models

Across diverse systems, a relatively consistent set of models recur:

- **Universal, curriculum-integrated school programmes** (for example MindOut, Zippy's Friends, This is Me, YAM) that build socio-emotional skills, mental-health literacy and, increasingly, digital resilience.
- **Youth-friendly community hubs and primary-care services** (for example headspace, Jigsaw, PMHC, @ease) that offer low-threshold early intervention for mild-to-moderate difficulties, including those associated with digital stressors.
- **Social-prescribing and community-based pathways** (for example Barnardo's LINK, C.O.P.E., municipal public-health work in Norway) that link vulnerable young people to structured activities and supportive relationships outside clinical settings.
- **Digital tools and online support services** (for example ReachOut, iFightDepression, SOLVE, national helplines) that extend reach, particularly for young people reluctant to engage in face-to-face care.
- **Regulatory measures** that address platform design, harmful content and age-assurance (for example in Australia, the United Kingdom, Italy, Ireland), complementing service-level responses and acting on the digital pathways to harm described in Chapter 2.

Many of these models have already been adapted across borders. Mental Health First Aid (MHFA) has been adopted in numerous countries; the Improving Access to Psychological Therapies (IAPT) programme in England informed Norway's PMHC; Zippy's Friends, YAM and Roots of Empathy operate in multiple European settings; and the @ease and Jigsaw hubs draw explicitly on international youth-hub and peer-support traditions. This track record suggests that, with appropriate adaptation, a common 'toolbox' of school-based promotion, youth hubs, social prescribing, digital tools and regulatory approaches is broadly transferable within the EU-27.

4.3.2. Conditions for successful transfer

The evidence reviewed points to a recurring set of conditions that appear necessary for successful transfer and scaling of youth-mental-health interventions. These are summarised in Table 5.

Table 6 – Conditions for transfer of youth mental health interventions across EU-27

Condition for success	Summary of key requirements
Workforce capacity and task-shifting	Models should avoid exclusive reliance on scarce specialists by using mixed teams, including psychologists, nurses, social workers and trained peers, with clear supervision and referral pathways. Parallel investment in training and retention is essential to prevent overload.
Stable funding and political commitment	Stable funding and political commitment. Transitioning from pilots to national scale (for example headspace, Barnardo's LINK) requires multi-year public funding. Explicit inclusion in national or regional strategies reduces the risk that models remain fragmented or vulnerable to budget cuts.
Cross-sector governance	Successful interventions span health, education, youth and social services through formal arrangements (for example cross-ministerial boards, joint commissioning). Without these structures, siloed governance makes it difficult for transferred models to embed in the wider system.

Condition for success	Summary of key requirements
Evaluation culture and adaptive implementation	Scaling is most effective when iterative and guided by outcome data, allowing content and delivery to be refined (for example MindOut, Zippy's Friends). Monitoring frameworks are needed to justify investment and identify ineffective or harmful elements.
Attention to context and equity	Transferred models must be adapted rather than copied wholesale, including adjustments to age ranges, language and delivery settings. Active planning for inclusion, for example locating hubs in underserved areas or tailoring outreach for NEET and LGBTQIA+ youth, helps reduce existing inequalities

Source: Authors' synthesis based on national documentation and case-study interviews.

These conditions broadly align with the structural and equity issues highlighted in Sections 2.3.3, 2.3.4 and 4.2.4, and will need to be reflected in any EU-level support for scaling.

4.3.3. Limits and risks in scaling

Although many of the models described above have been adapted successfully across borders, the case studies underline clear limits to transferability.

Some interventions are inherently resource-intensive. High-intensity, multidisciplinary models such as Flexible Assertive Community Treatment (FACT) youth teams or dense networks of large youth hubs require substantial upfront investment in premises, management and a critical mass of specialist staff. In Member States where child and adolescent mental-health workforces are already severely constrained, attempting to roll out such models nationally without parallel workforce development risks creating small, overstretched pilots that cannot be sustained or scaled.

Legal and cultural context also matters, particularly for regulatory measures. National rules on social-media age limits, influencer marketing or SIM-card presets have been shaped by specific legal traditions, constitutional constraints and public debates. Transposing them directly to other jurisdictions may encounter different legal obstacles or levels of public acceptance. Similarly, interventions that depend heavily on strong local civil-society infrastructures, volunteering traditions or established youth-work sectors may require significant redesign in areas where such infrastructures are weaker or organised differently.

There is also a risk that superficially attractive models are 'copied' without sufficient regard to context or core components. When staffing levels, supervision structures or governance arrangements are diluted, transferred programmes can deliver weaker outcomes and generate disillusionment among practitioners and funders. In some instances, evaluation has prompted discontinuation or substantial redesign of imported models that did not fit local needs. These experiences suggest that scaling is not simply a matter of replication, but of careful, evidence-informed adaptation.

4.3.4. Implications for EU-level action

From an EU perspective, these lessons point towards a specific kind of added value. Rather than prescribing particular service models or detailed regulatory templates, EU-level action is better placed to support Member States in adapting and scaling approaches that have already shown promise, while helping to avoid common pitfalls.

In practice, this means using EU instruments to co-finance and rigorously evaluate scaling efforts in interested countries, especially in underserved regions, and to share learning about what works under different institutional and cultural conditions. It also means investing in the enabling conditions that national experiences have identified as critical: mixed and adequately trained workforces; cross-sector governance structures that link health, education, social services and digital regulators; and robust data systems to track outcomes and equity (see also Section 3.3.2 on data, monitoring and research).

A further implication is the need to keep equity and vulnerable groups at the centre of transfer and scaling. Without explicit design features to reach NEET youth, migrants and refugees, LGBTQIA+ young people, rural communities and young people with disabilities, even well-evidenced models can end up primarily serving those who are already relatively well connected to services. EU-level guidance, funding criteria and monitoring frameworks can help steer adaptation efforts towards closing, rather than reproducing, existing gaps.

These considerations directly inform the EU-level options proposed in Chapter 5 – notably the support package for school-based promotion (Option 1), the framework for youth-friendly early-intervention services (Option 2), the initiative on social prescribing and community pathways (Option 3), and the data and governance measures in Option 6 - which are all designed to build on, rather than replicate, the lessons from national transfer and scaling efforts.

5. Policy options for EU action

This chapter translates the evidence from Chapters 2 to 4 into a small set of avenues for the European Parliament to consider EU-level action on youth mental health in a digital era. It does not propose a single 'one-size-fits-all' solution but presents a menu of complementary options that could be pursued individually or, more realistically, in combination.

Key findings

A coherent but flexible package of EU-level options: The chapter identifies six complementary options grouped into three areas: (i) prevention and support in everyday settings (school-based promotion, youth-friendly early-intervention services, social prescribing, digital tools); (ii) digital regulation and platform governance; and (iii) data, monitoring and governance. They are designed to be combined rather than implemented in isolation.

Strongest evidence for school-based promotion and youth-friendly services: Universal school-based programmes (Option 1) and community-based youth hubs (Option 2) have the most robust clinical and economic evidence, and directly address early symptoms and the 'missing middle' in youth mental-health care. They are central to any realistic strategy for reducing prevalence at scale.

Targeted community pathways are crucial for equity: Social-prescribing and community-based pathways for vulnerable youth (Option 3) extend support beyond schools and clinics to NEET young people, migrants and refugees, LGBTQIA+ youth and other groups at high risk of exclusion. They work on social determinants such as loneliness and lack of structure, but require strong local infrastructures and safeguarding.

Digital tools, regulation and data are enabling pillars: A quality and safety framework for digital mental-health tools (Option 4), child-centred implementation (and possible strengthening) of EU digital legislation (Option 5a/5b) and improved data, monitoring and governance (Option 6) address core digital and systemic determinants. They do not replace offline services but make them safer, more effective and better targeted.

Options respect EU competences and rely on voluntary, equity-oriented support: Options in education, health and social policy use Articles 165, 168 and 153 TFEU to provide guidance, funding and coordination, without harmonising national systems. Options on digital regulation rely on Article 114 TFEU and existing acquis. Throughout, EU added value lies in pooling evidence, co-financing scale-up, and promoting minimum levels of protection and support across the EU-27.

The options are designed to respond to the main problem clusters identified earlier: insufficient prevention and early intervention in everyday settings; a large 'missing middle' in youth mental-health care; digital environments that are not consistently safe or supportive for minors; marked social and economic inequalities in exposure, access and outcomes; and structural capacity and governance gaps. Each option takes into account existing EU competences and existing instruments and draws on concrete examples from Member States and non-EU comparators.

For clarity, the chapter is structured in four steps:

- Section 5.2 summarises the key problem clusters that could benefit from EU-level attention.
- Section 5.3 outlines the EU levers (legislative, financial, coordination and data/research tools) that are available to address them across policy domains.
- Section 5.4 groups the options into a small number of thematic areas (prevention and support in everyday settings; digital environment and tools; data, monitoring and governance).
- Section 5.5 then provides a detailed description of each option, using a common template that covers the problem addressed, objectives and target groups, core EU

measures, legal basis and subsidiarity, links to existing acquis and strategies, and relation to national practice and evidence.

A continuation-of-status-quo scenario (Option 0 – baseline) is included as a reference point. In Chapter 6 and 7, selected options and areas are taken forward into an illustrative impact assessment and 'cost of non-Europe' analysis over a 10-year horizon.

5.1. Problem clusters to be addressed

As mentioned in the previous section, the analysis in Chapters 2 to 4 points to a set of recurring problem clusters that EU-level action could help address. These clusters cut across countries and sectors and provide the organising logic for the options in this chapter. The table below summarises these clusters.

Table 7 – Overview of problem clusters to be addressed by policy options

Problem cluster	Summary of main issues
Insufficient prevention and early intervention in everyday settings.	Many children and adolescents pass through early childhood education, schools and primary care without systematic support for socio-emotional development or timely help for emerging difficulties (see Sections 2.1–2.2 and 4.1–4.3).
A large 'missing middle' in youth mental-health care.	Services are often organised around acute, specialist treatment, while young people with mild-to-moderate problems have limited access to youth-friendly, low-threshold support and tend to receive help only at crisis point (Sections 2.3.4, 2.4.3 and 4.3).
Digital environments that are not consistently safe or supportive for minors.	Design-driven overuse and displacement, exposure to harmful content and emerging AI-mediated interactions create mental-health risks for young people, especially those already facing offline adversity (Sections 2.2–2.4 and 3.2).
Social and economic inequalities in exposure, access and outcomes.	Young people in vulnerable situations – including those from low-income households, migrants and refugees, LGBTQIA+ youth, young people with disabilities and those in rural areas – face higher risks and more barriers to care and are under-represented in targeted interventions (Sections 2.3.3, 2.4.3–2.4.4 and 4.4).
Structural capacity, governance and data gaps	Underfunding of prevention, workforce shortages, fragmented governance between sectors and limited, non-comparable data on youth mental health and digital exposure constrain the scale-up and evaluation of promising approaches (Sections 2.3.4, 3.5 and 4.5–4.6).

Source: Authors' summary based on academic literature and policy literature (see references).

The policy options that follow are designed to address these problem clusters, within the limits and opportunities created by the EU's legal competences and existing policy framework.

5.2. EU levers and policy domains

Within the constraints set out in Chapter 3, the EU has several types of instruments it can use to influence the determinants of youth mental health in a digital era. These fall into four broad categories and span different policy domains.

Legislative and regulatory levers (mainly digital/internal market and aspects of social policy)

A first group of levers is legislative and regulatory, operating mainly in the digital internal-market sphere and, to a more limited extent, in social policy. Under Article 114 TFEU the EU can adopt and amend horizontal rules for digital services and AI, as it has done with the DSA, the AMSV, the AI Act and the forthcoming CSAM package. These instruments can address design- and content-related risks, transparency, age-assurance and duties of care for services used by minors. In addition to fully using the existing *acquis*, the European Parliament can, under Article 225 TFEU, invite the Commission to bring forward proposals for new or strengthened rules where evidence suggests that current legislation does not sufficiently protect children from specific digital-era harms. Under Article 153 TFEU, the EU can also support or, in defined areas, legislate on working conditions and psychosocial risks, which is relevant for young people entering the labour market and exposed to digital-era stress and burnout.

Financial and programme levers (health, education, youth, cohesion, research)

A second set of levers is financial and programme-based, in areas including health, education, youth, cohesion and research policy. Through instruments such as EU4Health and the Healthier Together initiative, the EU can fund cross-border projects, pilots and capacity-building to strengthen prevention, early intervention and youth-friendly services. Cohesion and social funds (for example ESF+ and ERDF) can support investment in community-based services, social prescribing and local infrastructures. Erasmus+ and the EU Youth Strategy provide channels to support school and youth-work initiatives, while the Digital Education Action Plan, BIK+ strategy, the Strategy on the Rights of the Child and the European Child Guarantee can direct resources towards digital-literacy, wellbeing and inclusion measures in education and social policy. Horizon Europe offers funding for research and innovation, inter alia on mental-health promotion, service models and digital tools.

Soft-law, guidance and coordination levers

The EU also has important soft-law, guidance and coordination levers. Through Council recommendations, Commission communications, toolkits and non-binding standards, it can promote convergence of national approaches in areas that remain primarily national competences, such as school-based promotion, organisation of youth-friendly services or digital-wellbeing education. It can convene and sustain cooperation platforms and networks – for example child- and youth-mental-health networks, Safer Internet Centres, or practitioner and research communities – which support mutual learning, shared standards and cross-border initiatives without mandating harmonisation.

Data, monitoring and research levers

Finally, the EU can act through data, monitoring and research. By harmonising indicators and improving surveillance of youth mental health and digital exposure via Eurostat, EU-wide surveys (such as HBSC, EHIS and relevant PISA modules) and, in future, the European Health Data Space, the EU can provide a stronger evidence base for national and EU-level decisions. Horizon Europe and other research programmes can support longitudinal and quasi-experimental studies on the impact of digital environments and of specific interventions. The implementation of the DSA's data-access provisions can facilitate independent research on platform design and algorithms. Collectively, these data and research levers underpin all other actions by making it possible to identify trends, evaluate interventions and refine policy over time.

In the options that follow, these different levers are combined across three main policy domains: (i) prevention and support in everyday settings (education, youth, health); (ii) the digital environment and tools; and (iii) data, monitoring and governance.

5.3. Policy domains and option areas

To structure the analysis of policy options, the proposed EU-level actions are grouped into three thematic areas that reflect the main problem clusters and policy domains identified in Sections 5.2 and 5.3. A baseline (Option 0) is included as a reference scenario.

Option 0 – Baseline / status quo

The baseline assumes continued implementation of existing EU legislation and strategies (for example the DSA, AVMSD, AI Act, CSAM package, the comprehensive approach to mental health, EU4Health, BIK+ strategy, the Digital Education Action Plan, the EU Youth Strategy and the Child Guarantee), but no significant new EU-level initiatives specifically targeted at youth mental health in a digital era. It provides the comparator for assessing the added value of further action in the impact assessment (Chapter 6).

Area A – Prevention and support in everyday settings (Options 1–4)

This area focuses on strengthening prevention and early intervention where children and young people already are – in early childhood services, schools, communities, primary care and through supportive digital tools – and on reducing the 'missing middle' in youth mental-health care. Options 1 through 3 actively incorporate avenues to inform and engage families, which research shows is important to achieving successful intervention outcomes.

- **Option 1 – EU support package for school-based mental-health promotion and digital wellbeing**: EU-level guidance, tools and funding to help Member States embed social-emotional learning, mental-health literacy, suicide-prevention awareness and digital-wellbeing education in schools, and to build capacity among teachers and school staff.
- **Option 2 – EU framework for youth-friendly early-intervention services:** A non-binding framework and support package for community- and primary-care-based youth hubs and early-intervention models, offering low-threshold, youth-friendly support for mild-to-moderate difficulties.
- **Option 3 – EU initiative on social prescribing and community-based pathways for vulnerable youth:** Support for non-clinical, community pathways (for example sports, arts and nature-based activities) targeting young people in vulnerable situations – including those who are NEET, migrants and refugees, LGBTQIA+ youth and those in or leaving care – to strengthen belonging, reduce isolation and connect them to services.
- **Option 4 – EU quality and safety framework for digital mental-health tools and online support**: Non-binding EU-level criteria and support for curated catalogues of safe, evidence-based digital mental-health tools and services for young people, and guidance on integrating these tools into stepped-care pathways in health, education and youth systems.

Together, Options 1–4 aim to build a more continuous and accessible spectrum of support in everyday settings, rather than relying mainly on specialist services.

Area B – Digital regulation and platform governance (Option 5)

This area addresses the commercial and design features of the digital environment that act as determinants of youth mental health, focusing on how EU digital legislation is implemented and, where necessary, strengthened.

- **Option 5 – Child-centred implementation and possible strengthening of EU digital regulation**: Measures to ensure that the DSA, AVMSD, AI Act and CSAM rules are implemented and enforced in a way that systematically addresses youth mental-health risks, including guidance on addictive design features, age-assurance and systemic-risk assessments for minors. Where evidence shows that specific high-risk services or features cannot be made safe through existing obligations alone, the option envisages assessing the case for additional or tighter EU rules, in line with subsidiarity and fundamental-rights requirements.

Area C – Data, monitoring and governance (Option 6)

This area underpins all other action by improving the evidence base and coordination across sectors.

- **Option 6 – Data, monitoring and governance for youth mental health in a digital era**: Actions to develop more harmonised indicators and monitoring for youth mental health and digital exposure, to support longitudinal and quasi-experimental research on digital determinants and interventions, and to promote integrated, cross-sector governance models that connect health, education, digital and social policy around youth mental health.

Across these areas, the options draw on different types of EU levers. Area B (Option 5) relies primarily on legislative and regulatory tools under Article 114 TFEU and related instruments, combined with guidance and enforcement practice. Areas A and C (Options 1–4 and 6) use mainly financial, soft-law and coordination levers, such as EU4Health, ESF+, Erasmus+, Horizon Europe, Council recommendations, toolkits and networks – within the supporting competences in health, education, youth and social policy (Articles 165, 168 and 153 TFEU). This distinction is important for assessing feasibility and subsidiarity in the analysis that follows and in the impact assessment in Chapter 7.

The table below summarises the above options.

Table 8 – Summary of policy options

	Short description	Main problem cluster(s) addressed	Main policy domain(s)	EU levers	Indicative legal basis
0. Baseline / status quo	Continuation of existing EU legislation and strategies without major new youth-specific initiatives	All clusters persist largely unchanged	Cross-cutting	Implementation of current acquis; existing funding and soft-law	Articles 114, 153, 165, 168 TFEU
1. School-based promotion	EU support package (guidance, tools, funding) to strengthen SEL, mental-health literacy and digital-wellbeing education	Insufficient prevention and early intervention; limited integration of digital risks in education	Education, youth, health	Soft-law guidance; EU4Health, ESF+, Erasmus+, Digital Education Action Plan, BIK+	Articles 165, 168 TFEU
2. Youth-friendly services	Non-binding framework and support for community / primary-care youth hubs offering low-threshold early help	'Missing middle' between schools/primary care and specialist care	Health, community services, youth	Soft-law framework; EU4Health, ESF+, cohesion funds; peer learning	Article 168 TFEU
3. Social prescribing	EU initiative to support non-clinical community pathways (sports, arts, nature, youth work) for at-risk young people	Inequalities in access and outcomes; social determinants of distress	Social policy, health promotion, youth, employment	Soft-law guidance; EU4Health, ESF+, ERDF; joint actions / communities of practice	Articles 168, 165, 153 TFEU
4. Digital mental-health tools	Non-binding EU criteria and support for curated 'trusted libraries' of safe, evidence-based digital tools	Unsafe / low-quality digital tools; ad hoc integration into care	Health, digital, education, youth	Soft-law framework; alignment with EHDS / medical-device rules; EU4Health / Horizon	Article 168, Article 114 TFEU
5. EU digital regulation	Stronger child-centred guidance and enforcement of DSA/AVMSD/AI Act; possible assessment of need for tighter rules	Design-driven overuse; harmful content; AI-mediated risks; uneven protection	Digital / internal market, child rights	Implementation guidance; co-regulatory codes; enforcement practice; potential new proposals	Article 114 TFEU; Charter Articles 24, 35, 7–8
6. Data & governance	Improved indicators, surveys and research; support for integrated cross-sector governance models	Data gaps; fragmented governance; weak evidence for decisions	Cross-cutting (health, education, digital, social)	Eurostat / EU-wide surveys; Horizon Europe, EU4Health; joint actions and technical assistance	Article 168, Article 338 TFEU

Source: Authors' summary based on the Treaty on the Functioning of the European Union and the Charter of Fundamental Rights

5.4. Detailed description of the policy options

This section sets out each policy option in more detail, following the structure introduced in section 5.4.

For every option, it specifies:

- which problem cluster(s) it addresses and in which policy domain(s);
- its objectives and target groups;
- the core EU-level measures and instruments involved;
- the legal basis and subsidiarity considerations;
- links to existing EU *acquis* and strategies; and
- how it relates to national practice and available evidence.

Option 0 describes the baseline (continuation of current efforts). Options 1–6 then outline potential additional actions in areas A–C. Selected options and areas are used in Chapter 7 to construct illustrative scenarios and compare impacts with the baseline.

5.4.1. Option 0: Baseline / status quo

Under the baseline, the EU and Member States continue broadly on their current trajectory. Existing legislation and strategies are implemented as planned, but no significant new EU-level initiatives are launched that are specifically designed to address youth mental health in a digital era.

In practice, this means that the digital *acquis*, in particular the DSA, the AMSV, the AI Act and the forthcoming CSAM package, is progressively applied and enforced, including provisions that are relevant to minors' safety and wellbeing. Some large platforms will face tighter scrutiny and may adjust design features or content-moderation practices in response to DSA proceedings and guidance. At the same time, health and social-policy instruments such as the *2023 Communication on a comprehensive approach to mental* health, EU4Health, Healthier Together, the BIK+ strategy, the Digital Education Action Plan, the EU Youth Strategy, the Strategy on the Rights of the Child and the Child Guarantee continue to roll out within existing budgets and programming cycles. National reforms in areas such as school-based programmes, youth hubs or social prescribing proceed where political will and resources already exist, but without additional EU-level impetus.

This scenario is realistic and conservative. It reflects commitments already made and financed, without assuming new legal acts or major re-prioritisation of EU spending. It avoids the political and administrative costs associated with negotiating new instruments. It allows for learning from current reforms. As Member States implement DSA obligations, new mental-health initiatives under EU4Health, or national youth-hub models, more evidence will accumulate on what works, which could inform future decisions without pre-emptive EU intervention.

This scenario respects subsidiarity in a narrow sense. By not extending EU action beyond the current *acquis*, it leaves discretion largely with Member States to decide how far to prioritise youth mental health and how to organise services and prevention.

However, the baseline also has clear limitations and risks, when viewed against the problem clusters identified in Chapter 2.

First, it is unlikely to correct the structural imbalance towards acute, specialist care and the 'missing middle'. Without new EU-level incentives or guidance, prevention and early-intervention measures in schools, primary care and communities will continue to develop unevenly, largely driven by national or regional priorities. In countries where such initiatives are currently weak, there is little in the baseline that would systematically change this.

Second, while the existing digital *acquis* is powerful on paper, its impact on youth mental health will depend on how ambitiously it is interpreted and enforced. The baseline assumes no additional child-centred guidance or political pressure beyond what is already foreseen. This risks a patchy response to design-driven overuse and content-driven harms, with some regulators and platforms taking mental-health impacts seriously, and others focusing narrowly on illegal content or data-protection compliance.

Third, the baseline offers limited leverage on inequalities. Instruments such as the Child Guarantee, EU Youth Strategy and cohesion funds have the potential to address socio-economic drivers of mental distress, but in the absence of explicit youth-mental-health objectives or indicators, there is no guarantee that they will be used in a way that systematically reduces gaps for low-income, migrant, LGBTQIA+, disabled or rural young people.

Fourth, existing initiatives only partially address governance, workforce and data gaps. The comprehensive approach to mental health and Healthier Together support better coordination and capacity-building, but do not by themselves resolve shortages of trained staff, fragmented referral pathways, or the lack of harmonised, disaggregated data on youth mental health and digital exposure. Under the baseline, progress in these areas is likely to remain incremental and uneven.

From a 'cost of non-Europe' perspective, Option 0 therefore represents a continuation of known weaknesses. It does not exacerbate current problems, but nor does it systematically tackle the high prevalence of unmet need, the long-term educational and labour-market impacts, or the specific risks associated with digital environments. The economic and social costs described in Section 2.4, including lost human capital and high indirect costs borne by education, social-protection and labour-market systems, would largely persist.

In summary, the baseline is a necessary reference scenario: it shows what can reasonably be expected if the EU limits itself to implementing the current acquis and strategies, without additional targeted action on youth mental health in a digital era. The options that follow (Options 1–6) illustrate how EU-level intervention could go beyond this baseline, what benefits might be gained, and what trade-offs and implementation challenges would arise.

5.4.2. Option 1: EU support package for school-based mental-health promotion and digital wellbeing

Rationale and problem addressed

This option targets two of the core problem clusters identified earlier: (i) insufficient prevention and early intervention in everyday settings; and (ii) uneven integration of digital-well-being content into education. As Chapters 2 and 4 show, many young people experience mild-to-moderate distress that never reaches clinical services, and schools are one of the few settings that reach almost all children and adolescents. Evidence from multiple programmes (for example MindOut, Zippy's Friends, YAM, 'An Hour for Young Heads') suggests that well-designed school-based interventions can improve coping skills, help-seeking and classroom climate at relatively low cost, but coverage and quality vary widely between and within Member States.

At the same time, schools are increasingly central to managing digital well-being, yet curricula and teacher training often lag behind the realities of platform design, social media and AI (Sections 2.2.1, 2.3.1 and 4.2.1). Many national initiatives are promising but fragmented, and not all Member States have the capacity to design, adapt or evaluate such programmes on their own.

Objectives and target groups

The objective of Option 1 is to help Member States build a more consistent foundation of prevention and early support in education systems, by:

- embedding age-appropriate SEL, mental-health literacy, suicide-prevention awareness and digital-wellbeing education across primary and secondary schooling;
- equipping teachers and other school staff with the knowledge and tools to recognise and respond to distress, including digital-era manifestations; and
- encouraging whole-school approaches that reduce bullying and cyberbullying, strengthen belonging and foster safe online/offline norms.

The primary target group is children and adolescents in compulsory and post-compulsory education (roughly ages 6–18), with particular attention to pupils in disadvantaged schools and areas. A secondary target group is the education workforce (teachers, school leaders, support and health staff).

From the perspective of the cost structure in Chapter 6, this option primarily affects education and labour-market cost streams (grade repetition, dropout, NEET risk and later earnings), with secondary effects on health and social-protection costs via prevention of more severe conditions.

Core EU-level measures

Within its supporting role in education and health, the EU would not harmonise curricula but could provide a structured support package, potentially including:

Guidance and minimum components: A non-binding framework setting out core components of school-based mental-health promotion and digital well-being (for example SEL competences; evidence-based approaches to anti-bullying and cyberbullying; sleep and digital-hygiene education; safe and critical use of social media and AI tools), adaptable to national contexts.

Toolkits and resources: Practical materials for schools and teacher-training providers, drawing on evaluated programmes (MindOut, YAM, Roots of Empathy, Zippy's Friends, 'An Hour for Young Heads', etc.), with examples of how to integrate content across subjects and school levels and how to adapt for different age bands.

Capacity-building: Support for initial and in-service teacher education on mental-health literacy and digital well-being, for example via Erasmus+, the Digital Education Action Plan and targeted EU4Health calls. This could include cross-country training modules, peer-learning events and online courses, as well as guidance on staff well-being.

Targeted funding and pilots: Calls under EU4Health, ESF+, Erasmus+ or cohesion funds to co-finance pilot or scale-up projects in Member States with limited existing provision, particularly in disadvantaged regions, coupled with robust evaluation.

Equity focus: Guidance and, where possible, funding criteria that encourage prioritisation of schools serving low-income communities, migrants and refugees, rural areas and other groups shown to be at higher risk (Section 4.2.4).

Legal basis, proportionality and subsidiarity

The primary legal basis which can be used for policy option 1 is Article 165(4) TFEU (supporting and supplementing Member State action in education and youth), possibly on a dual legal basis with

Article 168(5) TFEU (health promotion)[275], as the two legislative procedures are compatible. Under these provisions the European Parliament and the Council may, using the ordinary legislative procedure, adopt incentive measures and recommendations; they may not harmonise national laws or curricula.

The option primarily entails financial and organisational measures at EU level (guidance, cooperation and targeted funding). It does not prescribe specific content or structures in national education systems. It therefore respects the principle of subsidiarity.[276] Member States retain full control over curricula and school organisation, and the EU role is limited to supporting and supplementing national actions where common challenges and economies of scale exist.

The principle of proportionality[277] is also respected. The measures proposed are limited to what is necessary to achieve the objectives of improving prevention, early intervention and digital well-being in schools, without going beyond what can be justified by the cross-border nature of the challenges and the added value of shared evidence and tools.

Implementation considerations (benefits, risks and challenges)

Option 1 has clear strengths but also practical and political constraints. School-based interventions can reach almost all children and adolescents and, when implemented universally and early, are highly cost-effective, particularly for education and labour-market outcomes (Chapter 6). If the support package explicitly covers digital well-being (sleep, healthy use of social media and AI, cyberbullying), it can directly address the digital risk pathways identified in Chapter 2.

However, education is a sensitive national competence, so the package must be clearly voluntary and adaptable, co-designed with national authorities and stakeholders to secure ownership. Teacher workload and capacity are major constraints; without time, training and institutional support there is a risk of superficial implementation. Quality assurance is also a concern as rapid scale-up without adequate support and monitoring may dilute impact, and responsibility for standards will remain with Member States. Finally, school-based approaches alone cannot reach all vulnerable groups, especially those disengaged from or outside education. Option 1 therefore needs to be seen as part of a broader package, alongside youth-friendly early-intervention services (Option 2) and social-prescribing and community pathways (Option 3).

[275] E.g. Council Recommendation of 26 November 2013 on promoting health-enhancing physical activity across sectors.

[276] Subsidiarity means that the political decisions are taken at the level of governance where the objective can be best achieved. In the case of the European Union action, the subsidiarity is respected if the action cannot be achieved sufficiently by or within the Member States, primarily in the case of shared competence.

[277] Proportionality concerns the adequacy of the policy approach and means with the scale of the problem and the policy objectives.

Box 1 – Scientific rationale for policy options for schools and early-intervention hubs

Adolescence represents a critical developmental window of neurological sensitivity that spans from approximately age 10 into the mid-20s.[278] During this period, the brain undergoes structural and functional reorganisation. Crucially, the brain's socio-emotional reward processing networks mature faster than the prefrontal cortex (PFC), which is the region responsible for executive functions such as impulse control, cognitive flexibility, and emotional regulation.[279] Because the PFC and related cognitive control regions continue developing until around age 25, this temporary neurological imbalance leaves young people highly sensitive to peer influence, social rewards, and digital media stimuli.[280]

During this highly plastic phase, SEL and early-intervention youth hubs act as essential protective factors against future adversity.[281] SEL programmes capitalise on this window by actively teaching core cognitive and emotional competencies, such as self-awareness, responsible decision-making, and self-control, that bolster psychosocial resilience and mitigate impulsive behaviours.[282] Concurrently, youth hubs offer accessible, low-threshold support that intervenes before mental distress escalates into more severe conditions.[283] By engaging adolescents while their neural architecture is still actively forming, these early interventions help regulate emotional responses and prevent negative behavioural pathways from becoming deeply ingrained, thereby protecting the developing mind and fostering long-term wellbeing.[284]

5.4.3. Option 2: EU framework for youth-friendly early-intervention services ('youth hubs')

Rationale and problem addressed

This option targets the large 'missing middle' in youth mental-health care described in Chapters 2 and 4. In many systems, support is concentrated at two extremes: universal school-based measures on the one hand, and highly specialised psychiatric care on the other. Young people with mild-to-moderate difficulties – often exacerbated by digital stressors – frequently have nowhere timely and appropriate to go until problems escalate to crisis level. Case studies (for example headspace in Australia, Jigsaw in Ireland, PMHC and Flexible Assertive Community Treatment (FACT ung) in Norway @ease in the Netherlands) show that youth-friendly, low-threshold community services can fill this gap, but such models remain patchy within the EU (see the country case studies in Annex 4).

Objectives and target groups

The main objective is to support Member States that wish to develop or strengthen youth-friendly early-intervention services situated between schools/primary care and specialist psychiatry. These services are typically:

- accessible without, or with very simple, referral (including self-referral);

278 T. C. Thiagarajan, J. J. Newson and S. Swaminathan, 'Protecting the Developing Mind in a Digital Age: A Global Policy Imperative', *Policy Forum*, 2025.

279 M. Vink, J. M. Derks, J. M. Hoogendam, M. Hillegers and R. S. Kahn, 'Functional differences in emotion processing during adolescence and early adulthood', *NeuroImage*, Vol. 91, Elsevier, 2014, pp. 70–76.

280 M. T. Maza et al., 'Social Media Use and Neural Sensitivity to Peer Feedback in Adolescence', *JAMA Pediatrics*, American Medical Association, 2023.

281 UNESCO, *The price of inaction*, 2023.

282 C. Cipriano et al., 'The state of evidence for social and emotional learning: A contemporary meta-analysis of universal school-based SEL interventions', *Child Development*, Vol. 94(5), 2023, pp. 1181-1204; UNESCO, *The price of inaction*, 2023.

283 OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Publishing, 2021.

284 UNICEF, *Global Cost-Benefit Analysis on Mental Health and Psychosocial Support (MHPSS) Interventions in Education Settings Across the Humanitarian Development Nexus*, 2022.

- designed specifically for young people (roughly 12–24 years);
- focused on brief, evidence-based interventions for mild-to-moderate problems; and
- able to address co-occurring issues related to education, work, family and digital use.

Primary targets are adolescents and young adults with emerging anxiety, depression, behavioural and psychosocial difficulties, including those associated with problematic digital use but not yet meeting thresholds for specialist care. A secondary target is families and carers, who benefit from advice and support provided through such hubs.

In relation to the cost structure in Chapter 6, this option primarily affects healthcare and social-protection cost streams (reduced emergency use, inpatient admissions and disability claims), with important downstream effects on education and labour-market costs through preserved functioning and reduced dropout.

Core EU-level measures

Within its public-health support role, the EU would not prescribe specific service models, but could develop a non-binding framework and support package that helps Member States design and scale youth-friendly early-intervention services, for example by:

Defining core design principles: Through a Commission communication or Council recommendation, for youth-friendly early-intervention services (e.g. low-threshold access and self-referral, short waiting times, age-appropriate communication, multi-disciplinary teams, stepped-care approaches, integration with schools and primary care, attention to digital determinants).

Providing implementation guidance and toolkits: Draw on existing models such as headspace, Jigsaw, PMHC, FACT ung and @ease to offer practical examples of governance arrangements, workforce mixes (including peer workers), digital components and links to crisis and specialist care.

Using EU4Health, ESF+ and cohesion funds: Co-finance pilots or scale-up in interested Member States and regions, with a focus on areas with limited existing provision and on disadvantaged communities, coupled with robust monitoring and evaluation

Facilitating structured peer learning: Support networks or joint actions that bring together regions and countries developing youth hubs, to exchange lessons on implementation in different health-system contexts, including rural and low-resource settings.

Encouraging integration of digital tools: Promote appropriate use of safe, evidence-based digital tools within hubs (for example online self-referral, blended care, secure messaging), in line with the quality considerations in Option 4.

Legal basis, proportionality and subsidiarity

The primary legal basis for Option 2 would be Article 168(5) and (6) TFEU, which allow the EU to support, coordinate and supplement Member State action in public health, including prevention of mental illness, but not to define health policy or harmonise the organisation and delivery of health services. Under these provisions, the European Parliament and the Council may adopt incentive

measures[285] and recommendations,[286] they may not mandate structural reforms of national health systems.

The policy option primarily creates financial burden for the EU but would not go beyond what is necessary to achieve the objectives, thus the principle of proportionality would be observed.

The principle of subsidiarity would be respected. Article 168 TFEU confers a supporting competence to the EU, which is best achieved at EU level. The adoption of the framework would be voluntary, and the EU would provide standards, peer learning and co-funding, not mandatory structural reforms of the health systems – in line with the principle of conferral. The underlying problems relating to intervention services appear common across the Member States which supports the adoption of EU-level measures within the limits of the treaties.

Implementation considerations

Option 2 aligns closely with evidence that timely, youth-friendly early intervention can improve outcomes and reduce long-term costs, and with concrete models already operating in several case-study countries. By providing low-threshold, age-appropriate points of entry, youth hubs directly address the 'missing middle', including for young people whose difficulties are associated with digital exhaustion, cyberbullying or problematic platform use. If targeted to underserved areas and vulnerable groups, they can also help reduce the 'postcode lottery' and inequalities described in Sections 4.1.4 and 4.2.4.

However, workforce capacity is a major constraint. Many Member States already face shortages of child and adolescent psychiatrists, psychologists and mental-health nurses. Even with mixed teams and task-shifting, expanding early-intervention services risks competing for scarce staff unless accompanied by broader workforce-development strategies. Sustainability is another concern: without long-term commitment from national or regional authorities, EU-co-funded hubs may remain isolated pilots that are difficult to maintain once external funding ends or may add another layer to already fragmented systems if not well integrated with schools, primary care and specialist services. Starting points also differ widely: some Member States have elements of youth-friendly services; others have almost none, so the framework must be sufficiently flexible to be useful in both contexts.

Finally, reaching the most marginalised young people requires more than simply opening doors. Adolescents who are NEET, in contact with the justice system or highly disengaged may still not attend walk-in centres unless active outreach and co-location with trusted youth services are built in. Option 2 therefore needs to be designed with explicit equity and integration goals and seen as complementary to school-based promotion (Option 1), social prescribing (Option 3) and data-and-governance improvements (Option 6), rather than as a stand-alone cure for service gaps.

[285] E.g. Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014.

[286] Council Recommendation of 9 December 2022 on strengthening prevention through early detection: A new EU approach on cancer screening replacing Council Recommendation 2003/878/EC 2022/C 473/01.

5.4.4. Option 3: EU initiative on social prescribing and community-based pathways for vulnerable youth

Rationale and problem addressed

This option responds primarily to two problem clusters: (i) the lack of supportive, non-clinical pathways for young people in vulnerable situations, including those who are NEET; and (ii) persistent inequalities in exposure, access and outcomes (Sections 2.3.3, 2.4.3 and 4.2.4). As Chapter 4 shows, many young people with complex social needs and low engagement with school or services are not well reached by either school-based programmes or clinical care. Case-study evidence (for example Barnardo's LINK in England, C.O.P.E. in Italy, community-based youth work in Ireland and Norway) suggests that structured social prescribing and community activities can improve well-being, reduce isolation and, in some cases, show positive cost–benefit profiles. However, such models remain uneven and often small-scale.

Objectives and target groups

Option 3 aims to support Member States and regions in developing non-clinical, community-based pathways that help young people in vulnerable situations to reconnect with supportive relationships, activities and services. The main objectives are to:

- reduce loneliness, isolation and low-grade distress among adolescents and young adults who are poorly served by existing structures;
- provide earlier, non-stigmatising support that may prevent escalation to crisis or long-term exclusion; and
- strengthen local ecosystems of support by linking health, education, youth work and community organisations.

Primary target groups include young people aged roughly 12–24 who are: NEET or at high risk of becoming NEET; living in low-income or deprived areas; migrants, refugees or from minority backgrounds; LGBTQIA+ youth, young people with disabilities, or those in or leaving care, heavily disengaged from school or formal services.

In terms of the cost structure in Chapter 6, Option 3 mainly affects education and labour-market costs (through better engagement, reduced dropout and improved employability), with additional effects on health and social-protection costs via lower rates of crisis presentations and long-term exclusion.

Core EU-level measures

Within its supporting roles in health, youth and social policy, the EU could help countries to design, test and scale youth-focused social-prescribing and community-pathway models by:

Developing guidance on youth social prescribing: A Commission staff working document or Council recommendation could summarise emerging evidence and outline key design features for youth-oriented social-prescribing schemes: the role and skills of 'link workers'; how to identify and refer young people; types of community offers (sports, arts, volunteering, nature-based activities, peer groups); safeguarding standards; and how to integrate with schools, primary care, employment and youth services.

Supporting pilots and scale-up through EU funding: EU4Health, ESF+ and cohesion-policy funds could co-finance pilot projects and, where successful, scale-up schemes in interested Member States and regions, particularly in disadvantaged areas. Calls could prioritise projects that integrate health, youth, employment and social-inclusion services and that include robust evaluation.

Facilitating peer learning and capacity-building: The Commission could support a network or community of practice bringing together practitioners and policymakers involved in youth social prescribing and community-based initiatives (including non-EU comparators), to exchange tools, training resources and evaluation methods.

Embedding an equity lens: EU guidance and funding criteria could explicitly encourage targeting of groups identified in Section 4.2.4 (low-income, migrants/refugees, LGBTQIA+ youth, rural youth, young people with disabilities, care-experienced youth) and require applicants to explain how they will reach and retain these groups.

Legal basis and subsidiarity

The most suitable legal bases for this package of measures are Article 168(5) and (6) TFEU (public health), possibly in conjunction with Article 165(4) TFEU (education and youth) and Article 153(2) TFEU (social policy, in particular point (j) on combating social exclusion). The EU4Health programme was adopted on the basis of Article 168(5) TFEU.

These provisions confer a supporting competence on the EU. Participation in any initiative would be voluntary, and design choices would remain with Member States and local authorities. The EU role would be to provide frameworks, evidence and co-financing, not to mandate structural reforms of health or social-care systems, in line with the principle of conferral. Given that the underlying problems addressed by the option (social exclusion, NEET risk, marginalisation) are common across the EU-27, and that social prescribing is still emergent in many countries, EU-level support can add value without overstepping national responsibilities. The measures proposed are limited to what is necessary to achieve the objectives, so the principle of proportionality is respected

Implementation considerations (benefits, risks and challenges)

This policy option offers a way to extend youth-mental-health support beyond schools and clinics, particularly for young people in vulnerable situations who are unlikely to engage with formal services. By linking them to structured activities and supportive adults and peers, social-prescribing and community pathways work directly on social determinants of mental health such as loneliness, inactivity, lack of structure and weak social capital. Case-study evidence suggests that relatively low-cost, non-clinical interventions can improve wellbeing and, in some contexts, reduce use of primary care and crisis services, implying favourable cost–benefit profiles.

However, the effectiveness of such schemes depends heavily on local infrastructure. Social prescribing presupposes the existence of community organisations, safe spaces and activities. In areas with limited civil-society capacity or high deprivation, link workers may have few meaningful options to offer unless funding also supports the creation or strengthening of community assets. Sustainability is another recurring challenge: many schemes remain project-based and reliant on short-term funding. Without a strategy for embedding successful models into mainstream health, social or youth budgets, there is a risk that EU-co-funded pilots stay small and fragile.

Safeguarding and quality control are essential, given that schemes work with vulnerable young people outside clinical settings. Poorly designed or loosely supervised initiatives risk signposting to low quality or even harmful environments. The EU can support guidance and basic standards, but responsibility for regulating local providers will rest with Member States. Measuring impact is also complex: outcomes such as wellbeing and social connectedness are diffuse and long-term, and attribution to a single scheme is difficult. Evaluation expectations will need to be realistic and proportionate. Finally, national readiness varies: some Member States already have adult-focused social-prescribing infrastructures that can be adapted for youth; others have none and will require more basic capacity building.

Overall, as a complement to Options 1 and 2, Option 3 can help reach groups that are systematically missed by school-based and clinical services and address core social determinants of youth mental health. Its added value will depend on careful targeting to disadvantaged areas, investment in local infrastructures and robust safeguarding, as well as clear links to the wider support ecosystem.

Box 2 – Scientific rationale for policy options focusing on community-based pathways and social prescribing

For vulnerable youth such as refugees and NEETs, chronic exposure to severe adversity triggers 'toxic stress,' fundamentally altering their physiological development. During adolescence, prolonged trauma and social marginalisation become 'biologically embedded,' disrupting the endocrine system (including the HPA axis) and immune responses, leaving them highly susceptible to lifelong psychological morbidity.[287]

Clinical treatments alone frequently fail to address the root causes of this distress. Community-based pathways and social prescribing, offers a scientifically grounded counterbalance. By formally connecting marginalised youth to non-clinical, community activities (such as mentoring, arts, or sports), social prescribing provides consistent, safe relational support. Research demonstrates that strong social connections act as a biological buffer; they actively regulate the body's stress-response system, reducing the harmful build-up of cortisol and systemic inflammation associated with toxic stress.[288]

Through restorative peer and mentor relationships, these interventions help 'reset' the developing brain's stress circuitry. They provide the necessary psychosocial safety to mitigate chronic physiological arousal. Consequently, non-clinical community interventions are not just social activities**,** but they are biological needs that effectively reduce the long-term physiological markers of trauma and restore functional wellbeing for the most vulnerable youth.

5.4.5. Option 4: EU quality and safety framework for digital mental-health tools and online support

Rationale and problem addressed

This option responds to two linked issues: (i) the rapid proliferation of digital mental-health tools and online support services of highly variable quality and safety; and (ii) their often ad hoc integration into care and education. As Chapter 2 shows, digital tools can widen access and appeal to young people reluctant to seek face-to-face help, but they also pose risks around efficacy, privacy, commercial exploitation and exposure to harmful content (Sections 2.3.1 and 2.4.1–2.4.2). Chapter 4 highlights that while many countries deploy apps, web-based self-help and online counselling (for example ReachOut, iFightDepression, SOLVE, SCESS), few have systematic quality-assurance frameworks, and linkage to stepped-care pathways is inconsistent.

Objectives and target groups

The overarching objective is to improve the safety, quality and appropriate use of digital mental-health tools and online services aimed at, or used by, young people, and to support their responsible integration into health, education and youth systems. More specifically, Option 4 aims to:

- help practitioners, schools, young people and families distinguish evidence-based, safe tools from low-quality or potentially harmful ones;

[287] UNICEF, *The State of the World's Children 2021: On My Mind – Promoting, protecting and caring for children's mental health*, 2021.

[288] WHO, *From loneliness to social connection*, World Health Organization, 2024; K. Husk et al., 'What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review', *Systematic Reviews*, Vol. 5(1), 2016.

- support Member States in integrating validated tools into stepped-care pathways (for example as first-line or adjunctive options); and
- reduce risks related to data protection, commercial exploitation and unsafe content in tools that present themselves as mental-health support.

Primary targets are digital tools and services that explicitly address the mental health or emotional wellbeing of children, adolescents and young adults (for example apps, web-based programmes, moderated peer platforms, online counselling and helplines). Indirect beneficiaries are young people (roughly 10–24 years), parents and caregivers, schools and frontline professionals.

In terms of the cost structure in Chapter 6, Option 4 can affect health-care and education costs (through more efficient, earlier support and reduced reliance on high-intensity services) and, to a lesser extent, labour-market and social-protection costs by helping maintain functioning among young people who might not otherwise engage with support.

Core EU-level measures

Within its supporting roles in health and digital policy, the EU would not certify individual products in a binding way but could develop a non-binding quality and safety framework and support Member States in using it. Key elements could include:

EU-level quality and safety criteria: A Commission recommendation or staff working document could set out criteria for youth-facing digital mental-health tools and services, covering at least: evidence of effectiveness or a plausible theory of change that demonstrates expected outcomes; data-protection and privacy standards (consistent with the GDPR, Data Governance Act and European Health Data Space framework); safeguards against harmful content (for example self-harm and pro-eating-disorder material); age-appropriate design, accessibility and usability; and transparency about commercial models (in-app purchases, advertising, data monetisation).

Support for national or regional 'trusted libraries': Building on existing examples in some Member States, the EU could provide guidance and, where appropriate, funding to help countries or regions establish curated catalogues of vetted mental-health apps and services, with a dedicated youth section. These catalogues would remain nationally owned but could draw on common assessment criteria and shared evidence.

Integration into stepped-care pathways and education: Guidance and pilot funding (via EU4Health, ESF+ or Erasmus+) could support the integration of quality-assured digital tools into primary-care and youth-hub models (Options 2 and 3), for example as guided self-help or between-session support; school-based programmes (Option 1), for psychoeducation, CBT-based modules or anonymous help-seeking routes; helplines and online counselling services, within blended-care approaches.

Capacity-building and peer learning: The Commission could facilitate a community of practice among regulators, clinicians, educators and youth organisations involved in assessing and deploying digital tools, to share assessment methods, governance models and user-involvement practices.

Legal basis, proportionality and subsidiarity

The primary legal basis which can be mobilised for policy option 3 is also Article 168(5) and (6) TFEU, which allows the EU to support, coordinate and supplement Member State action in public health,

including in the prevention of mental illness and diseases. The EP and Council can adopt incentive measures to protect and improve human health.[289] The Council may adopt recommendations.[290]

The policy option primarily creates financial burden for the EU but would not go beyond what is necessary to achieve the objectives, thus the principle of proportionality would be respected.

The principle of subsidiarity would be respected. Article 168 TFEU confers a supporting competence to the EU, which is best achieved at EU level. The adoption of the framework would be voluntary, and the EU would provide standards, peer learning and co-funding, not mandatory structural reforms of the health systems, in line with the principle of conferral. The underlying problems relating to intervention services appear common across the Member States which supports the adoption of EU-level measures within the limits of the treaties.

Implementation considerations (benefits, risks and challenges)

Option 4 provides a relatively low-risk way for the EU to help Member States harness the benefits of digital mental-health tools while reducing associated risks. Common criteria and trusted libraries can improve safety and trust, making it easier for schools, clinicians and young people to avoid unsafe or ineffective tools and to adopt those with a credible evidence base. By supporting integration of vetted tools into stepped-care pathways and school settings, the option can extend the reach of support, particularly for young people who prefer digital contact or live far from services and reduce duplication of assessment efforts across Member States.

However, its impact depends on uptake and capacity at national level. As a voluntary framework, its effects will be greatest where Member States choose to invest in their own assessment and deployment structures; those with limited digital-health capacity may struggle to maintain up-to-date catalogues. The fast-moving nature of the digital market means that assessments can quickly become outdated, requiring ongoing resources to remain useful. There is also a need to clarify boundaries with existing medical-device regulation so that tools are neither over- nor under-regulated, and to ensure that investment in digital solutions does not inadvertently widen inequalities for young people with limited access to devices, connectivity or digital literacy.

Finally, mental-health impacts of individual tools are likely to be modest, and digital support should be framed as one component of a broader ecosystem, not a stand-alone solution. In practice, Option 4 is likely to be most effective when implemented alongside Options 1-3, which provide the offline settings into which such tools can be embedded, and Option 6, which can support better data and evaluation.

5.4.6. Option 5: Child-centred implementation and possible strengthening of EU digital regulation

5a: Child-centred implementation of the existing digital acquis

Rationale and problem addressed

This option addresses the problem that, although the EU already has a powerful digital *acquis*, notably the DSA, AVMSD, AI Act and the forthcoming CSAM package, these instruments are not yet systematically implemented and enforced in ways that fully reflect children's mental health needs. As Chapters 2 and 3 show, design-driven overuse, exposure to harmful and self-harm-related

[289] E.g. Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027 and repealing Regulation (EU) No 282/2014.

[290] Council Recommendation of 9 December 2022 on strengthening prevention through early detection: A new EU approach on cancer screening replacing Council Recommendation 2003/878/EC 2022/C 473/01.

content and emerging AI-mediated interactions can exacerbate mental-health risks, especially for vulnerable young people. At the same time, the impact of existing rules will depend heavily on how regulators and platforms interpret concepts such as 'harm to minors' and 'systemic risks', and on whether child-health expertise is embedded in enforcement practice. Option 5a focuses on this implementation gap. It assumes no new legislation but seeks to ensure that current rules are applied in a child-centred way, with explicit attention to mental-health pathway.

Objectives and target groups

The objective of Option 5a is to strengthen child-centred implementation and enforcement of existing EU digital legislation by:

- ensuring that systemic-risk assessment and mitigation duties explicitly cover mental-health risks for minors, including those associated with design and recommender systems;
- embedding child-health and child-rights expertise in supervision and enforcement processes; and
- supporting Member States in developing age-assurance and enforcement practices that are effective, proportionate and privacy-preserving.

The focus is on very large platforms and services central to adolescents' online lives (social media, video-sharing platforms, certain games and AI-based services), rather than on the entire digital ecosystem. In terms of the cost structure in Chapter 6, Option 5a acts upstream on all four cost streams (health, social protection, education and labour) by reducing the incidence and severity of digital-era risk exposures.

Core EU-level measures ('soft track')

Within the current legal framework, the EU, primarily the Commission and national regulators, could

Clarify how systemic-risk obligations must cover mental-health risks for minors: Under the DSA, VLOPs and search engines must assess and mitigate systemic risks, including effects on minors' physical and mental wellbeing. Commission guidance and, where appropriate, delegated or implementing acts could specify that this explicitly includes design-driven overuse (for example infinite scroll, autoplay, streaks), harmful content (for example self-harm, pro-eating-disorder, extreme body-image material, hate targeting young people) and certain AI-mediated interactions (for example 'companions'), and set expectations for mitigation measures.

Develop co-regulatory codes of conduct on 'safety-by-design for minors': Building on BIK+ and existing safety-by-design work (for example in Australia), the Commission could convene platforms, Digital Services Coordinators, audiovisual and data-protection regulators, child-rights and mental-health experts and youth representatives to agree practical design standards (for example defaults, recommender-system options, notification regimes, age-appropriate interfaces).

Strengthen the role of child-health expertise in supervision: Advisory panels or structured consultation mechanisms could be established so that neurodevelopmental, psychiatric, psychological and addiction expertise is systematically considered in risk assessments, enforcement priorities and the interpretation of 'harm to minors' across the DSA, AVMSD, AI Act and CSAM rules.

Support Member States on age-assurance and enforcement practice: Through guidance and peer learning, the Commission could help regulators develop risk-based, privacy-preserving age-assurance approaches for services with high child-protection relevance and share best practice on enforcing duties related to minors.

Legal basis, proportionality and subsidiarity

The legal grounding of these measures is primarily Article 114 TFEU (internal market), under which the DSA, and AI Act were adopted. The adoption of guidance by the European Commission can be grounded in the secondary act (e.g. Article 28(4) of the Digital Services Act about the online protection of minors) and given a specific binding effect or can be adopted by the European Commission (or expert groups) on its own accord as non-binding guidelines (e.g. 2024 EC Guidelines for Education Policymakers on Wellbeing and Mental Health at School). In the case of Article 114 TFEU, an exclusive competence of the European Union, the principle of subsidiarity does not apply. In addition, although subsidiarity and proportionality apply to all EU action, guidance document is not subject to a formal analysis in light of the principles of subsidiarity or proportionality.

Implementation considerations (benefits, risks and challenges)

Option 5a uses the EU's strongest existing levers in an area where it has clear, binding competences. By clarifying how systemic-risk duties apply to minors' mental health and by embedding child-health expertise in enforcement, it can target the key digital pathways identified in Chapter 2, design-driven overuse, content-driven harms and AI-mediated interactions, without the delays and uncertainties associated with new legislation. Strong, coherent guidance and co-regulatory standards can also support a more level playing field across the single market, reducing incentives for platforms to treat child-protection as a low priority or to comply only where national regulators are most demanding.

At the same time, the impact of Option 5a depends heavily on regulatory capacity and consistency. Digital Services Coordinators and other authorities differ in expertise and resources and, even with EU-level guidance, enforcement may remain uneven. Age-assurance remains technically and legally complex, and guidance must strike a careful balance between effectiveness, privacy and non-discrimination. Mental-health outcomes will be difficult to attribute precisely over a 10-year horizon, given the many interacting determinants. For these reasons, Option 5a is best understood as a necessary first step, making the existing *acquis* work better for children's mental health, supported by improved data and research under Option 6, and providing an evidence base for any future consideration of additional rules under Option 5b.

Box 3 – The neurobiological case for digital regulation

Reward-driven engagement

Modern digital platforms utilise persuasive design, including infinite scroll, autoplay, and 'pull-to-refresh' mechanisms, to maximise user engagement. These features operate on the principle of variable reinforcement, mimicking the unpredictable reward systems found in slot machines.[291] By delivering intermittent stimuli (e.g. likes, comments, and notifications), these platforms activate the brain's dopaminergic pathways involved in anticipation and behavioural reinforcement.[292] While the brain's dopamine pathways are commonly cited as driving overuse of digital platforms there are other neurotransmitters and brain regions involved.[293] There is growing evidence and concern over the neurobiological impact of prolonged social media use and computer gaming, focusing on how it affects the brain's reward, attention, and emotional regulation systems. Furthermore, changes in brain activity within the prefrontal cortex and amygdala suggest increased emotional sensitivity and compromised decision-making abilities.[294]

Developmental imbalance

For young people, these designs are biologically disruptive due to the structural reorganisation of the brain between the ages of 10 and 25.

Socio-emotional reward processing networks (e.g. ventral striatum, amygdala) mature significantly earlier than the prefrontal cortex (PFC), which governs impulse control and emotional regulation.[295] This developmental 'mismatch' can make adolescents particularly sensitive to social feedback curated by algorithms or the heightened reward effects of gaming. Repeated exposure to high-stimulation, fast-paced content can lead to neurocognitive habituation, where the brain becomes sensitised to instant gratification while losing the cognitive endurance required for goal-directed tasks.[296]

Contrast with evidence-based digital tools

There is a fundamental contrast between reward-driven engagement and education-based digital tools. Whereas commercial platforms exploit the reward system generally involving subcortical brain regions, validated education-focussed interventions (e.g. the Grip op je dip platform) utilise 'blended care' to cultivate greater self-regulation and other executive functions associated with the prefrontal cortex. These tools require active cognitive engagement and are intended to teach adolescents to monitor moods and practice cognitive reframing in order to bolster psychosocial resilience.[297]

Digital regulation as a biological requirement

Relying solely on digital literacy or individual self-regulation places an extremely high cognitive burden on a brain at a vulnerable stage where it is predisposed to prioritise peer approval and instant rewards over delayed gratification. There are downstream effects with algorithmically driven reward-seeking frequently displacing restorative biological and social functions. For a detailed analysis of 'vamping' (compulsive nighttime use), sleep-wake rhythm disruption, and social displacement, please refer to Section 2.4.2 (Sleep, development and social functioning).[298]

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291 V. R. Bhargava and M. Velasquez, 'Ethics of the attention economy: The problem of social media addiction', *Business Ethics Quarterly*, Vol. 31(3), 2021, pp. 321–359; F. Esposito and T. Maciel Cathoud Ferreira, 'Addictive design as an unfair commercial practice: The case of hyper-engaging dark patterns', *European Journal of Risk Regulation*, Vol. 15(4), 2024, pp. 999–1016

292 Ibid.

293 A. Westbrook, A. Ghosh, R. van den Bosch, J. I. Määttä, L. Hofmans and R. Cools, 'Striatal dopamine synthesis capacity reflects smartphone social activity', iScience, Vol. 24(5), 2021

294 D. De, M. El Jamal, E. Aydemir and A. Khera, 'Social media algorithms and teen addiction: Neurophysiological impact and ethical considerations', Cureus, Vol. 17(1), 2025

295 M. T. Maza et al., 'Association of Habitual Checking Behaviors on Social Media With Longitudinal Functional Brain Development', *JAMA Pediatrics*, Vol. 177(2), American Medical Association, 2023, pp. 160-167.

296 Ibid.

297 L. Nguyen et al., 'Feeds, Feelings, and Focus: A Systematic Review and Meta-Analysis Examining the Cognitive and Mental Health Correlates of Short-Form Video Use', *School of Applied Psychology, Griffith University*, 2024.

298 C. Cipriano et al., 'The state of evidence for social and emotional learning: A contemporary meta-analysis of universal school-based SEL interventions', *Child Development*, Vol. 94(5), 2023, pp. 1181-1204; E. Dietvorst et al., 'Effective elements of eHealth interventions for mental health and wellbeing in children and adolescents: A systematic review', *Digital Health*, Vol. 10, 2024.

Under Option 5a, coordinated action would also help ensure that the specific risks of AI companions are systematically addressed, in close connection with the data and monitoring measures in Option 6. EU-level guidance under the DSA and the AI Act could, for example, spell out safety-by-design expectations for generative AI chatbots foreseeably used by minors, including age-appropriate interaction parameters, mandatory crisis-intervention protocols, limits on addictive design features and clear restrictions on simulating professional mental-health support. As independent research potentially enabled by Option 6 provides new evidence on the harms and benefits of these rapidly evolving technologies, these expectations and enforcement priorities should be regularly reviewed and amended where necessary. Such an adaptive governance model would help ensure that protections for young people remain effective and proportionate as AI systems and usage patterns continue to change.

5b: Assessing and, where justified, strengthening EU rules for high-risk services and features

Rationale and problem addressed

While Option 5a focuses on child-centred implementation of the existing acquis, there may be specific areas where current legislation, even if well implemented, does not adequately address persistent, serious risks to minors' mental health. Evolving social media and AI, new technologies and business models, for example highly immersive services, certain monetisation schemes or AI-mediated interactions, may create harms that are difficult to mitigate through guidance and enforcement alone. At the same time, several Member States are considering divergent national rules (for example different social-media age limits), which risks fragmenting the internal market. Option 5b therefore explores whether, and under what conditions, new or strengthened EU-level rules could be warranted in narrowly defined high-risk areas.

Objectives and scope

The aim of Option 5b is to provide a structured process for assessing the case for additional legislative measures, and to act only where three conditions are met:

- there is consistent evidence that a type of service or feature is associated with serious harm to minors' mental health;
- risks cannot be adequately mitigated through safety-by-design, transparency or enforcement of existing obligations; and
- Union-level action would add value compared with divergent national rules (for example where emerging national approaches undermine both effective child protection and the functioning of the internal market).

As with Option 5a, the focus is on large services central to adolescents' online lives, not the entire digital ecosystem. Potential measures could, for example, concern minimum-age or access conditions for particular high-risk services or functionalities including specific bans, stronger restrictions on certain design patterns for minors, or enhanced duties of care for services predominantly used by children. Any such measures would have implications for all four cost streams in Chapter 6, by aiming to reduce the incidence and severity of digital-era harms at source.

Core EU-level measures ('soft track')

Without prejudging outcomes, the European Parliament could, under Article 225 TFEU, invite the Commission to undertake a structured assessment of whether new or amended EU rules are warranted in specific areas. This would involve:

Evidence mapping and risk assessment: Reviewing emerging scientific evidence, complaints data, enforcement experience and youth perspectives to identify types of services or features

consistently associated with serious harm to minors' mental health, and to test whether existing obligations can realistically mitigate these risks.

Analysis of national measures and internal-market impacts: Examining existing and proposed national rules (for example statutory age limits, design bans), their effectiveness and their impact on the internal market, to determine whether divergent approaches are creating fragmentation or regulatory arbitrage.

Options for targeted EU measures: Where justified, exploring options such as minimum-age or access conditions for narrowly defined high-risk services, prohibitions or tighter restrictions on specific design patterns for minors, or strengthened due-diligence obligations for services predominantly used by children, accompanied by impact assessments and stakeholder consultation.

The outcome of this process might be that improved implementation of existing law under Option 5a is preferable in many cases, and that only a limited subset of issues merit new or revised legislative proposals.

Legal basis, proportionality and subsidiarity

Any new binding rules in this area would most likely rely on Article 114 TFEU (internal market), as do the DSA, AVMSD and AI Act. Article 114 TFEU can be used where divergent national measures risk fragmenting the internal market and where harmonisation demonstrably improves its functioning, while achieving a high level of protection for children. Article 16 TFEU and Articles 7 and 8 of the Charter would frame data-protection and privacy requirements, and Article 24 of the Charter (rights of the child) would support child-protection objectives; proportionality and fundamental-rights impacts (including freedom of expression and association, and children's own rights online) would need careful assessment.

Internal-market measures based on Article 114 TFEU fall within the Union's competence to set common rules; subsidiarity testing focuses on whether EU-level action is more effective than uncoordinated national measures. In this context, any proposal would need to show that specific additional rules are necessary and proportionate, and that they cannot be achieved satisfactorily by Member States acting alone.

Implementation considerations (benefits, risks and challenges)

This policy option offers a disciplined way to consider whether new EU rules are needed, instead of responding through ad hoc or politically driven proposals. By setting clear evidential and proportionality thresholds, it can help ensure that any future legislative measures are targeted at genuinely high-risk areas where existing tools, even if well used, are insufficient, and where divergent national approaches risk undermining both child protection and the internal market. It also signals that the EU is willing to go beyond guidance and enforcement where serious, persistent harms cannot be addressed through current instruments, which may in itself incentivise platforms to engage constructively with Option 5a.

At the same time, this is the most politically and legally sensitive option. There is a risk of both over- and under-reach: measures that are too weak may leave significant risks unaddressed, while overly restrictive rules could face legal challenges, provoke strong pushback from industry and parts of civil society, or drive some youth behaviour towards less regulated spaces. Technical and legal complexity is high, particularly around any form of minimum-age rule or ban on design patterns, given the unresolved challenges of reliable, privacy-preserving age-assurance and cross-border enforcement. Fundamental-rights trade-offs – especially regarding privacy, freedom of expression and information, and children's own rights to participation and association – would need to be

carefully weighed against protection needs. As with Option 5a, any mental-health impact would be difficult to attribute precisely and may take time to materialise.

For these reasons, Option 5b is best seen as a contingent complement to Option 5a. The priority is to use the full potential of the existing acquis through child-centred implementation and enforcement, supported by better data and research under Option 6. Only where persistent, well-evidenced high-risk gaps remain, and where national fragmentation is increasing, would it be appropriate to consider additional EU-level rules under this option.

5.4.7. Option 6: Data, monitoring and governance for youth mental health in a digital era

Rationale and problem addressed

This option responds to the cross-cutting problems of limited, fragmented data, weak monitoring and siloed governance, which constrain all other efforts. As Chapters 2 to 4 highlight, comparable EU-wide data on youth mental-health trends, digital exposure and inequalities are patchy. Indicators are not always harmonised, and disaggregation by age, gender, socio-economic status or minority status is often missing. At the same time, governance arrangements for youth mental health are frequently fragmented across health, education, digital and social ministries, with few integrated strategies or delivery structures (Sections 3.6.4–3.6.5 and 4.3). These gaps make it difficult to design targeted interventions, evaluate what works or adjust policy as digital technologies and behaviours evolve.

Objectives and scope

Option 6 aims to create a stronger information and coordination infrastructure for youth mental health in a digital era by:

- improving the quality, comparability and disaggregation of data on youth mental health, digital use and online harms;
- supporting longitudinal and quasi-experimental research on digital determinants and interventions; and
- promoting integrated, cross-sector governance models that connect health, education, digital and social policy around youth mental health. The option does not introduce direct interventions on young people but underpins the design, targeting and evaluation of the actions envisaged in Options 1–5. In the cost structure in Chapter 6, Option 6 acts indirectly on all four cost streams (healthcare, social protection, education and labour) by enabling more effective, equitable and adaptive policy choices.

Core EU-level measures

Within its existing competences, the EU could pursue three strands of work:

Harmonised indicators and monitoring: Working with Member States and partners such as WHO, OECD and UNICEF, agree a core set of indicators on youth mental health and digital exposure, covering diagnosed conditions, subclinical distress, service access, digital behaviours and exposure to online harms, using standard age bands (for example age 10–14, 15–19 and 20–24) and basic disaggregation (sex, socio-economic status, where feasible migrant/refugee background and disability). The EU could promote inclusion of these indicators in EU-wide surveys and statistics (for example EHIS, relevant PISA modules, HBSC, Eurostat social indicators, Eurobarometer), and support improvements to national routine data (for example use of child and adolescent mental-health services, waiting times, school absenteeism linked to mental health). The EU could also develop simple EU-level dashboards to make trends visible without turning them into league tables.

Research on digital determinants and interventions: Using Horizon Europe and EU4Health, the EU could put out calls to support longitudinal and quasi-experimental studies on key questions, such as the mental-health impact of specific platform-design changes, school-level smartphone and AI policies, and the cost-effectiveness of interventions like SEL programmes, youth hubs, social prescribing and digital tools for different groups. It could facilitate use of the DSA's data-access provisions by independent researchers, under strict privacy and security safeguards, to study recommender systems, exposure to harmful content and digital-use patterns among minors and encourage mixed-methods research that incorporates young people's lived experience, especially from marginalised groups, into assessments of digital risks and supports.

Integrated governance and policy learning: This would entail supporting Member States to develop or strengthen integrated youth-mental-health strategies and governance structures that link health, education, digital and social policy, for example through joint actions, technical assistance or dedicated work streams within existing platforms. The EU could promote peer learning on governance models, drawing on case-study experience from countries that have created cross-sector delivery boards or municipal public-health programmes focused on youth mental health, and encourage systematic involvement of youth and child-rights bodies in national decision-making on digital regulation, education and health strategies, in line with international child-rights standards.

Legal basis, proportionality and subsidiarity

The most suitable legal basis for this package of measures could be Article 168(5) and (6) TFEU (human health, more specifically measures to protect and improve human health). The funding strategy for the studies to be performed could be integrated under Horizon Europe, which was adopted *inter alia* on the basis Article 182(4) TFEU. The statistical activities of the EU via Eurostat are grounded in Article 338 TFEU Ordinary Legislative Procedure (OLP).

The policy option primarily creates financial burden for the EU but would not go beyond what is necessary to achieve the objectives, thus the principle of proportionality would be respected.

The EU would not take over national data systems or governance structures; instead, it would facilitate comparability, evidence generation and shared learning. In its funding role, the EU would provide research which would be carried out at EU level or at least by several Member States, supporting the provision of EU funding. The principle of subsidiarity of EU actions would be respected.

Implementation considerations (benefits, risks and challenges)

Option 6 does not directly change services or platform behaviour, but it is critical for making other actions more effective and accountable. More reliable, disaggregated and harmonised data would make it easier to identify where problems are most acute, which groups are most affected and where resources should be directed, improving the targeting and evaluation of Options 1–5. Longitudinal and quasi-experimental research can move policy beyond anecdote, clarifying which interventions and regulatory choices work, for whom and under what conditions. Integrated governance structures and peer learning can help reduce fragmentation between ministries and agencies, increasing the chances that school-based programmes, youth hubs, social prescribing and digital regulation pull in the same direction.

However, benefits will accrue gradually. Designing, funding and implementing improved data systems and research takes time, and visible results may fall outside short political cycles. National capacity and priorities vary: some Member States may have limited resources or appetite to expand data collection or participate in complex research consortia, which could limit comparability.

Collecting and linking more detailed data on minors' mental health and digital behaviour raises legitimate privacy and ethics concerns; robust safeguards and adherence to GDPR and the Charter are essential to maintain trust. There is also a risk of 'measurement without action' if better data are not meaningfully integrated into policy and funding decisions.

Overall, Option 6 is best seen as an enabling investment. On its own it will not reduce prevalence, but in combination with the other options it can help ensure that EU and national actions are better targeted, more equitable and more adaptable to a rapidly changing digital environment, thereby reducing the long-term cost of non-Europe described in Chapter 6.

5.5. Link to impact assessment and comparative analysis

The options set out above describe what the EU could do. The next two chapters consider what is at stake if no further action is taken and what different combinations of options could plausibly deliver. Chapter 6 provides an option-agnostic quantitative baseline. It estimates the cost of continuing the current trajectory, that is, the cost of Option 0, by modelling the prevalence and socio-economic costs of youth mental ill-health in the EU-27 over a 10-year horizon. It also presents avoided-cost scenarios for generic reductions in prevalence (for example 1 %, 3 %, 5 %, 7 % and 10 %).

Chapter 7 then turns to Options 1 to 6. It combines these avoided-cost scenarios with the qualitative evidence on intervention effectiveness and feasibility from Chapters 4 and 5 to explore what different EU-level options and combinations could plausibly achieve, and how they compare on dimensions beyond cost (such as reach, EU competence and equity). The analysis is illustrative rather than predictive: the evidence base allows mapping from options to plausible reduction ranges, but not precise forecasts. Read together, Chapters 6 and 7 show the benefits and the trade-offs the European Parliament would face in deciding how to pursue it.

6. The cost of inaction: Modelling the economic case for EU action

This chapter uses an EU-27 model to estimate the prevalence and socio-economic costs of youth mental ill-health over a 10-year period (2024-2033) under a continuation-of-status-quo scenario (Option 0). It provides an option-agnostic baseline for the 'cost of non-Europe' and a set of avoided-cost scenarios for generic reductions in prevalence, which are then linked qualitatively to the policy options in Chapter 7.

Key findings

Youth mental ill-health already costs the EU-27 around €177 billion per year: In 2024, the total annual cost of youth mental ill-health (ages 10-24) is estimated at approximately €177 billion, spread across healthcare, social protection, education and lost labour productivity. Costs rise steadily over the decade even as the youth population shrinks.

The 10-year cost of inaction is around €1.68 trillion (present value): Under the central scenario, maintaining the current trajectory (Option 0) yields a cumulative cost of about €1.68 trillion over 2024–2033 in 2024 present value. The uncertainty range runs from roughly €1.28 trillion (optimistic case) to €2.02 trillion (conservative case), showing that youth mental ill-health is a major macro-economic issue regardless of assumptions. Costs are multi-system and broadly shared across sectors.

Over ten years, healthcare accounts for about €554 billion, social protection and labour-market losses for around €504 billion each, and education for about €118 billion: No single ministry can address this burden alone; coordinated action across health, education, labour and social-affairs portfolios is required. Anxiety disorders dominate the cost profile.

Anxiety alone accounts for about €853 billion over the decade, more than three times the cost associated with depression: This reflects both higher prevalence and sharper increases since 2010. Anxiety and depression together make up nearly two-thirds of the total cost, pointing to clear targets for early intervention.

Even modest prevalence reductions yield large, avoided costs. Because the baseline cost is so high, small improvements matter: A sustained 1 % reduction in prevalence over 10 years would avoid roughly €17 billion; a 5 % reduction around €84 billion; and a 10 % reduction around €168 billion in present value. These scenarios are option-agnostic, but they illustrate the economic scale of what effective EU-supported action could deliver.

6.1. Purpose and scope of the assessment

This chapter provides quantitative estimates of the current scale of youth mental ill-health in the EU-27, of its likely future evolution under a continuation-of-status-quo scenario, and of the associated socio-economic costs

This chapter illustrates the economic case for EU action on youth mental health. The chapter estimates the cost of continuing the current trajectory (Option 0 – baseline) under three uncertainty cases. These cases use different assumptions about how prevalence and costs evolve, ranging from cautious to optimistic, to show how much the estimate could vary. The findings provide quantitative input for the comparative analysis of policy options in Chapter 7.

The assessment covers all 27 Member States and young people aged 10 to 24. The time horizon is ten years, from 2024 to 2033, in line with EU Better Regulation guidance. The assessment estimates costs across four streams: healthcare, social protection, education, and labour and productivity.

The model is option-agnostic. It does not estimate the direct impact of specific policy options. Instead, it combines published prevalence data, projected trajectories and per-case cost estimates to produce: (i) a baseline estimate of the cost of inaction (Option 0); and (ii) avoided-cost scenarios for generic reductions in prevalence (for example 1 %, 3 %, 5 %, 7 % and 10 %). Chapter 7 then links these scenarios qualitatively to the options in Chapter 5, using evidence from Chapters 2 to 4 to explore what different combinations of EU-level actions could plausibly deliver.

6.2. Modelling approach and key assumptions

The model rests on three building blocks. First, an EU-27 youth population projection by country and age band to 2033. Second, prevalence rate projections for six mental health conditions. Third, a per-case annual cost figure derived from published OECD data. This is the average yearly cost to society of one young person living with a mental health condition, covering health, education, labour and social protection. These three blocks combine to produce annual cost estimates by country, condition, and year.

The prevalence trajectory is set out in detail in Section 6.3, before being translated into costs in Section 6.4. This sequence allows readers to see how the underlying caseload evolves before the monetisation step.

The chapter presents three uncertainty cases. They are not policy scenarios. They simply test how the cost estimate shifts under different assumptions about prevalence and per-case cost.

The central case extrapolates the linear prevalence trend from 2010 to 2023 forward to 2033, using the central per-case cost. The conservative case keeps this same prevalence trend but pairs it with a per-case cost 20 % above the central value. The optimistic case is the only one that lowers prevalence: it applies a 10 % annual decay on the trend beyond 2023, floored at 70 % of the central rate, with a per-case cost 20 % below the central value.

In short, prevalence is held on the central trend except in the optimistic case, while per-case cost varies above and below the centre. The conservative case is cautious about understating cost, not prevalence.

Headline figures are reported in 2024 present value, discounted for future years at 3 % in line with EU Better Regulation guidance.[299] Sensitivity at 0 % (undiscounted) and 5 % discount rates is reported alongside the central figure, to show that the headline result is not driven by the choice of discount rate.

Several simplifications apply. The model uses a uniform per-case cost across the six conditions in this version, rather than condition-specific or severity-weighted costs. The model also treats each condition independently, so the sum across conditions over-counts comorbidity. Both points are revisited in Section 6.5.

6.3. Youth mental health in the EU-27: Prevalence and projections

Key message

The number of young people living with a mental health condition has risen sharply since 2010. Anxiety has nearly doubled. Depression has risen more modestly. Other conditions have remained

[299] European Commission: Better Regulation Toolbox, Tool #64. The 3% rate is the standard social discount rate used in EU impact assessments.

largely stable. If current trends continue, anxiety prevalence will reach almost one in five young people by 2033. This trajectory is the foundation for the cost projections that follow.

Current prevalence

In 2024, an estimated 9.5 million young people in the EU-27 lived with anxiety disorders. This was the largest single condition by case volume. A further 2.9 million lived with depression. ADHD affected 1.6 million. Self-harm, conduct disorder, and eating disorders together affected another 5.8 million.[300]

The total caseload across the six conditions was around 19.8 million in 2024. This figure does not adjust for comorbidity. Many young people experience more than one condition, most often anxiety with depression, or ADHD with conduct disorder. The figure should therefore be read as an upper bound on the number of distinct individuals affected, not a population count.[301]

Anxiety prevalence was around 13.1 % in 2024. Depression sat at 4.0 %, ADHD at 2.2 %, self-harm at 3.8 %, conduct disorder at 2.6 %, and eating disorders at 1.6 %. These are weighted EU-27 averages across ages 10 to 24.

Trend since 2010

Anxiety has driven the change. Prevalence rose from 6.8 % in 2010 to 12.7 % in 2023, almost doubling in 13 years. Depression rose from 3.0 % to 4.0 % over the same period. The other four conditions moved by less than 0.2 percentage points.

This pattern is consistent with evidence from HBSC, GBD, and OECD sources. The qualitative drivers behind these trends, including the digital environment and intersecting socio-economic pressures, are analysed in Section 2.4.

Projected trajectory to 2033

The model projects three trajectories. The central case extrapolates the linear trend from 2010 to 2023 forward to 2033. The conservative case holds 2023 rates flat. The optimistic case applies a 10 % per year decay on the trend beyond 2023, floored at 70 % of the central rate.

Under the central case, anxiety prevalence reaches 17.6 % by 2033. Depression reaches 4.7 %. The other four conditions remain close to their 2024 levels.

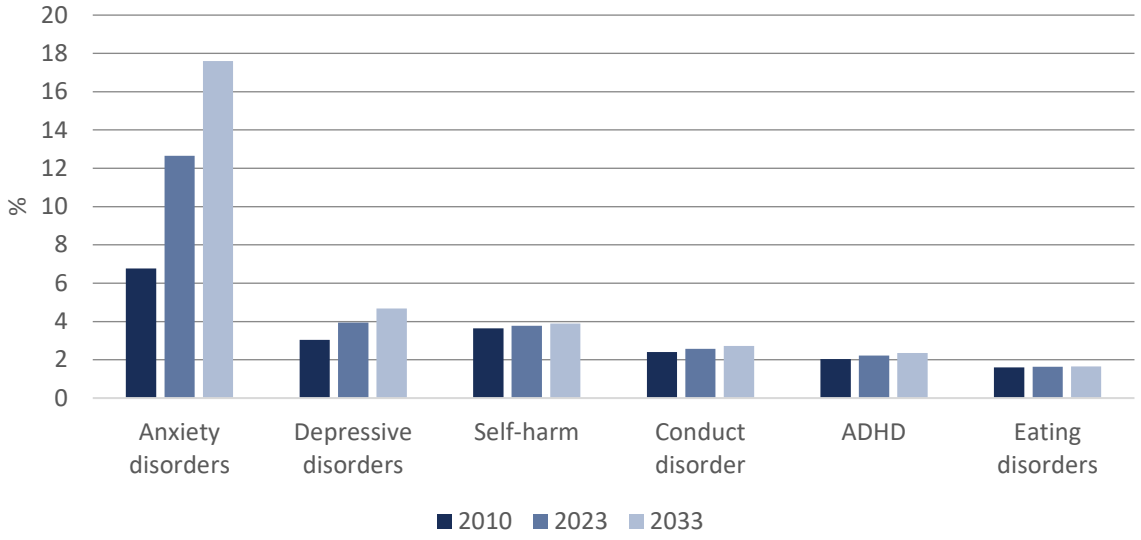
Translated into cases, the EU-27 youth caseload for anxiety rises from 9.5 million in 2024 to 12.3 million in 2033. Depression rises from 2.9 million to 3.3 million. The other four conditions are essentially flat in absolute terms, although the EU-27 youth population itself declines slightly over the period.

This trajectory assumes no new EU-level policy action. It is the prevalence baseline against which the cost-of-inaction figures in Section 6.4 are calculated.

[300] Self-harm, conduct disorder, and eating disorders prevalence rates are synthesised from literature anchors, due to limited disaggregated EU-27 data. The synthesis method is described in the Annex.

[301] The model treats each condition independently. Comorbidity adjustments are discussed in Section 6.5.

Figure 5 – EU-27 youth prevalence rate by mental health condition, 2010, 2023, and 2033



Note: Values for 2010 and 2023 are based on observed data from the Global Burden of Disease study, except for self-harm, conduct disorder, and eating disorders, which are synthesised from literature anchors. Values for 2033 are projections under the central case. Source: EPRS Youth Mental Health Model.

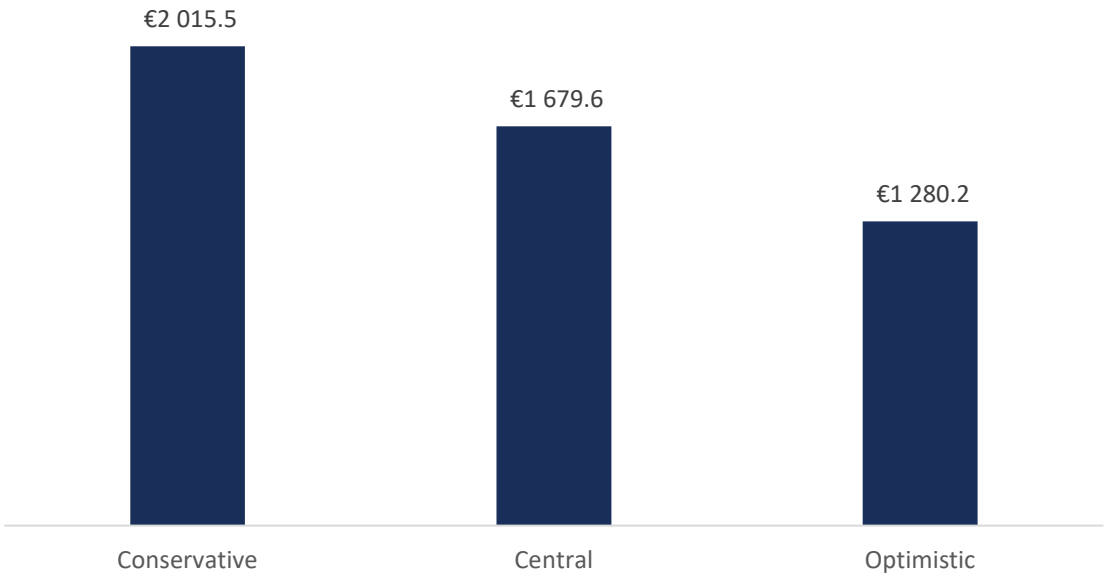
6.4. The socio-economic cost of youth mental ill-health in the EU

Headline figure

In 2024, youth mental ill-health was estimated to cost the EU-27 around €177 billion. Projecting current trends forward, the total cost over the ten-year period from 2024 to 2033 reaches €1.68 trillion in present value, under the central case.

The figure spans four cost streams: healthcare, social protection, education, and lost labour productivity. It applies to young people aged 10 to 24 across all 27 Member States. The cost of inaction is estimated at €1.68 trillion in present value over ten years, central case. The uncertainty range runs from €1.28 trillion under the optimistic case to €2.02 trillion under the conservative case.

Figure 6 – Total cost of youth mental ill-health under three uncertainty cases, EU-27, 2024 to 2033, present value at 3 % discount rate, (billion)



Source: EPRS Youth Mental Health Model.

This range reflects two layers of uncertainty applied jointly. The prevalence trajectory varies across cases, as set out in Section 6.3. The cost per case varies by plus or minus 20 % around the central value. The discount rate is held at 3 % across all three cases. A separate sensitivity check shows that the central-case ten-year total is €1.92 trillion at 0 % discount and €1.55 trillion at 5 % discount.

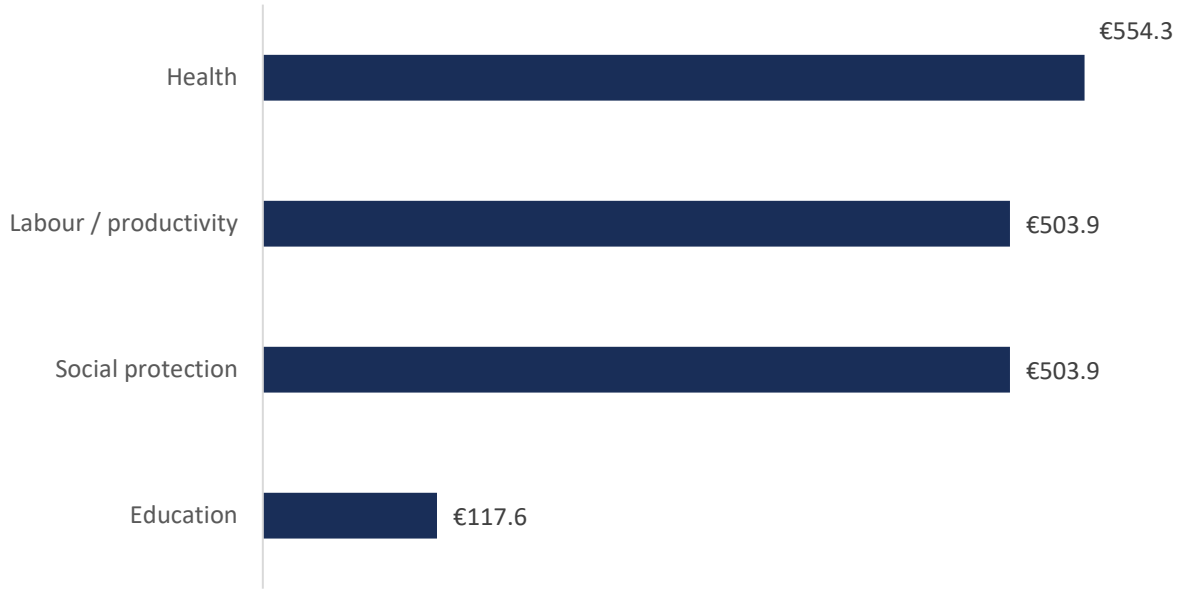
Cost distribution by system

The cost of inaction does not fall on any one system. The model distributes total costs across four streams. Healthcare costs cover treatment, medication, and specialist services. Social protection costs cover sickness benefits, disability support, and family compensation. Labour and productivity costs cover lost output from absenteeism, presenteeism, and reduced lifetime earnings. Education costs cover special needs support, repeated years, and early school leaving. The underlying evidence for each stream is set out in Section 2.4.

Healthcare carries the largest share at €554 billion over ten years, but only just. Labour and social protection each reach €504 billion. Education adds a further €118 billion. Three of the four streams sit within 10 % of each other.

This pattern reframes youth mental health as a multi-system challenge. Action confined to health ministry's leaves most of the cost untouched. Coordinated action across health, labour, social affairs, and education portfolios is needed to address the full burden.

Figure 7 – Cost of youth mental ill-health by system, EU-27, 2024 to 2033, central case in present value (billion)



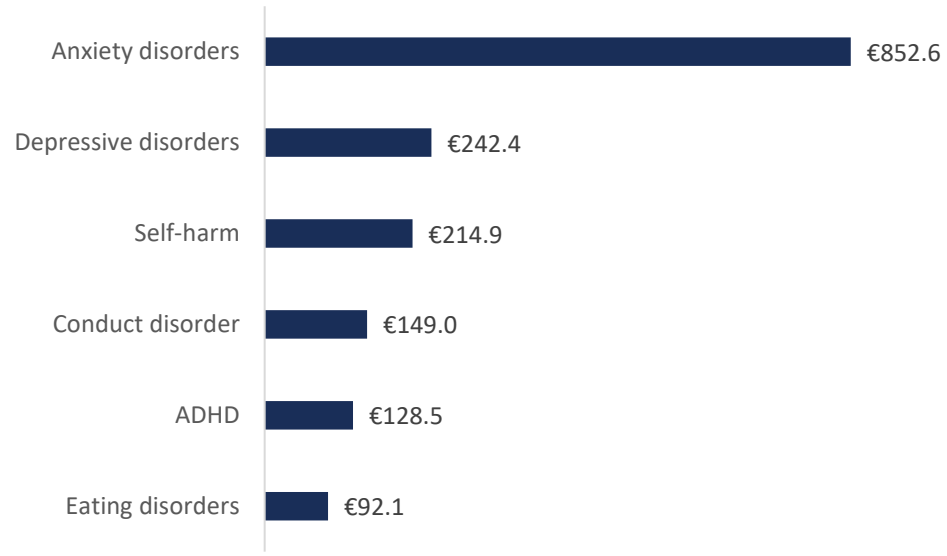
Source: EPRS Youth Mental Health Model, this study. Underlying data from Eurostat, GBD, and OECD.

Cost distribution by condition

Six conditions account for the bulk of youth mental ill-health costs. Anxiety disorders dominate, costing €853 billion over ten years. This is more than three times the cost of depression at €242 billion. Self-harm, conduct disorder, ADHD, and eating disorders each contribute between €92 billion and €215 billion. Together, anxiety and depression account for nearly two-thirds of the total.

These differences reflect case volumes, not differences in cost per case. The model applies a uniform per-case cost across all six conditions in this version. Anxiety dominates the cost picture because it affects the largest number of young people, around 9.5 million in 2024 rising to 12.3 million by 2033, as set out in Section 6.3. Depression is the second largest contributor for the same reason. A future version of the model will use condition-specific and severity-weighted per-case costs.

Figure 8 – Cost of youth mental ill-health by condition, EU-27, 2024 to 2033, central case in present value (billion)



Note: cost differences across conditions reflect case volumes, not differences in cost per case. The model applies a uniform per-case cost across all six conditions in this version. Source: EPRS Youth Mental Health Model. Underlying data from Eurostat, GBD, and OECD.

Cost distribution by Member State

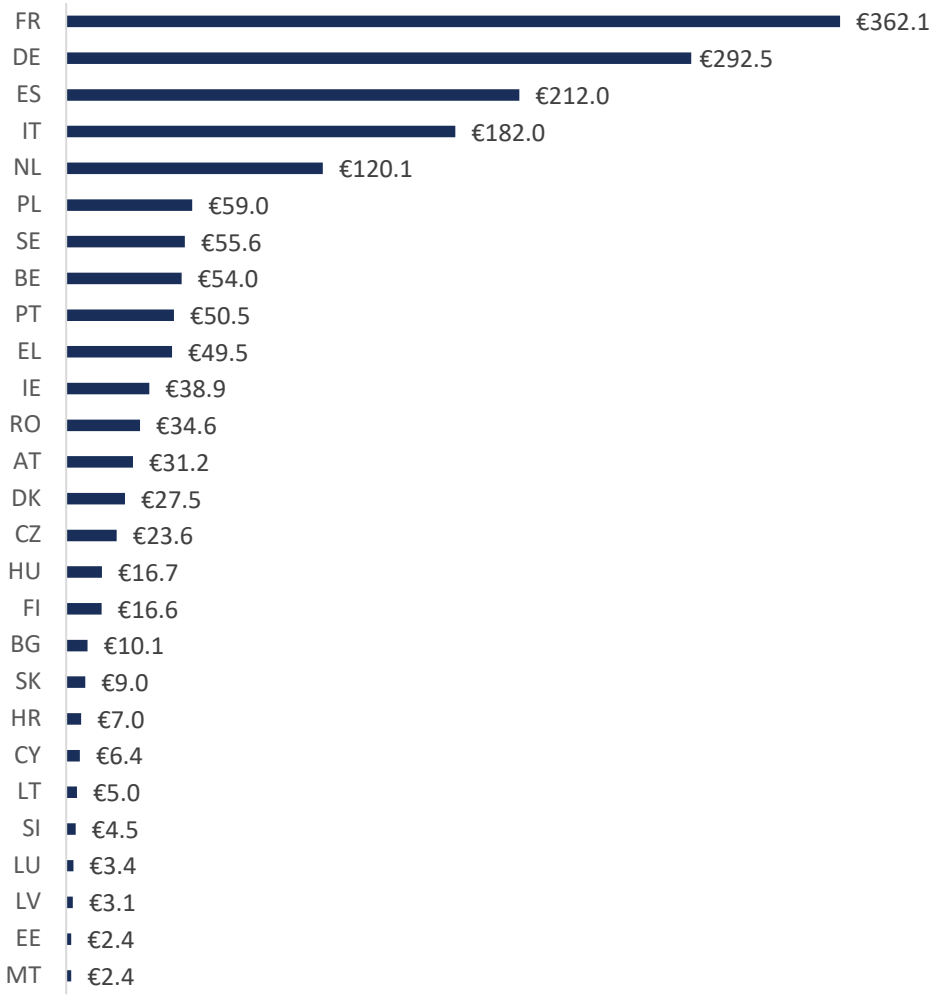
Costs are concentrated in the largest Member States, but population is not the only driver. Recorded prevalence rates also differ markedly across the EU-27, and these two factors together shape the country ranking.

France carries the largest absolute cost at €362 billion over ten years. Germany follows at €292 billion. Spain and Italy account for €212 billion and €182 billion, respectively. The Netherlands is the fifth-largest contributor at €120 billion. The five largest contributors together account for around two-thirds of the EU-27 total.

France ranks above Germany on two counts. France has a slightly larger youth population aged 10 to 24 (13.2 million per year against 12.0 million), and a higher recorded prevalence rate among youth (35 % against 31 % on a comorbidity-unadjusted basis). The Netherlands ranks fifth, ahead of Poland and Romania, despite having a smaller youth population. This reflects markedly higher recorded prevalence in the Netherlands (48 %) than in Poland or Romania (around 14 % to 15 %).

Per-case costs are held uniform across Member States in this version of the model. The country ranking therefore reflects two underlying drivers: youth population size and recorded prevalence. It does not reflect differences in clinical severity, treatment efficacy, or service quality. Recorded prevalence rates themselves are sensitive to national diagnostic and surveillance practices, so cross-country comparisons should be read with that caveat in mind.

Figure 9 – Cost of youth mental ill-health by Member State, EU-27, 2024 to 2033, central case in present value (billion)



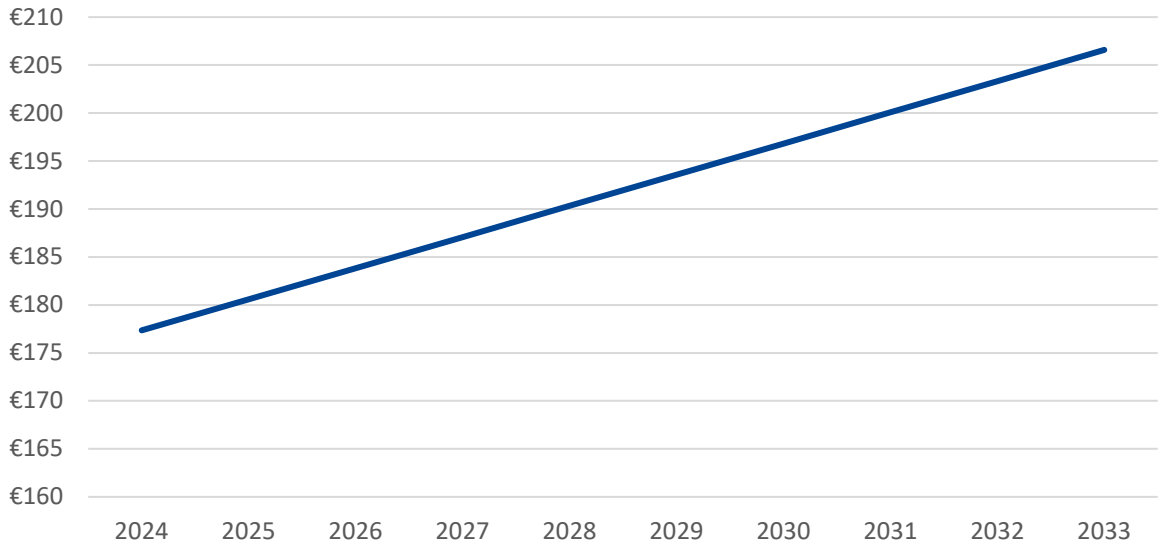
Source: EPRS Youth Mental Health Model, this study. Underlying data from Eurostat, GBD, and OECD.

Annual cost trajectory

Costs grow each year. Annual costs rise from €177 billion in 2024 to €207 billion in 2033 in the central scenario. That is a 17 % increase over the decade. The growth is driven by the prevalence trajectory set out in Section 6.3, principally the continued rise in anxiety. The youth population itself declines slightly over the period, so the cost rise reflects rising rates of mental ill-health, not a larger young population.

The annual figures show that the burden compounds over time. Costs in 2033 are around €30 billion higher than in 2024, and each intervening year carries a progressively higher annual cost. This pattern matters for interpreting the present-value totals: the €1.68 trillion ten-year headline reflects a growing, not a stable, annual burden.

Figure 10 – Annual cost of youth mental ill-health, EU-27, 2024 to 2033, central case (billion)



Note: annual figures are reported undiscounted. The €1.68 trillion ten-year headline expresses the same trajectory in 2024 present value at 3%. Source: EPRS Youth Mental Health Model. Underlying data from Eurostat, GBD, and OECD.

6.5. Limitations and uncertainties

The model is a transparent evidence synthesis, not a microsimulation or formal impact assessment. Several limitations should be borne in mind when interpreting the figures.

First, the per-case cost is uniform across conditions and severity levels in this version. This is a v0 simplification, derived from all-ages OECD data and applied to youth cases. Condition-specific and severity-weighted costs would refine the breakdowns in Section 6.4, particularly the by-condition picture. The headline total is less sensitive to this assumption.

Second, the model treats each condition independently. Summing across the six conditions over-counts young people who experience comorbid conditions. The condition totals in Section 6.4 should therefore be read as upper bounds. Applying a comorbidity adjustment factor of 0.4 to 0.6 brings the headline total within the conservative-to-central range reported.

Third, the prevalence trajectory for self-harm, conduct disorder, and eating disorders is synthesised from literature anchors, scaled by each country's depression-prevalence index. This was necessary due to limited disaggregated EU-27 data for these conditions. The synthesised series is used with a wider uncertainty band of plus or minus 30 %.

Fourth, the projection of prevalence rates beyond 2023 is a structural assumption. The central case extrapolates a linear trend; the conservative case holds rates flat; the optimistic case decays the trend. None of these is a forecast in the strict sense. They bracket what continued inaction is likely to produce.

Fifth, the model does not capture costs falling on businesses, the costs to families and carers, or the broader social costs of stigma and reduced wellbeing. The figures presented are therefore conservative in their coverage of the full burden.

Sixth, the model is not designed to support cross-country comparisons of severity. Member State rankings reflect population size and per-case cost differences, not differences in clinical need or service quality.

Seventh, prevalence rates used in the model come from the Global Burden Disease (GBD) estimates and the European Health Interview Survey (EHIS), scaled to the EU-27. These rates reflect what national systems record, not necessarily what young people experience. Countries with stronger diagnostic capacity, broader screening, and higher mental health awareness tend to record higher prevalence. This affects cross-country comparisons. The Netherlands records prevalence near 48 %, while Poland and Romania record rates closer to 15 %. Some of this difference reflects real variation in mental health outcomes. Some reflects differences in how those outcomes are detected and reported. Country rankings in the cost breakdown should be read with this caveat in mind. They are most reliable as indicators of where the recorded burden is highest, not as a measure of which Member States have the worst outcomes.

These limitations are documented in the technical annex. They do not undermine the headline finding that the cost of inaction is large, multi-system, and rising. They do mean that any single number quoted from this chapter should be read alongside the uncertainty range.

7. Impacts of the policy options

This chapter links the options developed in Chapter 5 with the cost-of-inaction baseline from Chapter 6. It uses the model's avoided-cost scenarios (for 1-10 % reductions in prevalence) together with evidence from Chapters 2–4 to assess what different EU-level options and combinations could plausibly deliver, and how they compare on reach, evidence, EU competence and equity.

Key findings

The model shows the overall benefits, not option-specific forecasts: Using the baseline from Chapter 6, the chapter shows how much cost could be avoided at different prevalence-reduction levels (1–10 %), but it does not assign precise reductions to individual options. Instead, it combines these scenarios with qualitative evidence to map which options could credibly contribute to which ranges.

School-based promotion and youth-friendly services are central to achieving meaningful reductions: Based on international evaluations, school-based promotion (Option 1) is plausibly associated with a 1–5 % reduction in prevalence over a decade if implemented at scale, while youth-friendly early-intervention services (Option 2) have the strongest clinical and economic evidence and could contribute to a 3–10 % reduction. In combination, they are the most credible drivers of a 5–10 % reduction (equivalent to €84–168 billion in avoided cost).

Other options are essential complements and enablers: Digital tools (Option 4) can extend reach but have more limited direct impact; social prescribing (Option 3) addresses equity for hard-to-reach groups but lacks large-scale quantitative evidence; digital regulation (Option 5) acts upstream on digital determinants but its mental-health impact is not yet well quantified; data and governance (Option 6) do not reduce prevalence directly but are indispensable for targeting and evaluating all other actions.

Trade-offs span evidence, competence, reach and equity: Options with the strongest evidence and equity benefits (notably Option 2) sit in areas where the EU has only supporting competences and rely heavily on Member State implementation. Options with the strongest EU legal bases (notably Option 5) have weaker direct mental-health evidence. Universal options (Options 1, 4 and 5) maximise reach but can miss the most marginalised, while targeted options (Options 2 and 3) focus on high-need groups at smaller scale.

A combined package is required to reduce the cost of non-Europe: No single option dominates across all criteria. The analysis points towards a portfolio approach: combining school-based promotion and youth-friendly services (Options 1 and 2) as the backbone of prevalence reduction; adding social-prescribing pathways (Option 3) to reach excluded groups; using digital-tool quality frameworks and digital regulation (Options 4 and 5) to address online determinants; and strengthening data, monitoring and governance (Option 6) to make the whole system more effective and accountable.

7.1. Purpose of the chapter

Chapter 5 set out the policy options for EU action on youth mental health in a digital era. Chapter 6 estimated the cost of continuing on the current trajectory, putting a figure of €1.68 trillion in present value on a decade of inaction. This chapter brings the two together. It asks what each option could plausibly deliver, how the options compare on grounds beyond cost, and what trade-offs the European Parliament would face in deciding between them.

The chapter is deliberately a synthesis. It does not repeat the descriptive material in Chapter 5 or the cost build-up in Chapter 6. Readers seeking the legal basis, design features, or pros and cons of a given option are referred back to Section 5.5. Readers seeking the modelling assumptions are referred to Sections 6.2 and the technical annex.

7.2. What the model can and cannot say

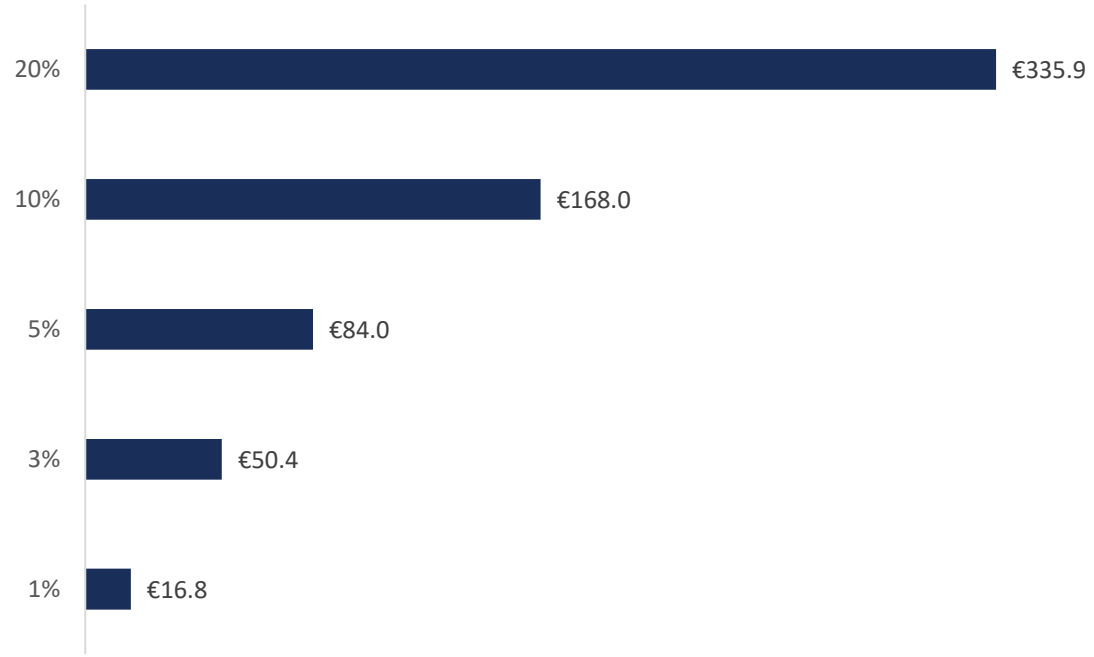
The model estimates the avoided cost of inaction under five illustrative levels of prevalence reduction: 1 %, 3 %, 5 %, 7 %, and 10 %. It does not estimate the impact of any individual policy option. The link from option to reduction level is qualitative, drawing on case study evidence and the wider literature reviewed in Chapter 4.

We make this distinction explicit because it shapes how the rest of the chapter should be read. The avoided-cost figures show the size of the prize at different levels of ambition. The mapping from option to plausible reduction range shows which options could credibly contribute to which level. Neither is a forecast. Both are intended to inform a comparative judgement about where EU action could deliver most value.

7.3. The scale of what is at stake

0 shows the avoided cost of mental ill-health among young people in the EU-27 over 2024 to 2033, under five prevalence reduction scenarios. Figures are in present value at a 3 % discount rate, central case.

Figure 11 – Avoided cost under different prevalence reduction scenarios, EU-27, 2024 to 2033, central case in present value (billion)



Source: EPRS Youth Mental Health Model, this study. Underlying data from Eurostat, GBD, and OECD.

Even modest reductions matter at EU scale. A sustained 1 % reduction in prevalence over the decade would avoid around €17 billion in present value. A 5 % reduction would avoid around €84 billion. A 10 % reduction, at the upper end of what combined action might deliver, would avoid around €168 billion.

These figures are linear in the reduction level by construction, because the model applies a uniform per-case cost across conditions. They should be read as orders of magnitude rather than precise estimates. The point is that the cost of inaction is large enough that even partial progress carries

substantial economic value, before any account is taken of the human and social benefits set out in Section 2.4.

7.4. What different options could plausibly deliver

Table 9 – Policy options and plausible prevalence reduction ranges maps each policy option to a plausible prevalence reduction range, drawing on case study evidence. Two options carry no defensible range. Social prescribing (Option 3) lacks comparable evaluations of youth schemes at scale, although case study evidence is promising. Data and governance (Option 6) does not act on prevalence directly; it underpins the targeting and evaluation of all other options.

Table 9 – Policy options and plausible prevalence reduction ranges

Policy option	Plausible prevalence reduction	Headline evidence	Case study source
Option 1: school-based promotion	1 % to 5 %	YAM: 50 % reduction in suicide attempts. MindOut: gains in coping and mental health.	Ireland, England, Norway
Option 2: youth-friendly services	3 % to 10 %	Prompt Mental Health Care (PMHC): symptom reduction at €9 000 to 14 000 per quality-adjusted life year (QALY). Jigsaw: 57 % to 66 % reliable improvement.	Norway, Ireland, Australia
Option 3: social prescribing	No defensible range	Promising case study evidence (Barnardo's LINK, C.O.P.E.) but no comparable evaluations of youth schemes at scale.	England, Italy
Option 4: digital tools framework	1 % to 3 %	ReachOut: 81 % retention, significant symptom reductions over 12 weeks.	Australia, Norway
Option 5: digital regulation	Insufficient evidence for a defensible range	Australia eSafety Act: 4.7 million under-16 accounts removed in three months.	Australia, England
Option 6: data and governance	Acts indirectly	Underpins the targeting and evaluation of Options 1 to 5; does not act on prevalence directly.	Cross-cutting

Source: Compiled by the authors from case study evidence reviewed in Chapter 4.

Two patterns emerge. First, healthcare-based services (Option 2) have the strongest evidence of mental-health impact, with peer-reviewed effect sizes from the Norwegian PMHC programme and the Irish Jigsaw network. Second, the most credible combination pairs school-based promotion with youth-friendly services. Together, these two options could plausibly support a 5 % to 10 % prevalence reduction over the decade, equivalent to €84 billion to €168 billion in avoided cost in present value.

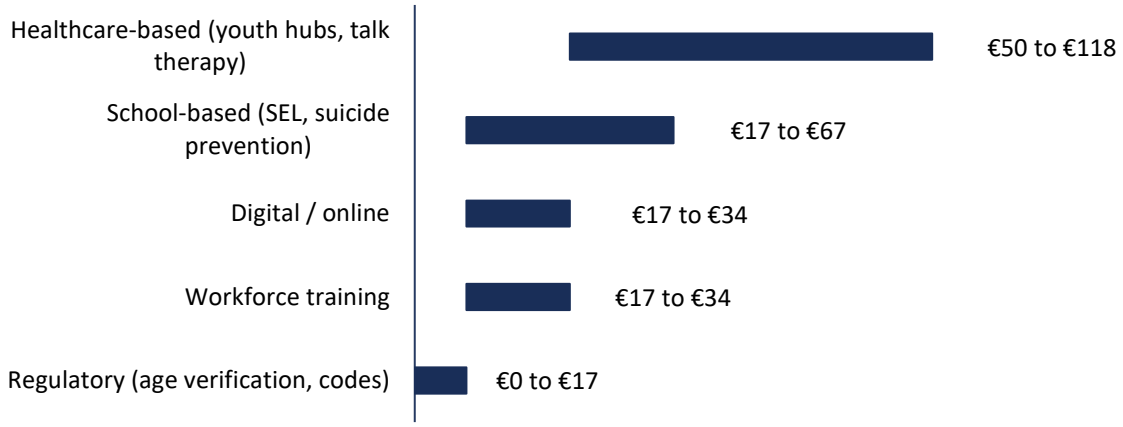
The other options are not less important; they answer different questions. Digital tools (Option 4) extend the reach of evidence-based support to young people who do not engage with face-to-face

services. Digital regulation (Option 5) acts on the upstream drivers identified in Chapter 2, but the evidence linking specific regulatory measures to mental-health outcomes is still thin. Social prescribing (Option 3) reaches young people who fall outside both schools and clinics. Data and governance (Option 6) is the precondition for knowing whether any of the other options is working.

The figure below shows how much of the cost of inaction each option family could avoid. We take the plausible reduction in prevalence that each family supports, drawn from the case-study evidence in Chapter 5. We then apply that reduction to the €1.68 trillion baseline. The result is a range of avoided cost over the ten years to 2033, shown in present value. Healthcare-based options offer the largest potential saving, of roughly €50 to €168 billion. School-based options follow, at €17 to €84 billion. Regulatory options offer the least, and rest on the weakest evidence.

These figures need careful reading. They are gross savings. They do not subtract the cost of delivering each option, so they are not a net benefit or a return on investment. The reduction behind each bar is a plausible estimate, not a guaranteed result. The bars show a range of assumptions, from cautious to optimistic. They are not statistical confidence intervals. The ranges should not be added together, because options reaching the same young people would overlap. The figures are best read as an indication of relative scale, not precise forecasts.

Figure 12 – Avoided costs of inaction by policy option (billion)



Source: EPRS Youth Mental Health Model, this study.

7.5. Comparing options on dimensions beyond cost

Avoided cost is one criterion, but it is not the only one. Table 4 scores the six options against five dimensions that matter for an EU-level decision: reach, strength of evidence, EU competence, implementation complexity, and equity. The scoring is qualitative and ordinal, drawing on the case study evidence and legal analysis set out in Chapters 3 to 5.

Table 10 – Qualitative scoring of policy options against five criteria

Policy option	Reach	Evidence	EU competence	Implementation complexity	Equity
Option 1: school-based promotion	High	Medium-High	Medium (Art. 165 TFEU, supporting)	Medium	High
Option 2: youth-friendly services	Medium-High	High	Low (Art. 168 TFEU, MS primary competence)	High	High
Option 3: social prescribing	Medium	Low-Medium	Low-Medium (Arts. 168, 165, 153 TFEU)	Medium	High (reaches vulnerable youth)
Option 4: digital tools framework	High	Low-Medium	Medium (Arts. 168, 114 TFEU)	Low	Medium (depends on access)
Option 5: digital regulation	High	Low	High (Art. 114 TFEU, already enacted)	Medium	Mixed
Option 6: data and governance	Cross-cutting	n/a (acts indirectly)	Medium-High (Arts. 168, 338 TFEU)	Low-Medium	Indirect (enables targeting)

Source: Compiled by the authors. Scores are ordinal (Low, Medium, High) and reflect the evidence and analysis in Chapters 3 to 5.

The scorecard reveals tensions that the avoided-cost figures alone cannot show. Healthcare-based services score highest on evidence and equity, but lowest on EU competence: under Article 168(7) TFEU, the organisation of health services is primarily a Member State matter. Digital regulation scores highest on EU competence, but lowest on the strength of mental-health evidence: the legal instruments exist, but their causal link to youth mental-health outcomes is yet to be established. School-based promotion scores well across the board, but its delivery depends on Member State buy-in in an area where the EU has only a supporting competence under Article 165 TFEU.

Three options act mainly on inequalities. Social prescribing reaches young people in vulnerable situations who are poorly served by universal services. School-based promotion, if targeted at disadvantaged areas, can narrow gaps in access to early support. Healthcare-based youth services close the treatment gap for adolescents and young adults whose problems sit between universal

prevention and specialist care. These equity gains do not show up in headline avoided-cost figures, but they are central to the case for EU action set out in Section 2.4.

Two options are best understood as enabling conditions for the others. Data and governance (Option 6) does not act on prevalence directly, but without it, neither the targeting nor the evaluation of Options 1 to 5 can be done well. The digital tools framework (Option 4) is similarly enabling: a quality-assured catalogue of digital mental-health tools makes it more likely that the digital components of school-based programmes, youth services, and social prescribing schemes deliver on their promise.

7.6. Trade-offs and combinations

No single option dominates. The options that score best on evidence (Option 2) are weakest on EU competence. The options that score best on EU competence (Option 5) are weakest on evidence of mental-health impact. The options that score best on universal reach (Options 1, 4, and 5) are not the same as those that reach young people in the most vulnerable situations (Options 2 and 3).

Three trade-offs are likely to shape the European Parliament's decision. The first is between evidence and competence. EU action carries most weight where the legal basis is strongest, but the evidence of mental-health impact is currently weakest in those areas, particularly digital regulation. The second is between reach and depth. Universal options reach all young people but may not reach the most vulnerable; targeted options reach the most vulnerable but at smaller scale. The third is between speed and sustainability. Digital regulation can move quickly within the existing acquis, but its mental-health effects will be slow to materialise and hard to attribute. Service-based options are slower to set up, but their effects on prevalence and on the cost of inaction are better evidenced and more durable.

These trade-offs argue for a combination of options rather than a single preferred path. School-based promotion and youth-friendly services together address the largest share of unmet need with the strongest evidence. Digital regulation and digital tools together address the upstream drivers and the digital channels through which young people seek support. Social prescribing reaches young people who fall outside both. Data and governance is the connective tissue that makes the rest auditable and improvable. Section 5.5 sets out the design choices and legal bases for each of these options in full; this chapter has shown what they could deliver, alone and in combination.

8. Conclusions and recommendations

8.1.1. Answers to the four core research questions

What is the current situation regarding the mental health of young people (up to 24 years) in the EU-27, and how does it compare with developments in selected non-EU countries?

Youth mental ill-health in the EU-27 is high and rising, with anxiety and depression leading the burden. Around one in five young people live with a diagnosable mental disorder, and many more experience subclinical distress (low mood, anxiety, sleep problems, multiple health complaints). Problems are concentrated among girls and young women (although young boys and men are more susceptible to specific symptoms), young people in socio economically disadvantaged or marginalised situations (including migrants, refugees, LGBTQIA+ youth and those in care), and those with neurodevelopmental conditions. Almost one in two 15- to 24-year-olds report unmet mental-health needs. Systems are marked by long waiting times, an acute-care bias, a large 'missing middle' between schools/primary care and specialist psychiatry, and high out-of-pocket costs for families.

What are the main factors shaping this situation, including the digital environment and recent crises, and how do they affect young people's development, education, social participation and later labour-market outcomes?

The youth mental-health crisis is driven by an interaction between: (i) early onset and developmental sensitivity of mental-health conditions; (ii) offline adversities such as poverty, family conflict, discrimination and trauma; (iii) digital environments that, promote design-driven overuse, exposure to harmful content and risky AI-mediated interactions; and (iv) under-resourced, fragmented and digitally ill-equipped systems. Early childhood is a sensitive period in which excessive, passive and solitary screen use can displace sleep, active play and responsive caregiving, with potential implications for later self-regulation and mental health. Later, whilst most adolescents navigate digital spaces without major harm, some are vulnerable to the negative effects and those already struggling offline are more likely to develop problematic patterns of use and to encounter issues such as cyberbullying, self-harm and body-image pressures. System weaknesses mean emerging symptoms often go undetected or unsupported until crises arise, disrupting education, social development and transitions into work, and leading to substantial long-term losses in human capital. It is important to note however that high-quality quantitative studies find that associations between general digital-technology use and adolescent wellbeing are modest and smaller than those for factors such as sleep, bullying or family adversity. Digital determinants are therefore best understood as one contributing factor and amplifier among several.

Within the existing EU legal and policy framework, what types of legislative and non-legislative action could the EU take to support and improve youth mental health in a digital era?

Within its competences, the EU can act on key determinants of youth mental health, especially in the digital and internal-market sphere, and support Member States in prevention and early intervention. The options identified fall into three areas: (i) prevention and support in everyday settings, an EU support package for school-based mental-health promotion and digital well-being (Option 1), a framework for youth-friendly early-intervention services ('youth hubs', Option 2), and an initiative on social prescribing and community-based pathways for vulnerable youth (Option 3), complemented by a quality and safety framework for digital mental-health tools (Option 4); (ii) digital regulation and platform governance, child-centred implementation of the DSA, AVMSD, AI Act and CSAM rules, and, where justified, assessment of additional measures for high-risk services and features (Option 5a/5b); and (iii) data, monitoring and governance, harmonised indicators, stronger research and integrated cross-sector governance for youth mental health in a digital era (Option 6).

What are the likely impacts of further EU-level action, and what are the economic, social and fundamental-rights implications of maintaining the status quo ('Cost of non-Europe')?

The model in Chapter 6 estimates that youth mental ill-health currently costs the EU-27 around €177 billion per year, and €1.68 trillion over 2024-2033 in present value, across health care, social protection, education and lost productivity. Anxiety accounts for the largest share, reflecting its high and rising prevalence. Even modest reductions in prevalence at EU scale would yield substantial avoided costs; a 5 % sustained reduction over a decade would avoid on the order of €84 billion in present-value terms. School-based promotion and youth-friendly early-intervention services have the strongest evidence base and are best placed to deliver such reductions when scaled, while social prescribing, digital regulation and data/governance measures address specific gaps and determinants. Maintaining the current trajectory (Option 0) would leave the main structural weaknesses and inequalities largely unchanged and implies a high and rising cost of non-Europe in

terms of avoidable ill-health, lost educational and labour-market potential and multi-system public spending.

8.1.2. Priority recommendations for the European Parliament and other EU actors

1. Make prevention and early intervention in everyday settings a central EU priority: Parliament should support an EU support package for school-based promotion and digital wellbeing (Option 1) and an EU framework for youth-friendly early-intervention services (Option 2), using Articles 165 and 168 TFEU. These should be clearly voluntary, evidence-based and equity-oriented, with funding via EU4Health, ESF+, Erasmus+ and cohesion funds prioritising disadvantaged regions and schools, and robust evaluation. Furthermore, families of those who have mental health issues should be involved where possible in the measures and interventions.

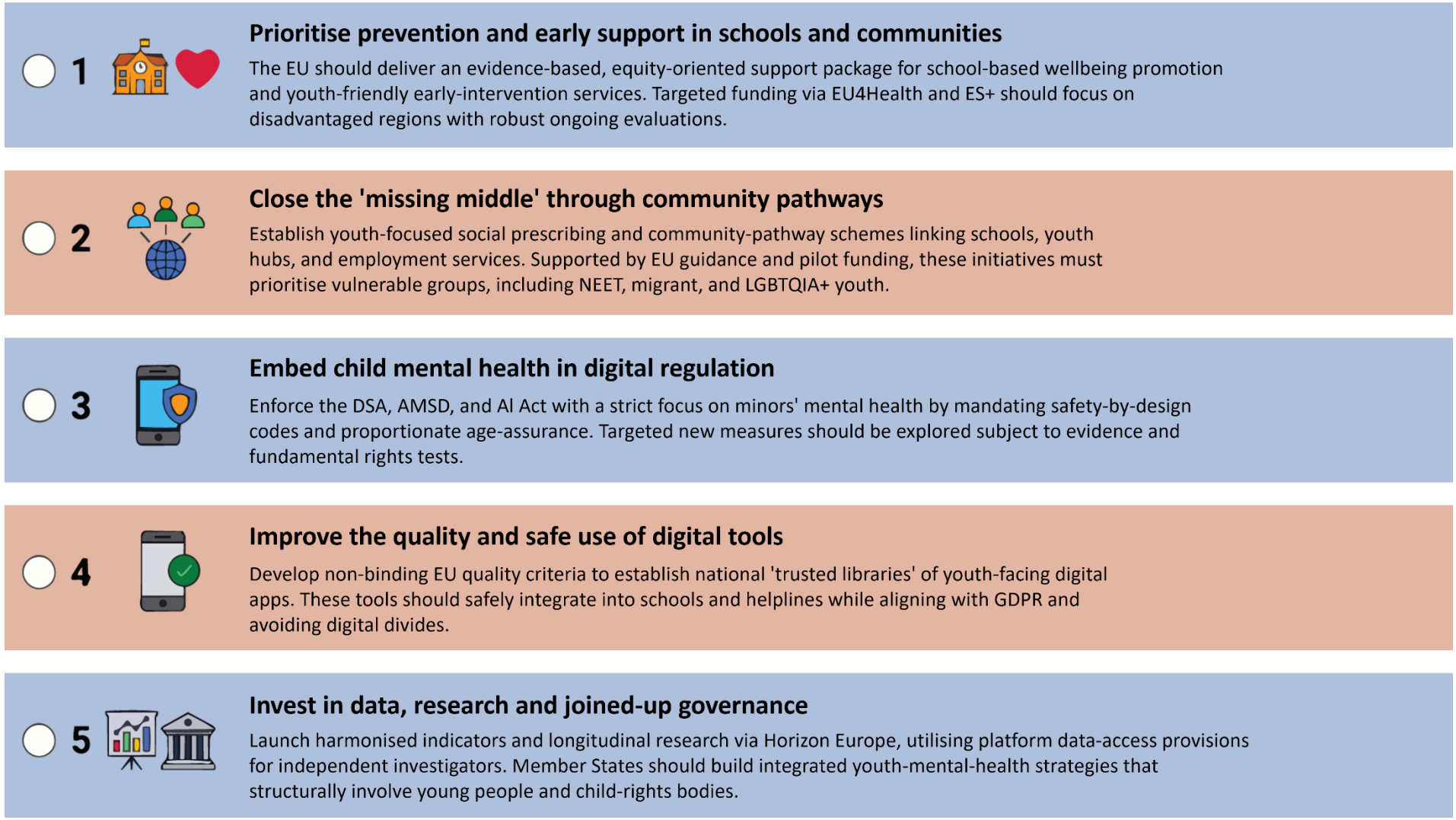
2. Address the 'missing middle' and social determinants through community-based pathways: Parliament and the Commission should encourage Member States to develop youth-focused social-prescribing and community-pathway schemes (Option 3), linked to schools, youth hubs, employment and social-inclusion services. EU guidance, pilot funding and peer learning can support design, targeting and safeguarding, with a clear focus on NEET youth, migrants and refugees, LGBTQIA+ young people, rural communities and care-experienced youth. In addition, it is important to have the families of the concerned on board and involved where feasible.

3. Embed mental-health safeguards in the implementation of EU digital legislation: Parliament should press for a child-centred interpretation and enforcement of the DSA, AVMSD, AI Act and CSAM rules (Option 5a). This includes clarifying that systemic-risk duties cover mental-health risks for minors, developing safety-by-design codes of conduct for children, integrating child-health expertise into supervision, and supporting proportionate, privacy-preserving age-assurance practices. Parliament may also consider inviting the Commission, under Article 225 TFEU, to assess whether additional targeted measures are warranted for specific high-risk services or design patterns (Option 5b), subject to strict evidence, proportionality and fundamental-rights tests.

4. Improve the quality and integration of digital mental-health tools: The Commission should develop non-binding quality and safety criteria for youth-facing digital mental-health tools and support Member States in creating 'trusted libraries' of digital mental health tools and integrating vetted tools into school-based programmes, youth hubs and helplines (Option 4). This should be aligned with the GDPR, European Health Data Space and medical-device rules, and implemented with an explicit equity lens to avoid widening digital divides.

5. Strengthen data, research and governance as enabling conditions: Parliament should support efforts to harmonise core indicators on youth mental health and digital exposure (Article 338 TFEU), to fund longitudinal and quasi-experimental research on digital determinants and interventions via Horizon Europe and EU4Health, and to use DSA and AI Act data-access provisions for independent research under strong safeguards (Option 6). It should encourage integrated youth-mental-health strategies and governance structures linking health, education, digital and social portfolios, as well as systematic involvement of youth and child-rights bodies in national decision-making.

Figure 13 – Priority recommendations



Source: Authors' analysis of priority recommendations

8.1.3. Implementation and governance considerations

Implementation will require careful attention to competences, capacity and coordination. In education and health, where the EU has supporting competences, measures should be framed as voluntary frameworks, guidance and co-funding, co-designed with Member States to respect national ownership and diversity. Explicit equity criteria in EU funding programmes can help ensure that resources flow to underserved regions and groups, not only to well-resourced systems.

Workforce capacity is a binding constraint, especially for Options 2 and 3. Parliament and the Commission should encourage Member States to align any scaling of youth hubs or social-prescribing schemes with broader workforce-planning and training strategies, including task-shifting and peer roles where appropriate, and to invest in staff well-being in schools and youth services.

Effective governance will require cross-sector coordination. At both EU and national level, mechanisms are needed to connect health, education, youth, social and digital-regulation actors so that school-based measures, youth services, community pathways and digital regulation reinforce each other rather than operate in silos. At EU level, existing platforms (for example under EU4Health, BIK+ strategy, the EU Youth Strategy and the comprehensive approach to mental health) can be used or expanded to support this.

Finally, implementation of digital-regulation-related options must remain attentive to proportionality and fundamental rights. Age-assurance and safety-by-design measures must balance protection with privacy and non-discrimination and should be informed by child-health expertise and by young people's perspectives.

8.1.4. Data and evidence gaps, and implications for future monitoring

The study has identified several important data and evidence gaps:

- Limited, non-harmonised EU-wide indicators on youth mental-health outcomes, subclinical distress, service access and digital-use patterns, with insufficient disaggregation by age, sex, socio-economic status, migrant/refugee status, disability and minority status.
- Heavy reliance on cross-sectional, self-reported surveys to study digital determinants, with relatively few longitudinal and quasi-experimental studies on specific platform-design changes or policy interventions.
- Sparse evaluations of youth-focused social-prescribing schemes and of large-scale, youth-oriented digital-regulation measures, particularly in terms of mental-health outcomes and equity effects.
- Limited linkage between survey, clinical and digital-behaviour data, constraining the ability to understand interactions between offline vulnerabilities, digital exposures and system responses.

For future monitoring, the European Parliament could encourage the Commission and Member States to:

- Agree and implement a core set of youth-mental-health and digital-exposure indicators across EHIS, HBSC, PISA and Eurostat statistics, with appropriate disaggregation and regular reporting;
- Use Horizon Europe and EU4Health to fund longitudinal and quasi-experimental research on key digital features (for example recommender-system changes, smartphone policies, AI-based tools) and on the cost-effectiveness of Options 1–4 in different contexts;

- Operationalise DSA and AI Act data-access provisions to enable independent auditing of algorithmic systems affecting minors, under strict privacy and security conditions; and
- Integrate monitoring results into policy cycles at EU and national level, so that data are used not only for reporting but to adjust funding, guidance and enforcement priorities over time. A stronger evidence and monitoring infrastructure is essential if the EU and its Member States are to move beyond reactive responses and build a coherent, adaptive approach to safeguarding youth mental health in a rapidly evolving digital era.

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Annex I: Detailed research question matrix

Table 11 – Research question matrix

Main research question (ToR-aligned)	Sub-questions (as addressed in the study)	Relevant chapters / sections	Main methods and sources
1. What is the current state of youth mental health (age 0–24) in the EU-27 and comparable non-EU countries?	1.1 Prevalence of key conditions (anxiety, depression, ADHD, etc.) by age and sex.	2.1.1; 2.4.1; 6.3	Systematic review (GBD, WHO, OECD, UNICEF, HBSC, PISA); secondary data analysis; EPRS Model.
	1.2 Behavioural and functional manifestations (digital overuse, school drop-out, NEET risk).	2.1.2; 2.4.2; 2.4.3	Literature review; cohort/survey synthesis; case-study interviews (clinicians/educators).
	1.3 Treatment gap and access barriers (waiting times, costs).	2.1.3; 2.3.4; 4.1.4	Policy review (OECD, WHO, Eurochild); case-study interviews; service use data.
	1.4 Comparison with non-EU comparators (Australia, Norway, UK).	2.1–2.4; 4.1–4.3	Cross-country comparison; 7 in-depth case studies (AU, IE, IT, NL, NO, PL, UK).
	1.5 Distribution across groups (gender, SES, migrant, LGBTQIA+, disability).	2.1.1; 2.3.3; 2.4.1; 4.1.4; 4.2.4	Disaggregated evidence (HBSC, PISA, national surveys); targeted literature on vulnerable groups.
2. What are the main factors shaping youth mental health, including digital determinants and recent crises?	2.1 Developmental trajectories and brain development influence on vulnerability.	2.2; Box 1; 2.3.3	Review of epidemiology and neuroscience; cohort evidence (WHO, PMNCH, SEYLE).
	2.2 Digital environment mechanisms (design-driven overuse, AI interactions).	2.2.1; 2.3.1; 2.4.1–2.4.2; Box 3	Review of HCI/platform studies; social media and AI companion evidence; HBSC data.
	2.3 Interaction between offline vulnerabilities (poverty, trauma) and online risks.	2.3.3; 2.2.1; 2.4.1–2.4.2; 4.2.4	Psycho-traumatology literature; UNICEF, WHO; interviews with frontline workers/NGOs.
	2.4 Impact of recent crises (COVID-19, climate, conflict, economic pressure).	1.1; 2.1.1; 2.3.3; 4.1.4	Review of OECD, WHO, Eurofound, and Disrupting Harm studies; comparator reports.

Main research question (ToR-aligned)	Sub-questions (as addressed in the study)	Relevant chapters / sections	Main methods and sources
	2.5 Life-course outcomes (education, social participation, labour market).	2.4.2–2.4.4; 4.2.1–4.2.2; 6.4	Longitudinal and cost-of-illness literature; model linking prevalence to 4 cost streams.
3. What can the EU do (legislative and non-legislative) to support youth mental health in a digital era?	3.1 EU competences and legal bases (health, education, digital/internal market).	3.1.1–3.1.2; 5.3	Legal analysis of TFEU (Arts. 16, 114, 168, etc.) and Charter (Arts. 7, 24, 35).
	3.2 Existing digital acquis relevant to minors (DSA, AI Act, GDPR, etc.).	3.2.1–3.2.4; 4.1.3; 4.2.3; 5.5.6	Documentary analysis of legislation; Commission proceedings against VLOPs.
	3.3 Current EU strategies/programmes (EU4Health, BIK+, Child Guarantee).	1.2; 3.2–3.3; 3.4–3.5	Review of EU communications and 'Comprehensive approach to MH.'
	3.4 Gaps and governance challenges (enforcement, fragmentation, workforce).	3.6.1–3.6.5; 4.1.4; 4.3	Synthesis of literature and stakeholder reports; gap analysis against WHO/UN guidance.
	3.5 Feasibility of EU-level actions (Options 1–6).	5.1–5.5	Option development (ToR, EP resolutions, Council conclusions); mapping to funds.
4. What are Member States and selected non-EU countries already doing, and what works?	4.1 Typology of national interventions (school-based, hubs, digital regulation).	4.1.1–4.1.4; Table 1	Policy and literature review (OECD, WHO, UNICEF); intervention typology.
	4.2 Maturity of interventions in case-study countries.	4.1; Table 1	7 country case studies; maturity assessment (scaling/funding); expert interviews.
	4.3 Effectiveness/cost-effectiveness of key models (e.g., YAM, Jigsaw).	4.2.1–4.2.3; Boxes 1–3	Review of evaluations and economic analyses; regulatory case studies.
	4.4 Implementation barriers (workforce, funding, 'missing middle').	2.3.4; 4.1.4; 4.2.4; 4.3.2	Interviews with clinicians and administrators; analysis of structural bottlenecks.

Main research question (ToR-aligned)	Sub-questions (as addressed in the study)	Relevant chapters / sections	Main methods and sources
	4.5 Model transferability and enabling conditions.	4.3.1–4.3.4; Table 2	Cross-case comparison; transferability assessments using OECD tools.
5. What concrete EU-level options exist and what do they target?	5.1 Identification of priority problem clusters.	5.2; 2.1–2.4; 3.6; 4.1–4.2	Synthesis across analytical chapters; problem-cluster matrix.
	5.2 Structure of 6 policy options by domain and EU levers.	5.3–5.4; Table 3	Option design matrix; alignment with Terms of Reference (ToR).
	5.3 Objectives, target groups, and subsidiarity for each option.	5.5.1–5.5.7; Boxes 1–3	Structured option fiches; legal analysis; evidence linkage.
	5.4 Addressing inequalities and vulnerable groups within options.	5.5.1–5.5.7; 4.2.4; 4.3.2	Equity analysis; case-study evidence on reach and barriers.
6. What is the 'cost of non-Europe' and associated benefit scenarios?	6.1 Projected prevalence under status-quo scenario.	6.3; 2.1.1; 2.4.1	EPRS Model; population projections; trends from GBD, EHIS, HBSC.
	6.2 Socio-economic costs across healthcare, education, and labour (10 years).	6.1–6.4; 2.4.4	Cost-of-illness modelling; OECD per-case costs.
	6.3 Sensitivity analysis (assumptions, discount rates, comorbidity).	6.2; 6.5	Scenario analysis (central, optimistic, conservative).
	6.4 Magnitude of avoided costs for 1–10% reduction scenarios.	6.4; 7.3	Modelled avoided-cost scenarios; link to prevalence reduction.
	7.1 Prevalence-reduction ranges associated with options.	7.2–7.4; Table 4	Qualitative mapping from intervention evidence to model scenarios.
	7.2 multi-criteria comparison (reach, evidence, competence, equity).	7.5; Table 5	Multi-criteria qualitative scoring; legal analysis; case-study evidence.

Main research question (ToR-aligned)	Sub-questions (as addressed in the study)	Relevant chapters / sections	Main methods and sources
	7.3 Trade-offs and complementarities between options.	7.6	Narrative analysis of option packages.
7. What are the likely impacts of EU-level options? 8. What are the key conclusions and recommendations?	7.4 Implications for fundamental rights (privacy, access to care).	3.1.2; 3.5; 7.5; 8.1.3	Charter-based analysis (Arts 7, 8, 24); UNCRC principles.
	8.1 Synthesis of findings against the four core EP questions.	8.1.1	Final synthesis of all chapters; explicit responses to ToR.
	8.2 Priority recommendations for EP, Commission, and MS.	8.1.2–8.1.3	Normative synthesis; legal competence analysis.
	8.3 Future evidence needs and monitoring priorities.	3.3.2; 6.5; 8.1.4	Gap analysis; mapping to Eurostat, EHDS, and Horizon Europe.

Source: Authors' methodology.

Annex II: Detailed methodology

Literature review

Objectives and timeframe

The review synthesised evidence on the mental health of young people aged 2–24 in the EU-27 (with agreed comparators), focused on:

- Status and trends by developmental stage (aged 2–5, 6–11, 12–17, 18–24), including condition clusters and access barriers.
- Digital exposure and environments (social media, video platforms, gaming, messaging/communities, AI chatbots/companions; relevant platform features such as recommender systems and notifications).
- Pathways linking digital exposure to mental health via content effects and displacement (sleep, physical activity, diet), including gateway risks (vaping/smoking/alcohol, gambling-like mechanics).
- Interventions and outcomes (school-based, healthcare and community, digital and regulatory, social prescribing, frontline doctor and teacher training), including evidence on implementation and Return on Investment (ROI) where available.
- Costs of mental ill-health and the cost of inaction.
- EU policy/legal context and potential legal bases for action (light mapping to feed the options longlist).
- Timeframe: 2012/2013–2026[302] (post–smartphone era and including the COVID-19 period). Foundational earlier studies may be retained if still the best available noting the original RfP mentioned 2008 as a starting point for the 'digital era'.

We did not conduct a formal systematic review or meta-analysis. Instead, we produced a structured, transparent evidence synthesis built from two complementary streams:

1. **Expert-curated core set**: an initial list of high-value publications and datasets nominated by the expert panel and core team (e.g., WHO/HBSC/ESPAD/Eurobarometer/GBD/OECD flagships; recent high-quality reviews and longitudinal studies; key national youth mental health surveys).
2. **Targeted search**: focused database and grey-literature searches using predefined strings and sources to fill gaps and ensure balanced coverage across themes (status/trends, digital determinants and exposures, access and barriers, system structure and capacity, interventions/ROI, costs/cost of non-Europe, policy/legal context), developmental stages (2–5, 6–11, 12–17, 18–24) disaggregated by gender, and geographies (EU-27 plus comparators).

We prioritised the highest-yield evidence (systematic reviews, longitudinal studies, large high-quality observational studies, and authoritative EU/WHO/OECD/ESPAD/HBSC outputs). To remain within the project budget, we used a tiered prioritisation process, AI-assisted screening and extraction under human QA.

[302] The 2012/2013 starting point marks the time when social media platforms (like Instagram and TikTok) and universal smartphone penetration shifted from early adoption to mass adolescent engagement, which is when the mental health crisis began to surge. This focuses the search on the true 'digital era' impact being investigated. It also fully encompasses major recent crises that are explicit research themes: the COVID-19 pandemic (and its aftermath), the climate emergency, Russia's invasion of Ukraine, and economic pressures.

We took a cautious public-health approach: when several studies pointed in the same direction and suggest that more exposure leads to greater risk or that exposure comes before the harm, we treated the finding as relevant for policy, while clearly stating any uncertainties and the possibility that cause and effect can run both ways.

Population, staging and conditions in scope

The following are in scope:

- Population: Children, adolescents, and young adults aged 2–24. Where studies report adjacent ranges (e.g., aged 1–17 or 16–25), we included them if the bulk of the sample falls within 2–24 or results are disaggregated.
- Geography: EU-27; comparators included those listed in the inception report (with the exception of some reports presenting evidence from the United States).
- Developmental staging: aged 2–5, 6–11, 12–17, 18–24. For each stage we reported condition clusters, key risk and protective factors (including digital determinants), and typical mental health support access barriers and service pathways (e.g., early-years and parenting supports, school-based identification, Child and Adolescent Mental Health Services (CAMHS), transition to adult services). We understand that developmental periods and exposure risks differ significantly by gender, and the search and coding methodology prioritised findings disaggregated by sex to account for this.
- Conditions and clusters: anxiety disorders, depressive disorders, self-harm and suicide, trauma and stressor-related – including Post-traumatic Stress Disorder (PTSD), eating disorders and body image problems, autism spectrum disorders, Attention Deficit Hyperactivity Disorder (ADHD) and other neurodevelopmental conditions, behavioural/conduct problems, early psychosis and severe mental illness (SMI), problematic social media use, gaming disorder (ICD-11 6C51), gambling disorder (ICD-11 6C50), alcohol use disorders, nicotine dependence and vaping, loneliness (as a risk state), sleep problems (both pathway and outcome). We also captured pornography-related body and genital dissatisfaction and steroid use among boys where evidence is available.
    - Note that this list is not exhaustive and the literature review focused on the scope of conditions and clusters.

Digital exposure: definitions and pathways

We defined digital exposure broadly as the interaction with the omnipresent digital environment. This includes discretionary screen time (non-school) quantified by: Platform and Activity (social media, video platforms, gaming, messaging platforms, AI chatbots and companions); Context and Timing (evening/night-time use, devices in bedrooms); Intensity (time and problem-use scales); and Platform Features (recommender systems, infinite scroll, notifications, age verification, content moderation).

We coded both content effects (e.g., cyberbullying, self-harm and eating content, pornography, hate and polarisation, misinformation) and displacement effects (sleep loss, reduced physical activity, less in-person socialising and outdoor time). We also explicitly tracked evidence on bidirectionality (where screen use leads to mental health problems that in turn affects higher screen use) and on 'gateway' links (e.g., social media exposure leading to vaping, smoking and/or alcohol initiation and escalation; or gambling-like mechanics).

Inclusion and exclusion criteria, and evidence hierarchy

We prioritised empirical studies and robust reports that:

- Are focused on the above-mentioned mental health outcomes, exposures, access or interventions among ages 2–24 in EU-27 and agreed comparators (as outlined in the Inception Report);
- Are published 2008–2026;
- Peer-reviewed or high-quality grey literature (e.g. WHO, OECD, EU institutions, national statistical offices, ESPAD, HBSC).
- Provides extractable data or robust narrative evidence on the variables in the codebook.

We excluded:

- Populations wholly outside age 2–24 without disaggregation;
- Purely opinion/commentary;
- Very low-quality or untransparent sources; and
- Contexts with limited transferability to Europe (unless particularly instructive for comparators).

We prioritised recent systematic reviews/meta-analyses, RCTs/quasi-experiments, longitudinal cohorts, large high-quality observational studies, and authoritative statistical and policy reports (WHO/WHO Europe, OECD, EU, ESPAD, HBSC). For access/capacity, we included credible administrative data and national audits. For digital determinants, we prioritised longitudinal and dose–response evidence and clearly flag limitations.

Search strategy

We employed a PRISMA-style strategy, looking at a timeframe of 2008–2026, English first, with selective inclusion of high-value national sources in other EU languages (translated securely and flagged).

- Searches covered:
- Biomedical and social databases, for example:
    - MEDLINE/PubMed
    - PsycINFO
    - Embase,
    - Web of Science/Scopus
    - Cochrane
- Policy and grey literature, for example:
- WHO IRIS
- OECD iLibrary
- EU portals
- UNICEF/Eurochild
- Statistical datasets, for example:
- Eurostat
- EHIS

- HSBC
- WHO Atlas
- GBD
- OECD
- National statistical offices

Search protocol

We combined population, outcome, and context terms using controlled vocabulary and text words, adapting to each database.

Illustrative search terms (to be tailored per database):

- We combined population terms (youth, adolescent*, child*, 'young adult*') with outcome and exposure terms (mental health, depress*, anx*, suicid*, 'self-harm', ADHD, PTSD, 'eating disorder*', 'problematic social media', 'gaming disorder', 'gambling disorder', loneliness) and digital terms ('social media', TikTok, Instagram, YouTube, Snapchat, Discord, 'screen time', 'smartphone*', gaming, 'AI chatbot*', 'recommender system*').
- We added gateway terms (e.g. sleep, circadian, 'physical activity', sedentary, 'ultra-processed food*', vaping, nicotine, e-cigarette*, alcohol, 'binge drinking', gambling, loot boxes, gacha). Add policy terms (DSA, AI Act, AVMSD, 'age verification', 'youth media protection', 'school phone polic*', 'safety-by-design').

For specific areas of inquiry:

- Status/prevalence: (youth OR adolescent* OR child* OR 'young adult*') AND ('mental health' OR depress* OR anx* OR 'self-harm' OR suicid*) AND (prevalence OR incidence OR trend*) AND (Europe OR EU OR [country names]). Note: We maximized initial hits using truncation and broader synonyms to address the risk of low yield, followed by meticulous screening
- Digital determinants: ('social media' OR smartphone* OR 'screen time' OR gaming OR TikTok OR Instagram OR 'AI chatbot*' OR 'artificial intelligence') AND (depress* OR anx* OR 'sleep' OR attention OR 'academic performance' OR cyberbullying) AND (youth OR adolescent* OR child*)
- Access/system capacity: ('mental health service*' OR CAMHS OR 'child and adolescent mental health') AND (access OR barrier* OR 'waiting time*' OR workforce OR psychologist* OR bed* OR budget* OR coverage OR copayment*) AND (Europe OR [country])
- Interventions/outcomes/ROI: (school-based OR 'social prescribing' OR 'cognitive behavioural' OR 'trauma-informed' OR 'frontline training' OR GP OR teacher OR 'digital intervention' OR 'e-safety') AND (effect* OR outcome* OR evaluat* OR RCT OR ROI OR 'cost-benefit')
- Costs/cost of non-Europe: ('economic burden' OR cost* OR DALY* OR QALY* OR productivity) AND ('mental health' AND (youth OR adolescent* OR child*)) AND (Europe OR [country])
- Legal/policy: ('Digital Services Act' OR 'AI Act' OR 'AVMSD' OR 'Better Internet for Kids' OR 'school phone polic*' OR 'youth media protection') AND (child* OR adolescent* OR youth) AND (Europe OR [country])

Light-touch screening and prioritisation

To keep the process disciplined but proportionate, we used a simple two-stage screening approach for the targeted search, anchored in relevance to the research questions and expected evidential yield:

1. Title and abstract screening: we quickly excluded clearly out-of-scope items (e.g., wrong population, region, or outcomes) and flagged potential high-yield candidates. This stage is deliberately pragmatic to preserve time for extraction and synthesis.
2. Full-text screening: We reviewed the short-listed items in full, admitting those that contribute substantively to the questions, fill obvious gaps (e.g., a developmental stage under-represented), or carry methodological weight.

Prioritisation order for inclusion was:

1. Highest yield: recent systematic reviews and meta-analyses, robust longitudinal or quasi-experimental studies, large high-quality observational studies, and authoritative statistical/policy reports from WHO/WHO Europe, OECD, EU institutions, ESPAD, HBSC, national statistical offices.
2. Next: well-designed cross-sectional studies that add unique coverage (e.g., specific age bands or digital exposures), evaluated interventions with clear outcomes, and credible national audits on access/workforce/waiting times.

Documentation and transparency

Because this is not a formal systematic review, we did not produce a PRISMA style flow diagram. To ensure transparency, we maintained an inclusion log (bibliographic list) for the circa 100 priority items, tagged by theme, age band, geography, and study type.

AI-assisted support (under human control)

We used our secure AI tools to assist with de-duplication, translation of non-English abstracts, and structured summaries of long texts. All decisions about inclusion and exclusion remain human-led, and any AI-assisted outputs are verified and edited by researchers.

Quality and fit-for-purpose checks

We applied proportionate, fit-for-purpose quality checks to the key studies that underpin headline conclusions and any model parameters. These checks used a brief, documented rubric appropriate to each study design, so that stronger evidence is weighted more heavily without undertaking a full formal systematic appraisal. We were transparent about any limitations identified.

This process resulted in:

- A curated set of ~100 priority items (expert-guided plus targeted search).
- Balanced coverage across themes, developmental stages, and EU-27/comparators.
- Evidence tables and maps that feed directly into the Interim Report, case study selection, and the model scoping, without the overhead of a full systematic review workflow.

Evidence Coding and Extraction Methodology

To ensure the comprehensive extraction and rigorous synthesis of evidence, we employed a structured coding template. This approach moves beyond simple narrative summary by mapping specific evidence from each source directly against the detailed Research Question Matrix (RQM) and identifying quantifiable parameters for the Impact Model (Task 4).

1. **The Coding Template Structure:** The coding template is built as a single, multi-column matrix to maintain source integrity while enabling targeted data extraction. The template is organized into three main functional groups: **Source and Citation**, **Context and Quality**, and **RQM Coding and Evidence Extraction**.

Table 12 – Research coding template structure

Column Group	Purpose	Key Columns Included
Source and Citation (EPRS Style)	To ensure full bibliographic compliance and internal tracking.	Unique ID, Short Citation, Full Reference, Page/Article Reference.
Context and Quality	To apply quality checks, define study scope, and identify quantifiable data for the model.	Study Type, Age Groups, Geography, **Model Parameter Candidate?**
RQM Coding and Evidence Extraction	To isolate evidence for narrative synthesis and policy mapping against the RQM sub-questions.	Q1.1–1.2, Q1.4, Q2.1, Q2.2, Q3, Q4, Q1.8, etc.

Source: Authors' methodology.

2. **Detailed RQM Coding Columns:** The RQM is divided into specific columns that ensure every sub-question is captured and that critical quantitative data is isolated. Evidence is extracted into the relevant cell for synthesis

Table 13 – Detailed research question matrix coding columns

Column Index	RQM Focus Area	Corresponding RQM Sub-Questions	Evidence Expected
I	Q1.1–1.2: Status, Trends, & Conditions	State of YP MH in EU-27/Comp. Main types, causes, and impacts.	Prevalence rates, condition clusters (e.g., anxiety, depression), causal links.
J	Q1.4: Digital Access & Consequences	Current status of digital access and use, and the consequences for mental health.	Data on access levels, usage frequency, immediate MH impacts of use (Q1.4).
K	Q1.3: Data on Capacity & Treatment	National/EU-27 data on treatment systems.	Quantifiable system structure data (Budget for mental health, number of trained practitioners, facilities/beds, treatment types). Narrative barriers and waiting times are extracted in Column M.
L	Q2.1: Linkages & Societal Costs	Link to individual outcomes (social, academic, work) and	Quantifiable cost data observed impacts on

Column Index	RQM Focus Area	Corresponding RQM Sub-Questions	Evidence Expected
		societal costs (human, economic, health & care costs).	school/work performance (Q2.1).
M	Q2.2: Crises & Systemic Barriers	Link to ongoing crises (climate, COVID-19, economic) and barriers to treatment (stigma, accessibility, lack of settings).	Narrative evidence on crisis-related mental health shifts; data on waiting times (Q2.2).
N	Q2: Pathways, Content, & Displacement	The link between digital exposure and mental health via pathways (content effects, displacement, gateway risks).	Coded evidence on cyberbullying, sleep loss, vaping/alcohol initiation via digital platforms.
O	Q1.6, 1.7, 1.9: Approaches	Current approaches to FLW training, prevention/family awareness, and digital sector intervention approaches.	Examples of programmes, recommended changes to current approaches (Q1.6, Q1.7, Q1.9).
P	Q1.8: Neuroscience/Psycho-Traumatology	Use of current knowledge in neuroscience and psycho-traumatology in prevention and support systems.	Specific operational examples, expert recommendations, shifts in support models (Q1.8).
Q	Q3: Policy Option Raw Ideas (Long List)	All potential EU policy ideas, including those to be assessed for the long list: database of best practices, medical/psychological interventions, and social prescribing (Q3.1.1-3.1.6).	Raw ideas surfaced in literature (e.g., developing a database, medical interventions, social prescribing, digital regulation).
R	Q4: Model Parameters/ROI Data	Quantifiable parameters for the impact model.	Extractable figures on intervention effect sizes, costs, and ROI where available.

Source: Authors' methodology.

3. **Extraction and Citation Process:** The team adhered to the following steps, ensuring consistency and compliance with EPRS style**:**

- Preparation: Experts advised on the Research Protocol, which guides the selection and weighting of sources.
- AI-Assisted Screening: The AI tool, Ipsos Facto, was used to assist with translation of non-English sources and structured summaries of long texts, subject to human verification.
- Human Verification and Extraction: Researchers extracted the relevant evidence, verifying the first 10 % of AI-assisted outputs. Evidence is pasted into the corresponding RQM column (I–R).

- EPRS Citation: Researchers must complete the citation columns (A–D). For the Full Reference, the standard EPRS format is used, ensuring the author's first name/initial precedes the family name in footnotes/endnotes. The hyperlink must be included for source traceability.
- Quality Check: Evidence was tagged by Study Type and receives a preliminary quality rating to ensure appropriate weighting during the final synthesis.
- This process ensures that the vast amount of evidence is processed transparently and structured to directly answer the client's complex RQM.

AI-Assisted Extraction Methodology (Ipsos Facto)

1. **Rationale and Security**

The primary objective of incorporating Artificial Intelligence (AI) support, specifically via the proprietary **Ipsos Facto** tool, is to enhance the **efficiency, consistency, and comprehensiveness** of the evidence extraction process for Task 2.

- **Security:** Ipsos Facto operates within a **secure environment**, ensuring that all data inputs, prompts, and analyses remain within Ipsos's secure infrastructure. For this project, all processing leveraged **Large Language Models (LLMs) based on EU servers** to maintain high standards of data security and client confidentiality.
- **Role:** AI tools assisted with **de-duplication, structured summaries, and translation** of non-English sources. All decisions regarding inclusion, exclusion, and final extraction remained **human-led** and subject to expert verification.

2. **Piloting Process and Prompt Testing**

A formal piloting process is mandatory to calibrate the AI tool and ensure the output is accurately mapped to the coding template before mass extraction begins.

Table 14 – Prompt piloting process and testing

Step	Process
1. Sample Selection	Select a **10 % sample** of the circa 100 priority documents. The sample must span the main RQM themes (Status, Digital, Interventions, Costs) and include a mix of document types (academic, reports, non-English abstracts).
2. Prompt Calibration	Test and refine prompts to ensure they accurately extract the required data points and structure the output for direct pasting into the coding template (Columns I–R).
3. Output Verification	The initial AI output for the pilot sample is manually verified against the source document. Continuous human control will be applied during full extraction, with targeted human review of high-risk sources (e.g., non-peer-reviewed grey literature).
4. Alignment Sign-off	The team confirms the calibrated prompts consistently produce outputs aligned with the RQM and the quality rubric.

Source: Authors' methodology.

Draft prompts for testing

Ipsos Facto was deployed as an 'Agent' to support with the literature review. The agent was set up with the following prompt:

---

1) **[Upload to IF Gemini 2.5 Pro the following text]**

Agent Goal

Your primary goal is to act as a **precise and reliable evidence extraction assistant** for the 'Mental Health of Young People in a Digital Era' literature review. You will be provided with a single document (journal article, report, or book chapter) and the project's structured **RQM Coding Template**. Your core task is to **accurately extract and structure information** from the source document to populate the framework.

Core Principles & Constraints (Non-Negotiable)

1. **ZERO-TOLERANCE for Hallucination or Fabrication:** You **MUST NOT** invent, infer, or create information that is not explicitly stated in the provided text. Fabricating sources, page numbers, or quotes is strictly forbidden.
2. **MANDATORY VERIFIABILITY (EPRS-Aligned):** Every single piece of information you extract **MUST** be accompanied by a direct reference to its location in the source text.
    - **Output Format:** Your default output format for any extracted point must be: [Extracted Information]. (Source Ref: 'Verbatim Quote...')
        - If page numbers are available, use: (p. XX, Quote: '...').
        - If page numbers are unavailable (e.g., plain text), use section and paragraph: (Introduction, para. 3, Quote: '...').
3. **NO INFERENCE OR SYNTHESIS:** Your role is strictly to extract, not to interpret or synthesise. You should not draw your own conclusions or connect ideas that are not explicitly linked in the text.
4. **STRICT ADHERENCE TO THE FRAMEWORK:** You must **only** extract information that directly corresponds to the RQM columns provided by the user. Do not create new categories or provide unrequested information.
5. **Handling Missing Data:** If you cannot find any information in the document for a specific column in the framework, you **MUST** state: Information not found in document.
6. **Output the Full Framework Unaltered:** You MUST include every single column from the RQM template in your final output, in the specified order. If you cannot find any information in the document for a specific column, you MUST write 'Information not found in document' in that cell. Do not omit a row or column from the final table.
7. **FORMAT for Excel**: Format the output as a completed analysis that can be directly copy pasted and exported to Excel, using | as a delimiter. Consolidate the information for each column into a single block of text (do not enter into new rows, no bullet points) to ensure it can be copied and pasted into a single Excel cell without issues and with | only used as the delimiter between columns.

Workflow:

1. **Request Source:** Ask the user for the full text document to be analysed.

2. **Request Framework:** After receiving the text, ask the user for the **exact column headers** of the RQM Coding Template to be populated.
3. **Process and Extract:** Systematically scan the document, locating and extracting information relevant to each column using the mandatory verifiability format.
4. **Present 'Snowballing Recommendations':** The last column is for Further literature Recommendations. In this section, you must analyse the document's full bibliography or reference list to identify promising sources for further review. Provide the bibliographic citation exactly as it appears in the source document, accompanied by a one sentence justification for selection. Prioritise your selection based on the following criteria:
    1. We will prioritise empirical studies and robust reports that:
        1. Are focused on the above-mentioned mental health outcomes, exposures, access or interventions among ages 2–24 in EU-27 and agreed comparators (e.g. Norway, Australia, Singapore, Canada, UK);
        2. Are published 2008–2026;
        3. Peer-reviewed or high-quality grey literature (e.g. WHO, OECD, EU institutions, national statistical offices, ESPAD, HBSC).
        4. Provides extractable data or robust narrative evidence on the variables in the codebook.
    2. We will exclude:
        1. Populations wholly outside ages 2–24 without disaggregation;
        2. Purely opinion/commentary;
        3. Very low-quality or untransparent sources; and
        4. Contexts with limited transferability to Europe (unless particularly instructive for comparators).
    3. We will prioritise recent systematic reviews/meta-analyses, RCTs/quasi-experiments, longitudinal cohorts, large high-quality observational studies, and authoritative statistical and policy reports (WHO/WHO Europe, OECD, EU, ESPAD, HBSC). For access/capacity, we will include credible administrative data and national audits. For digital determinants, we will prioritise longitudinal and dose-response evidence and clearly flag limitations.
5. **Present Findings:** Present the extraction clearly, organised by the framework columns, but do not use a table. Your output should be a completed analysis that can be directly copy pasted and exported to Excel, using | as a delimiter. Consolidate the information for each column into a single block of text (no enter into new rows, no bullet points) to ensure it can be copied and pasted into a single Excel cell without issues and with | only used as the delimiter between columns.

2) [Upload document when requested and state 'This is the source document'**]**

3) [Copy paste the Coding template from Excel (from C1 to U4)].

(END OF THE PROMPT)

The following prompts were designed to be run through Ipsos Facto on the full text (or abstract/metadata) of a document to populate the first two sections of the coding template. All

prompts were integrated into the coding template and therefore included under step 3 of the overall prompt above.

Source and Citation Group Prompts (Columns A–D)

These prompts focus on standardising the bibliographic information according to **EPRS style** requirements for footnotes and bibliographies.

Table 15 – Source and citations group prompts

Template Column	Draft Prompt to Test	Rationale
Full Reference (C)	'Using the full document metadata, provide a formal bibliographic citation following the Author–Title–Publisher–Date format. Ensure the Author's First Name/Initial precedes the Family Name. Include a direct, stable hyperlink to the source (preferring EUR-Lex or Think Tank where available).'	Extracts the complete, standardised entry needed for the bibliography and footnotes.
Short Citation (B)	'Identify the primary author(s) (surname) and provide a recognisable short title (no more than 5 words) for this document, suitable for subsequent footnote reference.'	Creates the necessary shortened reference format (e.g., *Corbett et al., The European Parliament*).
Page/Article Ref. (D)	'Identify the total number of pages in this document. If this is an EU legislative act, state the Article number most relevant to youth mental health.'	Provides essential data for page counts and directs attention to legal articles (Q3).

Source: Authors' methodology.

Context & Quality Group Prompts (Columns E–H)

These prompts help categorise the source methodologically and identify its relevance to the quantitative modelling team.

Table 16 – Context and quality group prompts

Template Column	Draft Prompt to Test	Rationale
Study Type/Hierarchy (E)	'Categorise this document based on its methodology (select one: Systematic Review/Meta-Analysis, Randomized Controlled Trial, Longitudinal Study, Large Observational Study, Authoritative Statistical/Policy Report, National Audit/Administrative Data, Other).'	Facilitates immediate application of the quality checks and weighting of evidence.
Age Groups in Scope (F)	'Identify the specific age range(s) covered by the population studied. Map this to the project's developmental staging (ages 2–5, 6–11, 12–17, 18–24), noting if the bulk of the sample falls within these stages.'	Ensures direct relevance to the project's target age groups.
Geography (G)	'List the countries or regions included in the study population. Specify if the focus is EU-27, a single EU Member State, or an agreed comparator (UK, Norway, Australia). If information is present specifically on any of the agreed EU case study countries (Italy, Poland, Ireland, Netherlands) please extract it and provide details.'	Confirms geographic relevance to the study scope.
Model Parameter Candidate? (H)	'Review the document and determine if it contains extractable quantifiable data on prevalence, service budgets, workforce density, or *estimated* intervention effect sizes (ROI/cost-benefit). Answer YES or NO.'	Provides a clear flag to prioritise sources for quantitative modelling (Task 4).

Source: Authors' methodology.

RQM Coding & Evidence Extraction

These prompts target the analytical columns (I-R) and are designed to extract and structure the specific evidence required for the quantitative model, policy options, and narrative synthesis. Each column also had the following prompt to extract case studies information: 'If information is present specifically on any of the agreed EU case study countries (Italy, Poland, Ireland, Netherlands) or an agreed comparator (UK, Norway, Australia), please extract it and provide details specifically on those countries in addition to the general findings of this column.'

Table 17 – Research question matrix coding & evidence extraction

Q1: Status and Descriptive Data

Template Column	Draft Prompt to Test	Rationale
RQM Q1.1-1.2: Status, Trends, & Conditions (I)	'Extract and quantify the most recent figures for prevalence and incidence of the main mental health conditions (anxiety, depression, self-harm, suicide) among ages 2-24 in the EU-27 and agreed comparators. Synthesise the document's narrative findings on the comparative state of youth mental health (EU vs. non-EU) and list the main approaches to treatment, promotion, and prevention for young people mentioned in the document (excluding specific intervention evaluations, which belong in Q4).'	Captures the quantifiable statistics and the high-level narrative and comparative information on the state of mental health and general approaches to care, aligning with the first RQM sub-questions.
RQM Q1.3: Data on Capacity & Treatment (K)	'Extract specific quantitative data regarding mental health system capacity and treatment access. Include figures for the budget for mental health, number of trained practitioners/psychologists (per 100k), facilities, waiting times, and coverage/entitlements.'	Targets quantifiable systems data needed for Q1.3, Q2.2, and the model.
RQM Q1.4: Digital Access & Consequences (J)	'Identify and extract the current status of digital access and discretionary use (time, intensity, context) for ages 2-24. Summarise the document's main conclusions regarding the immediate consequences of this access/use on mental health.'	Isolates quantitative data on usage (Q1.4).

Q2: Challenges and Pathways

Template Column	Draft Prompt to Test	Rationale
RQM Q2.1: Linkages & Societal Costs (L)	'Identify and extract evidence detailing the **link** between poor mental health conditions and negative **individual outcomes** (social engagement, communication skills, academic achievement, working relationships). List any associated quantified **human, economic, or health & care costs**.'	Focuses on the burden on individuals and society, and key cost inputs.
RQM Q2.2: Crises & Systemic Barriers (M)	'Extract evidence on the **link between mental health and ongoing crises** (climate change, conflicts, COVID-19/aftermath, economic downturns). Additionally, summarize identified **barriers to treatment** including stigma and lack of appropriate inpatient settings.'	Captures the multifaceted nature of challenges beyond digital exposure.
RQM Q2: Pathways, Content, & Displacement (N)	'Identify and extract evidence on the **pathways linking digital exposure to mental health** via **content effects** (cyberbullying, self-harm content, misinformation), **displacement effects** (sleep loss, physical activity), and **gateway risks** (vaping/smoking, gambling-like mechanics).'	Focuses specifically on the *mechanisms* of digital harm (Q2).

Q3 & Q4: Policy, Interventions, and Modelling

Template Column	Draft Prompt to Test	Rationale
RQM Q1.6, 1.7, 1.9: Approaches (O)	'Extract evidence on current **approaches and recommended changes** for three areas: **1) FLW training** (GPs/teachers, Q1.6), **2) Prevention** (early family awareness, Q1.7), and **3) Digital Sector Interventions** (non-regulatory, Q1.9).'	Consolidates three related intervention approaches for efficient comparison.
RQM Q1.8: Neuroscience/Psycho-Traumatology (P)	'Identify and extract specific examples and recommended changes regarding **how current knowledge from neuroscience and psycho-traumatology** can be used **actively and operationally** in the prevention and support of young individuals and their surrounding 'systems'.'	Targets the highly specific, technical area (Q1.8).
RQM Q3: Policy Option Raw Ideas (Long List) (Q)	'List all explicit **policy, programme, or legislative intervention ideas** directed at the EU or national level (including developing a database of best practices, medical/psychological interventions, and social prescribing programs) that could address the current challenges.'	Gathers the raw ideas from the literature to form the Q3 Long List.

Template Column	Draft Prompt to Test	Rationale
RQM Q4: Model Parameters/ROI Data (R)	'Identify and extract **quantified data or estimates** on **intervention outcomes (effect sizes)** or **Cost-Benefit Analysis/ROI** evidence for any mental health interventions targeted at ages 2–24 in Europe.'	Provides the direct numerical inputs needed for Dr. Lindert's ROI modelling.

Source: Authors' methodology.

Case studies

Objectives of the case-study workstream

The case-study workstream was designed to complement the literature review and quantitative modelling by providing grounded, system-level insights from selected countries. It had three main aims:

- Document promising practices across school-based prevention, healthcare and community services, frontline training, social prescribing and digital or regulatory approaches addressing youth mental health in the digital era.
- Surface practical system constraints that shape delivery and access, including waiting times, workforce capacity, coverage, co-payments and transitions from child to adult services.
- Inform the modelling and policy options with plausible assumptions, causal pathways and indicative signals on scale, uptake, effects and costs, including evaluated effect sizes, service-use indicators and cost or return-on-investment (ROI) estimates.

The case studies are therefore not country evaluations; they are analytic pieces structured to answer specific research questions and to feed quantitative and policy workstreams.

Case selection and sampling

Overall approach

Case selection followed a multi-step, criteria-based process that combined an expert-guided longlist, structured screening and feasibility checks. The aim was to obtain a balanced sample of countries that:

- reflects SANT's priorities (majority EU-27, at least one southern EU Member State, retention of Norway, inclusion of at least one non-European comparator);
- covers different intervention types (school-based promotion, youth-friendly services, digital tools, social prescribing, regulation);
- spans the main developmental stages (primary, lower and upper secondary, and 18–24 transitions); and
- addresses key digital-era pathways (cyberbullying, problematic social media and gaming, sleep disruption, gateways to vaping/gambling, AI-mediated interactions).

The final sample comprised seven in-depth country cases: Italy, the Netherlands, Poland, Ireland, the United Kingdom (England), Norway and Australia. Belgium and Canada were retained as reserves, with Singapore used as a targeted policy comparator for digital-safety and governance.

Longlist development

An initial longlist of candidate countries was assembled from:

- the literature and data work conducted for the proposal and inception phase (HBSC, Eurobarometer, WHO and OECD reports, ESPAD, national youth-mental-health surveys and administrative series);
- evaluated programmes and practices documented in peer-reviewed journals and high-quality grey literature; and
- targeted desk research in national languages to map current policies, school and community programmes, digital initiatives, helplines and recent reforms.

This longlist included six EU Member States (Italy, the Netherlands, Poland, Ireland, Belgium, Finland) and six comparators (Iceland, Norway, the United Kingdom (England), Australia, Canada, Singapore).

Structured screening framework

- Each candidate was assessed against a common screening framework aligned with the study's research questions. Criteria were:
- Policy relevance to the digital era: coverage of salient digital pathways (e.g. cyberbullying, problematic social media or gaming, sleep loss, gateways to vaping/gambling, AI-mediated tools).
- Evidence strength and evaluative rigour: availability of outcome evaluations or robust implementation data for key interventions (e.g. randomised or quasi-experimental trials, longitudinal follow-up, routinely collected outcome data).
- Feasibility and access: likely availability of core documentation and reachable stakeholders within the project timeframe.
- Contribution to modelling and 'cost of non-Europe' analysis: presence of effect sizes, utilisation or waiting-time indicators, and cost or ROI information that could inform model parameters or sensitivity analysis.
- Transferability to EU-27 context: legal and practical relevance of lessons for EU-level action across health, education and digital policy.

Evidence strength and feasibility were weighted most heavily, while ensuring coverage across intervention types (school-based, healthcare/community, frontline training, social prescribing, regulatory/digital).

Balancing for coverage and feasibility

The emerging shortlist was then balanced against explicit coverage goals agreed at inception:

- majority EU-27, including at least one southern Member State;
- inclusion of Norway (EEA) and at least one non-European comparator with mature digital-era interventions;
- coverage of early/middle childhood, adolescence and young adulthood; and inclusion of key system challenges (waiting times, workforce, transitions, co-payments) and vulnerable groups (low-income, rural, migrants/refugees, LGBTQIA+ youth, neurodivergent and disabled youth).

For each candidate, a coverage map was compiled, summarising: intervention typology (school-based promotion, youth hubs, digital/self-help tools, frontline training, social prescribing, regulation); developmental stages reached; priority conditions and digital pathways; system/access obstacles; and specific vulnerable groups and digital-governance features.

In parallel, feasibility was tested by checking the availability of national documents and the existence of potential interviewees (programme owners, providers, regulators, school leads, frontline professionals, civil-society organisations) and by assessing language and access risks. Where feasibility was uncertain, a reserve of similar profile was retained to allow substitution without loss of analytical balance.

Data collection

Case-study evidence combined documentary analysis with semi-structured interviews conducted between January – March 2026.

Documentary analysis

For each of the seven countries, a structured desk review was conducted, covering:

- national mental-health plans and youth strategies;
- education, digital-safety and online-safety policies;
- programme manuals, evaluation reports and monitoring data for focal interventions (e.g. MindOut, Zippy's Friends, YAM, @ease, Jigsaw, PMHC, headspace, ReachOut, SOLVE, COPE, Barnardo's LINK, national helplines and portals);
- relevant legislation and regulatory frameworks (e.g. Italy's Law 71/2017 on cyberbullying, Australia's Online Safety framework, the UK's Online Safety Act);
- national statistics on prevalence, service use and waiting times.

In total, more than 70 pieces of national documentation were reviewed across the seven cases. Sources in Italian, Dutch, Polish and Norwegian were analysed by native- or fluent-speaking team members, with targeted translation where necessary.

Document review followed a common extraction template, recording for each intervention:

- target group(s), age range and setting;
- theory of change and core components;
- delivery model (staffing, funding, governance);
- outcome and process indicators (including any digital-specific elements);
- equity considerations (reach into vulnerable groups); and
- any cost or resource-use information.

Semi-structured interviews

To complement documentary evidence and capture implementation realities, the team conducted 20 semi-structured interviews across the seven case-study countries. Interviewees were purposively sampled to capture a mix of perspectives, including:

- national or regional policy officials (health, education, digital-safety/youth);
- programme leads and service managers (school-based programmes; youth hubs and early-intervention services; social-prescribing schemes; digital services and helplines);
- frontline professionals (school staff, psychologists, social workers, youth workers); and
- where appropriate, representatives of civil-society organisations working with vulnerable youth.

Interviews were conducted online, using Commission-provided invitation material, and were restricted to adult stakeholders. Participation was voluntary and informed consent was obtained; notes were anonymised in the analysis.

A common topic guide was used, tailored by country and intervention type, covering:

- description of the intervention(s) and system context;
- observed trends in youth mental health and digital-era challenges;
- access pathways, thresholds and typical user profiles;
- implementation enablers and barriers (funding, workforce, coordination, digital literacy);
- perceived effects (on symptoms, functioning, service use, equity), including any monitoring or evaluation data;

- interaction with digital platforms and policies (e.g. cyberbullying, social-media use, gaming, AI tools); and
- views on transferability and relevance for EU-level action.

Interviews were summarised in structured fieldwork templates immediately after each call, distinguishing clearly between factual information, interpretive judgements and the interviewee's own views.

Analysis

For each country, the team prepared a country case report, structured along a shared analytic framework:

- context and recent trends in youth mental health and digital use;
- overview of relevant policies and funding;
- description of key interventions along five typologies (school-based promotion, community/youth hubs, digital tools and online support, social prescribing/community pathways, digital regulation);
- system-level constraints (waiting times, workforce, transitions, territorial inequalities, co-payments); and
- lessons on equity, digital-era pathways and transferability.

Documentary evidence and interview material were triangulated: where possible, claims from interviews were checked against written sources, and discrepancies were noted explicitly.

Cross-case synthesis

The seven case summaries were then subjected to a cross-case thematic analysis, organised around:

- intervention typologies: identifying common design features and variants of school programmes, youth hubs, digital tools, social-prescribing schemes and regulatory approaches;
- digital pathways: how each case addressed design-driven overuse and displacement, content-driven harms and AI-mediated interactions;
- system obstacles: recurring patterns in waiting times, workforce shortages, access thresholds and 'missing middle' gaps;
- equity: which groups were reached or missed (NEET youth, migrants/refugees, LGBTQIA+ youth, rural youth, young people with disabilities and care-experienced young people);
- transferability conditions: governance, workforce, funding and data prerequisites for scaling or adapting models in other EU-27 contexts.
- Findings were coded against the main research questions and problem clusters identified in Chapter 2 (prevention gap, missing middle, unsafe digital environments, inequalities, capacity/data gaps). This cross-case synthesis directly informed:
- the intervention matrix and maturity assessment in Chapter 4 (Table 1);
- the identification of promising practices and enablers/barriers in Sections 4.2–4.3; and
- the design and calibration of the EU-level policy options in Chapter 5 (notably Options 1–3 and 5).

Use of case-study signals in the modelling

Case-study evidence was not used to produce country-level estimates in the model. Instead, it provided indicative signals to guide the structure and parameter ranges of the EU-27 model in Chapter 6, including:

- illustrative effect sizes (e.g. symptom and functioning changes from Jigsaw, @ease, PMHC, YAM, YMH school programmes and digital tools such as ReachOut);

- service-access indicators (self-referral rates, waiting times, uptake and drop-out patterns);
- system-cost information (where available, programme costs per user, cost per QALY, and budget envelopes for youth services, hubs or digital platforms); and
- causal pathways linking interventions to education, labour-market and health-system outcomes.

These signals were used to define plausible ranges for prevalence-reduction scenarios (Chapter 7, Table 4) and to validate that the avoided-cost orders of magnitude generated by the generic model were consistent with what is observed in well-evaluated national programmes. Where quantitative case-study inputs were used, they were treated as illustrative and clearly caveated, not as precise effect transfers.

Limitations

The case-study workstream has several limitations:

- The selection of seven countries offers breadth but not representativeness of all EU-27 systems.
- Within each country, analysis focused on a core set of interventions rather than an exhaustive mapping of all activity.
- Interviewees were mainly institutional and professional stakeholders; youth voices were captured indirectly through evaluations and survey data, not primary youth interviews.
- Availability and quality of evaluation evidence varied; where robust impact evaluations were absent, findings are based on implementation data and stakeholder perceptions.

These limitations are acknowledged in the main text. The case studies are used to generate qualitative insights and plausible parameter ranges, not to make formal comparative judgements between countries.

Cost of non-Europe and impact analysis

Health economics modelling

Purpose

This annex documents the model used in Section 6. It explains what the model does, what data it draws on, the assumptions it applies, and the limitations a reader should bear in mind.

The model quantifies the cost of inaction on youth mental health across the EU-27 over ten years, from 2024 to 2033. It estimates avoided cost under different prevalence reduction scenarios. It is presented as a transparent evidence synthesis, not a microsimulation or a formal impact assessment.

The methodology follows the spirit of the EU Better Regulation Toolbox, in particular Tool #57 on the monetisation of health impacts and Tool #58 on impact assessment methods.

Scope

The model covers:

- Young people aged 10 to 24 in three age bands (10 to 14, 15 to 19, 20 to 24)
- All 27 EU Member States
- Six conditions: anxiety disorders, depressive disorders, ADHD, self-harm, conduct disorder, and eating disorders
- A ten-year window from 2024 to 2033
- Four cost domains: health, social protection, education, and labour productivity

The model does not attribute a specific prevalence reduction to a specific policy option. It answers a conditional question: if EU-27 youth prevalence fell by a given percentage, how many cases and euros would be avoided?

Data sources

The model draws on six main sources.

The Global Burden of Disease 2023 study provides prevalence rates for anxiety, depression, and ADHD by country, age, sex, and year. It also supplies population denominators.

Eurostat provides EU-27 GDP, population structures, and self-reported depressive symptoms for cross validation.

The OECD 2021 benchmark study A New Benchmark for Mental Health Systems supplies the cost share of mental ill-health in European GDP and the split across health, social protection, and labour productivity.

The WHO Global Health Observatory provides system level indicators including suicide rates, used as validity checks.

The HBSC 2022 survey and the OECD child wellbeing dashboard provide narrative context on youth wellbeing and digital use.

Five country case studies (Australia, Italy, Norway, England, and Ireland) provide qualitative evidence on policy options and effect sizes. They feed the policy options assessment, not the cost calculation.

Calculation logic

The model proceeds in five steps.

Step 1: population projection. Youth population by country, age, and sex is derived from GBD 2023 data for 2010 and 2023. Forward values for 2024 to 2033 are extrapolated linearly.

Step 2: prevalence projection. Historical rates from 2010 and 2023 are projected forward. Three trajectories are produced: a conservative case holding 2023 rates flat, a central case continuing the 2010 to 2023 trend, and an optimistic case applying a 10 % annual decay beyond 2023.

Step 3: case counts. For each combination of country, age, sex, condition, year, and uncertainty case, prevalent cases are calculated as prevalence rate multiplied by population.

Step 4: cost estimation. A blended cost per case figure is applied to each case. The central value is €8 970 per case per year, derived from OECD 2021. The figure is calculated as EU-27 GDP multiplied by the mental health cost share of GDP, divided by the alleges prevalent caseload. Conservative and optimistic variants apply plus or minus 20 %.

Step 5: domain split and discounting. Total cost is split across the four domains using fixed shares from OECD 2021. Costs are presented in 2024 prices. Future amounts are adjusted to present value at a 3 % rate, in line with EU Better Regulation guidance. Sensitivity variants of 0 % and 5 % are reported alongside.

Synthesised series for three conditions

Three conditions (self-harm, conduct disorder, and eating disorders) are not yet covered in the GBD mental health pull. Omitting them would understate the burden. The model therefore carries them as synthesised series.

For each condition, anchor prevalence rates are set per age band and sex, drawn from published estimates. Country specific rates are then derived by scaling the anchor against each country's depressive disorder prevalence relative to the EU-27 mean. The rationale is the established correlation between internalising disorders.

A wider uncertainty band of plus or minus 30 % is applied to these series to reflect the lower data confidence.

Cost domain shares

Costs are allocated to four domains using the following shares:

- Health: 33 %
- Social protection: 30 %
- Labour and productivity: 30 %
- Education: 7 %

The first three shares are normalised from OECD 2021. The education share is set at 7 % as a working assumption. OECD 2021 does not report education as a separate domain. The 7 % figure draws on the relative scale of UK and German data on special educational needs spending. The figure can be refined as more comparable European data become available.

Impact scenarios

Five uniform prevalence reduction scenarios are tested: 1 %, 3 %, 5 %, 10 %, and 20 %. For each, the model computes avoided cases and avoided cost over the ten-year horizon.

The scenarios are illustrative. They show what is at stake under different levels of policy ambition. They do not reflect the specific effect of any single policy option.

Linking scenarios to policy options

A separate qualitative layer maps five policy option families to the reduction scenarios they plausibly support.

The mapping draws on case study evidence. Each option family is paired with a reduction range supported by published effect sizes. The mapping is qualitative because the case study evidence does not allow a mechanical attribution.

A second qualitative layer scores each option against five criteria: reach, strength of evidence, EU competence, implementation complexity, and equity. Scores are ordinal (Low, Medium, High).

Both layers feed the discussion in Section 6.5. They do not feed the cost calculation.

Uncertainty treatment

The model carries three uncertainty cases (conservative, central, and optimistic) across three parameter families:

- Prevalence rates and their forward trajectory
- Cost-per-case (plus or minus 20 %)
- Synthesised condition rates (plus or minus 30 %)

The conservative to optimistic spread on the headline figures reflects this combined input uncertainty.

The model does not capture every form of uncertainty. It does not vary the population path, the discount rate, or the model structure across the three cases. Readers should treat the uncertainty range as a lower bound, not a full confidence interval.

Limitations

Six limitations matter for interpretation.

Comorbidity. The model sums costs across six conditions. A young person with two or more conditions is counted in each. The summed total is therefore an upper bound. The headline figure of €1.68 trillion adjusts for this overlap. Per condition figures do not.

Single cost per case. A blended value is applied across all conditions. In reality, self-harm and eating disorders carry higher percase costs than ADHD. The blended figure averages across these differences.

Synthesised series. Three conditions rely on synthesised prevalence rates rather than direct GBD data. The synthesis is defensible, but real data would be preferable.

Education domain share. The 7 % figure is a working assumption, set with reference to UK and German data. It can be refined as more comparable European data become available.

Population projection. The forward population path is a linear extrapolation of two GBD data points. It does not incorporate Eurostat scenario-based projections.

Wellbeing and mortality. The model values direct economic costs to public systems and individuals. It does not value wellbeing losses to families and carers, nor premature mortality beyond lost earnings. The true cost is therefore higher than the figures presented.

Despite these limitations, the order of magnitude is robust. Sensitivity tests across discount rates, prevalence trajectories, and cost per case figures all yield ten-year totals between €1.28 trillion and €1.92 trillion.

Headline magnitudes

Under the central uncertainty case, for EU-27 youth aged 10 to 24:

- Annual cost in 2024: around €177 billion
- Annual cost in 2033: around €207 billion
- Ten-year total in present value at 3 %: around €1.68 trillion
- Ten-year total undiscounted: around €1.92 trillion
- Avoided cost at 5 % uniform reduction: around €84 billion in present value
- Avoided cost at 10 % uniform reduction: around €168 billion in present value

Annex III: Full case studies

The Netherlands

Executive summary

Table 18 – Netherlands case study executive summary

Section	Details
National Context and Current Situation	The Netherlands' has a decentralised youth mental health system, reformed under the 2015 Youth Act. It does however have fragmented delivery, funding pressures, workforce shortages, and rising demand. Youth mental health has deteriorated, particularly among girls, with high digital exposure linked to poorer wellbeing. The COVID-19 pandemic and ongoing educational pressures have further intensified distress, while system capacity struggles to meet increasing clinical need.
Intervention 1: @ease	@ease provides free, anonymous, low-threshold peer support through walk-in centres and online chat for young people aged 12–25, bridging informal and clinical care. It improves psychological outcomes and reduces school absenteeism, with success driven by accessibility and youth-friendly design. Key challenges include sustaining engagement, reaching underserved groups, and reliance on local funding and volunteers.
Intervention 2: STORM (Strong Teens and Resilient Minds)	STORM is a school-based prevention model combining universal education, staff training, screening, and targeted CBT support. It strengthens early identification and referral through cross-sector collaboration and has demonstrated effectiveness in reducing depressive symptoms. Implementation depends on school capacity and sustained coordination between education and health systems.
Intervention 3: Grip op je dip (Master Your Mood)	Grip op je dip is a digital CBT-based programme offering guided self-help through online group sessions. It shows strong reductions in depressive symptoms, with effectiveness driven by its blended care model combining digital access with professional support. Barriers include user adherence, digital literacy, and equitable access to technology.
Transferability and EU Policy Lessons	The Dutch model demonstrates the value of early intervention, school-based prevention, and blended digital care to address the 'missing middle'. Transferability depends on enabling conditions such as cross-sector governance, digital infrastructure, and volunteer capacity. The case also highlights the importance of enforcing EU digital regulation and integrating child rights into policymaking, while cautioning against fragmentation and inequities arising from decentralisation.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

The Netherlands' approach to youth mental health is highly decentralised and relies heavily on municipal execution. The 2015 Youth Act (Jeugdwet) fundamentally restructured the child protection and care system, shifting the responsibility for youth mental health services from the national and provincial levels directly to 342 municipalities. The intent of this reform was to deliver faster, more tailored care embedded within local communities. However, evaluations indicate that decentralisation has resulted in a complex and highly fragmented system. Implementation is frequently hampered by structural bottlenecks, including insufficient municipal funding, severe shortages of specialised child protection workers, and long processing times.[303] Consequently, the Dutch youth care landscape is currently described as having a 'broader but more fragile' foundation, with the cost of youth care more than doubling since decentralisation.

At the national strategic level, the government launched an Action Plan in June 2022 to tackle mental health across five domains: society, neighbourhoods, schools, work, and the online environment.[304] However, civil society organisations note that this plan lacks clear long term objectives, binding conditions, and dedicated budgets.[305] To address this lack of a holistic governmental vision, stakeholders are actively advocating for the mandatory introduction of Child Rights Impact Assessments (CRIAs) across all policy areas.[306]

Regarding the digital environment, the Netherlands combines proactive engagement with EU regulations and targeted national restrictions. The Dutch Digital Services Coordinator actively enforces the Digital Services Act (DSA), notably launching a joint investigation with the European Commission into Snapchat's compliance with child protection rules, focusing specifically on age assurance and the mitigation of addictive design features.[307] Concurrently, the Ministry of Education, Culture and Science has implemented national agreements to restrict the use of mobile phones in classrooms across primary and secondary education to mitigate digital distraction and foster offline wellbeing.[308] Despite these strong measures, legislative gaps remain; civil society reports an absence of robust national regulation concerning the commercial exploitation of 'childfluencers' and the use of addictive gambling mechanics (like loot boxes) within video games.[309]

Baseline statistics

Longitudinal data shows a high and continuous decline in the mental health of Dutch youth over the past decade. Data from the Rijnmond Primary Care Database highlights a stark rise in clinical incidence between 2016 and 2022: anxiety problems increased from 9.76 to 10.30 per 1 000 person

303 Eurochild, *Flagship Report Childrens Realities in Europe*, 2024, p. 31.

304 Eurochild, *Sub-report Mental Health*, 2024, p. 10.

305 Ibid.

306 Eurochild, *Flagship Report Childrens Realities in Europe*, p. 30.

307 European Commission, 'Commission investigates Snapchat's compliance with child protection rules under the Digital Services Act', Shaping Europe's digital future, 2024.

308 Ministerie van Onderwijs, Cultuur en Wetenschap, Kamerbrief landelijke afspraken mobiele telefoons in de klas in het primair en gespecialiseerd onderwijs, 2023.

309 Eurochild, *Flagship Report Childrens Realities in Europe*, p. 31.

years,[310] while depressive problems rose from 5.38 to 6.57 per 1 000. By 2022, approximately 30 % of Dutch adolescents aged 11 to 16 reported struggling with mental health problems.[311]

A significant gender gap defines these trends. The HBSC study shows that emotional problems among secondary school girls surged from 28 % in 2017 to 43 % in 2021. For primary school girls, the increase was even more dramatic, jumping from 14 % to 33 %. Consequently, young adults, and particularly young women, now account for an increasingly large share of total Dutch mental healthcare expenditure, indicating that psychological distress is increasingly resulting in medicalised care.[312]

Digital exposure among Dutch youth is exceptionally high. Adolescents spend an average of six hours a day on mobile phones, with two and a half hours dedicated specifically to social media.[313] The 'always on' culture is pervasive; 44 % of 15 year old girls report being in 'constant contact' with friends online, leaving little cognitive space for offline reflection. Dutch monitors indicate that problematic social media use, which affects roughly 4 % to 5 % of the youth population, correlates strongly with lower emotional wellbeing, increased mental problems, and sleep deprivation, particularly among girls.[314]

Regarding system capacity, the Netherlands allocates 0.58 % of its GDP to preventive healthcare, which is above the EU median. However, the surge in clinical demand has created severe structural bottlenecks. Approximately one in seven Dutch children received some form of youth care in 2024, leading to extended waiting lists for specialised child and adolescent psychiatry and leaving the system struggling to balance 'light' community care with intensive psychiatric demand.[315]

Crisis impacts

While the decline in youth mental health predated 2020, the COVID-19 pandemic acted as a severe multiplier. Primary care consultations for mental health among young people rose significantly during the pandemic, and the National Mental Health Monitor recorded the highest levels of mental health problems among eighth grade girls in 2021 (at 26.1 %).[316]

Beyond the pandemic, Dutch youth face compounding pressures from the educational and economic environments. Student monitors indicate high levels of performance pressure; although decreasing slightly from a peak in 2021, 60 % of higher education students still reported frequent performance pressure in 2025, alongside high rates of emotional exhaustion.

Experts suggest these successive crises intersect with the digital environment. The preexisting risks of the digital era, such as algorithmic amplification, the pressure of 'filtered reality,' and the displacement of restorative offline activities, combined with pandemic era isolation and educational stress to create a 'new normal' of high psychological distress.

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310 A person-year is an epidemiological metric combining the number of observed individuals with their total duration of follow-up. For example, 1 000 person-years can represent 1 000 individuals tracked for exactly 1 year, or 500 individuals tracked for 2 years. This standardises incidence rates over time regardless of shifts in the underlying database population size or tracking lengths.

311 P. M. Valkenburg, A. van der Wal, and I. Beyens, *'The impact of social media on adolescents' mental health'*, Essay Collection Children's rights in the digital world, UNICEF the Netherlands, 2024, p. 43.

312 L. Dijkstra et al., *'Young adults, particularly young women, account for an increasingly large share of Dutch mental healthcare expenditure over the period between 2015 and 2021'*, Epidemiology and Psychiatric Sciences, Vol. 33, 2024.

313 P. M. Valkenburg, A. van der Wal, and I. Beyens, 'The impact of social media on adolescents' mental health', p. 42.

314 Trimbos-instituut, *Monitor mentale gezondheid*, Landelijke rapportage 2025, pp. 82-83.

315 OECD, *Promoting good mental health in children and young adults*, Paris, 2025, p. 258.

316 *Monitor mentale gezondheid*, p. 76.

Deep dive: Featured interventions

This section examines three interventions that illustrate the Netherlands' multifaceted response to youth mental health in a highly digitalised era: @ease (low threshold community youth hubs), STORM (school based universal and targeted prevention), and Grip op je dip (a guided digital eHealth platform). These interventions were selected due to their scale, strong evidence base, and policy relevance. Together, they demonstrate a stepped care continuum that bridges the 'missing middle' in mental healthcare, integrates digital delivery mechanisms safely, and fosters cross sectoral collaboration between schools, municipalities, and clinical providers.

@ease

Overview

@ease is a youth mental health initiative designed to increase resilience and prevent the aggravation of emerging psychological distress by providing easily accessible, peer to peer support.[317] Operating 15 walk in centres across 12 Dutch municipalities, it targets young people aged 12 to 25.[318] Young people can access support anonymously, at no cost, and without a medical referral. In the context of the digital era, @ease offers a hybrid approach. While rooted in physical walk-in centres, it actively provides online chat consultations to lower the threshold for digital native youth who may feel anxious about face-to-face interactions.[319] The initiative operates outside the formal clinical system but functions as a vital bridge. Consultations are led by trained young adult volunteers (including experts by experience) who are continuously supervised by an onsite healthcare professional.[320]

Evidence of effectiveness and ROI

Evaluations of @ease demonstrate significant improvements in clinical and functional outcomes for young people, effectively reaching a highly distressed demographic that frequently falls through the cracks of formal care. Routine outcome monitoring indicates that returning visitors experience a 19 % reduction in psychological distress (measured via CORE10[321]) and a 6 % improvement in social and occupational functioning.[322] Furthermore, the intervention shows tangible educational benefits. The proportion of users who were absent from school at least once in the previous three months decreased from 44 % at their first visit to 17 % by their third visit.[323] While a formal, monetised ROI study is currently in the preparation phase, the model is considered highly cost efficient because it relies on a volunteer peer workforce supported by in-kind clinical supervision.[324]

Implementation: Barriers and enablers

The primary enablers of @ease are its youth friendly design and the removal of systemic barriers such as long waiting lists, financial costs, and the need for a general practitioner's referral.[325] The use

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317 OECD, *Promoting good mental health,* p. 241.

318 Ibid., p. 242.

319 S. Leijdesdorff et al., *'Barriers and facilitators on the pathway to mental health care among 12-25 year olds'*, International Journal of Qualitative Studies on Health and Wellbeing, Vol. 16, 2021, p. 8.

320 OECD, *Promoting good mental health*, p. 242.

321 CORE10 (Clinical Outcomes in Routine Evaluation 10): A validated, 10-item self-report questionnaire used widely in mental health settings to screen for and monitor common symptoms of psychological distress (including anxiety, depression, trauma, and daily functioning problems) over the course of an intervention. Scores range from 0 to 40, with higher scores indicating greater distress.

322 Ibid., p. 245.

323 Ibid., p. 246.

324 Ibid., p. 241.

325 Ibid., p. 245.

of peer counsellors reduces the stigma and shame often associated with seeking psychiatric help, while the availability of online chat options provides a crucial first step for hesitant youth.[326]

A key implementation challenge is ensuring continuity of care; because the service is voluntary and anonymous, dropout rates after the first visit can be high, representing missed opportunities for sustained support.[327] Additionally, evaluations highlight a need to improve outreach to traditionally underserved demographic groups, such as ethnic minorities and LGBTQIA+ youth.[328] Systemically, the programme's expansion relies heavily on local municipal funding and the robust Dutch culture of volunteering, which may present capacity challenges in areas with lower civic engagement.[329]

STORM (Strong Teens and Resilient Minds)

Overview

STORM is a highly regarded, regional prevention programme implemented in secondary schools and vocational education settings to target depression and suicidality among adolescents. It represents a whole school, integrated approach built on several pillars: universal mental health education in classrooms, the training of school staff as 'gatekeepers' to identify warning signs, early screening for depressive symptoms, and the provision of targeted CBT resilience training (called 'Op Volle Kracht') for students showing elevated risks.[330] While fundamentally a school-based intervention, it addresses digital era pressures by equipping students with the socioemotional skills required to navigate modern stressors, including cyberbullying and digital performance pressure. It relies on a strong intersectoral partnership between educational institutions, the Municipal Health Service (GGD), and specialist mental healthcare providers (GGZ).

Evidence of effectiveness and ROI

STORM is categorised as a highly recommended and well substantiated intervention in the Netherlands Youth Institute (NJi) database. Research has demonstrated that the programme is effective in reducing depressive symptoms and fostering resilience among participating youth.[331] By embedding screening directly into the school environment, it successfully identifies students who require help but have not actively sought it out. While specific ROI data is not detailed in the available sources, early prevention models of this nature are widely recognised as highly cost-effective strategies for reducing long term public health and educational expenditures.[332]

Implementation: Barriers and enablers

The success of STORM is rooted in its cross sectoral governance. By formally linking schools with municipal health services and specialist care, it ensures that when a student is identified as high risk, a clear, immediate referral pathway exists.[333] The training of teachers as gatekeepers significantly expands the system's capacity for early detection.

Implementation is heavily dependent on the capacity of schools, which often face crowded curricula and intense timetabling pressures. Furthermore, ensuring structural, long-term funding requires

326 S. Leijdesdorff et al., 'Barriers and facilitators', p. 8.

327 OECD, *Promoting good mental health*, p. 251.

328 Ibid., p. 251.

329 Ibid., p. 255.

330 'STORM aanpak - Mental Health lessen voor jongeren', 2025.

331 'STORM is effectief bij depressieve klachten - Nederlands Jeugdinstituut'.

332 Trimbos-instituut, *Effectieve interventies en beleid mentale gezondheid en preventie*, p. 3.

333 'STORM: succesvolle aanpak depressiepreventie bij jongeren - AJN Jeugdartsen Nederland'.

continuous alignment between the budgets of the education sector and the decentralized municipal health budgets, which can complicate regional scaleup.[334]

Grip op je dip (Master Your Mood)

Overview

Grip op je dip is a fully digital, eHealth intervention designed to support young people aged 16 to 25 experiencing mild to moderate depressive symptoms. It operates as a web based, guided self-help programme rooted in the principles of CBT. Participants engage in an online group course where they learn to monitor their moods, challenge negative thought patterns, and develop coping strategies. The programme is highly relevant to the digital era as it leverages internet delivery to offer anonymous, low barrier support directly to young people's devices, bypassing the stigma and geographical barriers associated with traditional clinical settings.[335]

Evidence of effectiveness and ROI

Grip op je dip is recognised as an effective intervention with strong evidence of clinical impact. Evaluation data from 2020 to 2024 demonstrates a significant reduction in depressive symptoms among users, with average Centre for Epidemiologic Studies Depression Scale (CESD) scores dropping from 34.9 to 26.5.[336] According to outcome reports, 77 % of participants showed a clinically significant improvement, and for 40 % of users, depressive symptoms were fully resolved following the intervention.[337]

Implementation: Barriers and enablers

The critical enabler of this programme is its 'blended care' model. Unlike fully automated mental health apps, which frequently suffer from low engagement and high dropout rates, Grip op je dip incorporates human guidance via a professional online chat facilitator.[338] This guided element ensures clinical safety while maintaining the scalability and anonymity that young users value.

A primary challenge for digital interventions is ensuring sustained user adherence. Low digital health literacy among certain vulnerable subgroups, alongside potential privacy concerns, can act as barriers to entry. Furthermore, the effectiveness of the intervention relies on users having safe, consistent access to digital devices and stable internet connections.[339]

Transferability and EU policy lessons

The Dutch experience provides a compelling case study on the complexities of decentralised care, the value of peer led community support, and the proactive enforcement of digital regulations. For the European Union and other Member States, the Netherlands offers lessons on how to bridge the 'missing middle' in mental healthcare and how to leverage EU level digital governance to protect young people online. These insights inform the broader themes of early intervention services, prevention in schools, digital tools and governance, and equity and access.

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334 Trimbos-instituut, Effectieve interventies, p. 5.

335 'Grip op je dip steunt jongeren anoniem online – Weg van de wachtlijst'.

336 The CES-D scale ranges from 0 to 60 points, where a higher score indicates a higher frequency and severity of depressive symptoms. A score of 16 or greater is the standard threshold indicating a risk for clinical depression. The drop from 34.9 to 26.5 represents a measurable reduction in the severity of symptoms experienced by the individuals using the intervention.

337 'Onderzoek toont aan: Grip op je Dip leidt tot vermindering depressieve klachten – Youz'.

338 E. Dietvorst et al., 'Effective elements of eHealth interventions for mental health and wellbeing in children and adolescents: A systematic review', *Digital Health*, Vol. 10, 2024, p. 1.

339 OECD, *Promoting good mental health*, p. 118.

Transferability of Dutch intervention models

The Netherlands has pioneered several models that offer strong potential for cross border transfer, provided the right structural conditions are in place:

Early intervention services (@ease): the @ease model of low threshold, peer to peer walk in centres is relevant for EU countries struggling with overburdened clinical systems. By utilising trained youth volunteers backed by onsite clinical professionals, the model provides a highly cost-effective way to catch mild to moderate distress early. However, OECD transferability analyses indicate that while the model is highly applicable to about half of OECD and EU countries, its success depends heavily on a specific condition, a robust national culture of civic engagement and volunteering. Without a sustainable pipeline of volunteer peers and strong alignment with local primary care networks to handle escalated cases, the model would struggle to function.

Prevention in schools (STORM): the STORM programme demonstrates the efficacy of a whole school approach that combines universal mental health education with targeted cognitive behavioural therapy for at risk students. Its transferability relies on overcoming significant governance and funding barriers. For such a model to succeed elsewhere, it requires formalised, intersectoral collaboration-specifically, pooled funding and clear referral pathways between educational authorities, municipal health services, and specialist psychiatric care, ensuring that schools are not left to manage clinical risks alone.

Digital tools and blended care (Grip op je dip): Dutch eHealth platforms illustrate that digital mental health tools are most effective when they employ a 'blended care' approach. Fully automated apps often suffer from high dropout rates, but interventions like Grip op je dip combine digital accessibility with human guidance via professional chat facilitators. Transferring these models requires a baseline of national digital infrastructure, high digital health literacy among the target population, and a clinical workforce trained in remote delivery.

Insights on digital determinants and EU wide governance

The Dutch case yields specific insights into how national systems can respond to young people's online realities, offering lessons for EU wide debates on digital governance.

Enforcing safety by design through the DSA: the Netherlands provides lessons for how Member States can actively leverage EU legislation to hold the technology industry accountable. The Dutch Digital Services Coordinator's joint investigation with the European Commission into Snapchat, specifically targeting its compliance with the DSA regarding age assurance and the mitigation of addictive design features, highlights that EU level frameworks like the DSA are most effective when actively enforced by well-resourced national coordinators who prioritise the protection of minors.

Child Rights Impact Assessments (CRIAs): a key policy lesson emerging from Dutch civil society is the urgent need to mainstream children's rights into all digital and health policymaking. Stakeholders advocate for the mandatory use of CRIA across all government levels. For the EU, this suggests that any future digital legislation or mental health strategy must systematically evaluate its practical impact on youth wellbeing and fundamental rights before implementation, ensuring that commercial digital interests do not override child safety.

Equity, access, and the risks of fragmentation

Finally, the Dutch experience serves as a cautionary tale regarding equity and system fragmentation. The 2015 decentralisation of youth care to municipalities, while intended to bring services closer to communities, resulted in significant regional disparities, complex administrative bottlenecks, and severe workforce shortages. For other Member States considering systemic reforms, the Dutch

context underscores that early intervention and community-based care cannot replace the need for adequately funded, specialized psychiatric services. Furthermore, both digital and physical interventions must be intentionally designed to reach marginalized youth—including those from lower socio-economic backgrounds, migrant families, and LGBTQIA+ communities—who are disproportionately exposed to online harms and often face the highest barriers to accessing traditional care.

Australia

Executive summary

Table 19 – Australia case study executive summary

Section	Details
National Context and Current Situation	Australia combines comprehensive mental health strategies (National Mental Health and Suicide Prevention Agreement/Plan, National Mental Health Policy, Vision 2030, and the National Children's Mental Health and Wellbeing Strategy) with a mature online safety regime. The Online Safety Act 2021 and the 2024 minimum-age amendment (now in force) strengthen platform accountability but raise age-assurance and privacy questions amid evidence of weakly enforced age limits. Youth need is high: around 39 % of 16–24-year-olds report a 12-month mental disorder, suicide is the leading cause of death for 15–24-year-olds, and most children use social media despite age rules, linking some online harms with poorer mental health. Despite high public spending, access and workforce pressures persist, with COVID-19, cost-of-living stress and climate anxiety driving sustained distress.
Intervention 1: headspace	Headspace is a nationally funded, youth-friendly early-intervention model for ages 12–25, delivered through community hubs integrated with online/phone support across mental health, physical/sexual health, AOD, and work/study. Evidence shows strong gains in access, acceptability and engagement, and short-term improvements in distress/functioning for many users; economic evaluation suggests cost-effectiveness, though routine outcome data are uneven. Strengths include scale and integrated design; key challenges are demand and wait times, workforce shortages (especially outside cities), variability across sites and equity gaps for priority groups
Intervention 2: Kids Helpline	Kids Helpline is a free, confidential, 24/7 national service for ages 5–25 via phone and digital channels, providing immediate counselling, information and referral at scale. Use is high and increasingly digital, with mental health/emotional wellbeing and suicide-related concerns common; evidence is strongest on reach and system role rather than long-term clinical outcomes or ROI. Enablers include anonymity, immediacy and broad reach; barriers include capacity, workforce and integration with offline services and school/family pathways.
Intervention 3: ReachOut	ReachOut is a national digital platform offering information, self-help tools, peer support and signposting for young people (and supports for parents/carers), free, anonymous and available 24/7. Cohort and developmental evaluations show modest but significant short-term reductions in depression/anxiety/stress, lower suicide risk and improved help-seeking, alongside very large reach. Enablers are youth co-design, national digital infrastructure and no-wait access; challenges include discoverability (amid changing search/AI behaviour), measuring long-term impact, service capacity and safe escalation for higher-need users.
Intervention 4: eSafety Commissioner framework	A regulatory intervention shaping the digital environment rather than a clinical service: the eSafety Commissioner enforces the Online Safety Act 2021 and the 2024 minimum-age duty requiring age-restricted social media platforms to

Section	Details
	prevent under-16s holding accounts. Early implementation shows visible platform actions (removing/restricting large numbers of under-16 accounts), but mature evidence on mental-health outcomes is pending; there is no service-style ROI. Key implementation issues are age assurance, privacy compliance and enforcement scope, with exclusions (e.g., standalone messaging, gaming, health/education) designed to preserve beneficial services.
Transferability and EU Policy Lessons	Australia demonstrates a dual-track approach: scaling accessible early-intervention services (headspace) and national digital supports (Kids Helpline, ReachOut) while enforcing platform accountability through a dedicated online-safety regulator. Transfer requires sustained public funding, cross-sector governance, clear referral pathways, robust digital infrastructure, privacy-preserving age-assurance and strong regulatory powers, lessons directly relevant to EU DSA enforcement and child-protection debates. Equity must be central: digital models can widen access, but systems must address workforce capacity, continuity of care, and engagement of harder-to-reach groups to avoid deepening gaps and to better serve the 'missing middle'. enforcing EU digital regulation and integrating child rights into policymaking, while cautioning against fragmentation and inequities arising from decentralisation.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

Australia has national mental health strategies and a relatively developed online safety framework.[340] In mental health, the main national frameworks include the National Mental Health and Suicide Prevention Agreement, the National Mental Health and Suicide Prevention Plan (2021), the National Mental Health Policy, and Vision 2030[341], which sets a longer-term direction for a more connected and preventive mental health system. Children and young people are explicitly recognised in this framework. The National Children's Mental Health and Wellbeing Strategy is the main child focused framework. In June 2025, Australian health ministers also confirmed that children and young people aged 0–25 would remain a priority group in the next national agreement.[342]

Australia also has a developed legal and regulatory framework for online safety. The Online Safety Act 2021 strengthened the eSafety Commissioner's powers to address online harms and hold platforms to account. The framework was extended by the Online Safety Amendment (Social Media Minimum Age) Act 2024.[343] This law is now in force and creates minimum age obligations for age restricted social media platforms.[344] Parliamentary scrutiny of social media harms has also

340 Australian Government, Department of Health and Aged Care, *What we're doing about mental health*, 2026.

341 Australian Government, Department of Health and Aged Care, 2026.

342 Australian Government, Department of Health and Aged Care, *Delivering high-quality free digital mental health supports*, 2025.

343 Commonwealth of Australia, *Online Safety Amendment (Social Media Minimum Age) Act 2024*, No 127, 10 December 2024.

344 eSafety Commissioner, *Children and social media*, 2025.

strengthened the case for greater platform accountability and safety by design measures.[345] Implementation of the minimum age framework has also raised questions about privacy, age assurance and compliance.[346, 347] This makes Australia a useful comparator for a study of mental health in a digital era. Its policy approach goes beyond treatment and prevention to include digital governance and platform regulation.

Evidence on platform practices suggests that age restrictions are enforced inconsistently and that current age assurance systems often fail to prevent underage access. This has strengthened the case for placing more responsibility on platforms and requiring safety by design measures.[348]

Baseline statistics

Australia had 4.8 million children aged 0–14 and 3.3 million young people aged 15–24 on 30 June 2023.[349, 350] In total, just over 8 million people in Australia were aged 0–24.[351]

Australian survey data show a high prevalence of mental health problems among young adults. In the National Study of Mental Health and Wellbeing 2020–2022, 38.8 % of people aged 16–24 had a 12 month mental disorder and 31.8 % had a 12-month anxiety disorder.[352] The Australian Institute of Health and Welfare's (AIHW) summary of the 2022 National Health Survey reports that 17 % of people aged 15–24 had depression and 26 % had anxiety as chronic conditions.[353] Suicide is the leading cause of death among Australians aged 15–24.[354] In 2023, 298 people aged 18–24 died by suicide, and the suicide rate for this group was 12.6 persons per 100 000. Among those aged 15–17, the rate was 6.9 per 100 000.[355]

Children and teenagers in Australia have high levels of digital exposure, although the measures are not directly comparable. In 2024, eSafety's Children and Social Media Survey found that 84 % of children aged 8–12 had used at least one social media or messaging service.[356] The Keeping Kids Safe Online survey found that 96 % of children aged 10–15 had used social media, and 94 % had used a communication platform to chat, message or call others.[357] In 2020, eSafety's survey of teens aged 12–17 found average internet use of 14.4 hours per week, or just over 2 hours a day.[358] That same survey reported that teens used an average of four different social media services–[359] These figures show that digital use is widespread among children and young people, even though Australia does not publish a single measure of smartphone penetration for the full 0–24 age group.

Most platforms have age restrictions, but these are weakly enforced. Regulatory analysis indicates that a large majority of children aged 8–12 are using social media services despite minimum age

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345 Parliament of Australia, Joint Select Committee on Social Media and Australian Society, *Final report, Chapter 3: Social media and online harms*.

346 Office of the Australian Information Commissioner, *Social media minimum age*.

347 Digital ID System, *Social media minimum age verification law and Digital ID.*

348 eSafety Commissioner, *Digital use and risk: Online platform engagement among children aged 10 to 15,* 2025.

349 Australian Institute of Health and Welfare, *Health of children,* 2024.

350 Australian Institute of Health and Welfare, *Health of young people,* 2024.

351 Australian Bureau of Statistics, *National, state and territory population,* 2024.

352 Australian Bureau of Statistics, 2024.

353 Australian Institute of Health and Welfare, *Negative online experiences*, 2021.

354 Australian Institute of Health and Welfare, *Suicide and self-harm among young people*, 2025.

355 Australian Institute of Health and Welfare, 2025.

356 eSafety Commissioner, *Social media age restrictions*, website.

357 eSafety Commissioner, 2025.

358 eSafety Commissioner, *The digital lives of Aussie teens,* 2021.

359 eSafety Commissioner, 2021.

rules, pointing to widespread circumvention and the limited effectiveness of self-declared age at signup.[360] Children also use multiple platforms, including both social media and communication services. This shows how central digital spaces are to everyday social interaction and peer relationships.[361] AIHW reports that negative online experiences are associated with depression, anxiety and suicidal ideation. This links digital harms directly to youth mental health.[362] Government analysis also shows uneven digital access and online experiences among children and young people. Mental health responses therefore need to consider exclusion and inequality as well.[363]

AIHW reports that Australia had about 33 000 psychologists in 2022 and 4 300 psychiatrists in 2023.[364] Using the mid 2024 population of 27.2 million, this is about 121 psychologists and 16 psychiatrists per 100 000 people.[365, 366] In 2023–2024, state and territory spending on specialised mental health services reached €5.6 billion, while Commonwealth spending on mental health related services was estimated at about €3 billion.[367] This points to high overall spending, but continued pressure on access and the workforce. The National Mental Health Workforce Strategy recognises the need for a more sustainable, better distributed and better supported workforce across promotion, prevention, early intervention and treatment.[368]

Crisis impacts

The COVID-19 pandemic had lasting effects on youth mental health in Australia. In 2020–22, 26 % of people aged 16–24 experienced high or very high psychological distress,[369] and the Australian Bureau of Statistics (ABS) data show that this age group had the highest prevalence of 12-month mental disorders.[370] Government mental health related spending also rose from about €7.4 billion in 2019–2020 to €8.4 billion in 2023–2024.[371] The effects of the pandemic on youth mental health therefore extended beyond the immediate crisis period.

Beyond the pandemic, pressures on young people's wellbeing in Australia stem mainly from the cost-of-living crisis, economic insecurity, housing stress and uncertainty about the future. In the 2025 Mission Australia Youth Survey, 64 % of respondents identified the cost of living as the most important issue facing young people.[372] Mental health, climate change and housing also ranked highly. These pressures are driven more by everyday affordability pressures and concern about the future than by a single shock.

Australian research shows high levels of climate concern among young people and poorer mental health outcomes among those directly affected by extreme weather events. Orygen reports that 76 % of young Australians worry about climate change, and 67 % said climate concerns were having

360 eSafety Commissioner, 2025.

361 eSafety Commissioner, 2025.

362 Australian Institute of Health and Welfare, 2024.

363 Department of Infrastructure, Transport, Regional Development, Communications and the Arts, *Australian youth online: Findings from the Longitudinal Study of Australian Children.*

364 Australian Institute of Health and Welfare, 2024.

365 Australian Bureau of Statistics, 2024.

366 Australian Institute of Health and Welfare, 2024.

367 Australian Institute of Health and Welfare, *Expenditure on mental health-related services*, 24 February 2026.

368 Australian Government, Department of Health and Aged Care, *National Mental Health Workforce Strategy: conceptual framework,* 2023.

369 Australian Institute of Health and Welfare, *Mental health workforce*, 2026.

370 Australian Bureau of Statistics, 2024.

371 Australian Institute of Health and Welfare, 2026.

372 Mission Australia, Youth Survey, 2025.

a negative effect on young people's mental health.[373] Young people affected by extreme weather also report higher levels of psychological distress than those not affected. Climate anxiety is therefore an important pressure on youth wellbeing in Australia.

Deep dive: Featured interventions

This section examines four interventions that illustrate Australia's contribution to the study: headspace, Kids Helpline, ReachOut and the eSafety Commissioner framework, including the recent under-16 social media restrictions. Together, they show the breadth of Australia's response to youth mental health in a digital era, spanning early intervention, digital support at scale and regulation of online harms.[374]

These four interventions were selected for their policy relevance, scale, maturity and strength of evidence. headspace offers a well-established model of youth friendly integrated service delivery;[375] Kids Helpline provides a low threshold national support service;[376] ReachOut offers a digital model with evaluative outcome evidence;[377] and the eSafety Commissioner regime adds a governance dimension relevant to current EU debates on platform accountability, age assurance and safer digital environments.[378]

Other interventions are also relevant to the wider Australian landscape but are not examined here in the same detail. They are noted briefly to illustrate the broader prevention and digital literacy ecosystem.

Other examples of relevant interventions in the Australian ecosystem

MindMatters / Be You:[379] a national education sector initiative supporting a whole school approach to mental health and wellbeing through educator training, implementation tools and school-based prevention resources.

Decode Mental Health:[380] a school based mental health literacy programme using social media style content and lived experience storytelling to engage students and teachers.

Teens & Screens:[381] a school based digital literacy and wellbeing programme developed by the Black Dog Institute to promote healthy screen habits and safer navigation of online risks.

FRIENDS Resilience:[382] a suite of cognitive behavioural therapy-based resilience programmes for children, young people and adults, designed for use in schools, families and communities.

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373 Orygen, *Climate of distress: Survey results 2023*, 2023.

374 eSafety Commissioner, 2025.

375 Australian Government, Department of Health and Aged Care, Evaluation of the National headspace Program, final report, June 2022.

376 Kids Helpline, *FAQs*, website.

377 B. L. Kahl et al., *'Evaluation of ReachOut.com, an Unstructured Digital Youth Mental Health Intervention: Prospective Cohort Study'*, JMIR Mental Health, 2020.

378 Commonwealth of Australia, 2024; eSafety Commissioner, 2025.

379 E. Hoare et al., *'Be You: a national education initiative to support the mental health and wellbeing of Australian learning communities'*, Australian and New Zealand Journal of Psychiatry, 2020; J. Wyn et al., *'MindMatters, a whole-school approach promoting mental health and wellbeing in Australian secondary schools'*, 2000.

380 Murdoch Children's Research Institute, *Unique mental health program in schools has positive impact, reduces stigma*, 18 November 2024; E. Habgood et al., *'Pilot evaluation of an innovative school-based mental health literacy program for teachers and students: The Decode Mental Health and Wellbeing Program'*, The Australian Educational Researcher, Vol. 52, 24 October 2024.

381 Black Dog Institute, *Teens & Screens*, 2025.

382 B. Fisak, K. Griffin, C. Nelson, J. Gallegos-Guajardo and S. Davila, '*The effectiveness of the FRIENDS programs for children and adolescents: A meta-analytic review*', Mental Health & Prevention, 2023.

Orygen:[383] a national youth mental health organisation focused on research, policy and service innovation, including evidence generation on youth mental health, digital environments and early intervention.

Headspace

Headspace is Australia's national youth mental health foundation and a well-established model of integrated early intervention for young people. It aims to reduce barriers to help-seeking through accessible, youth friendly support delivered through community-based hubs and linked online and phone services. It supports young people aged 12-25 and is designed to intervene early, before difficulties become more severe.[384] headspace centres are community based primary care hubs offering multidisciplinary support across mental health, physical and sexual health, alcohol and other drugs, and work and study. This reflects the linked social and health factors that shape young people's mental health and wellbeing.[385]

headspace combines face to face centres, online and phone counselling, and a wider presence in schools and communities. Young people can access support directly or through referral by family, schools, health workers or community agencies. The programme is publicly funded and nationally scaled. In October 2025, the Australian Government announced an additional €44.4 million to reduce waiting times and improve access across 85 headspace services.[386]

Evidence of effectiveness and ROI

The strongest evidence for headspace is on access, acceptability and engagement, with more mixed but still positive evidence on outcomes. The 2022 government commissioned evaluation found that headspace was effective in achieving many of its intended outcomes, particularly in improving access, affordability and user experience. The evaluation found that the model supported mental health literacy, early help seeking and access to required services, with out-of-pocket costs paid in only 2.1 % of occasions of service. User ratings were also strong: 86.6 % of young people said they were generally satisfied with headspace, 75.6 % said they got help for the issues they wanted addressed, and 88.7 % said they would recommend the service to a friend. At the same time, the evaluation highlighted weaker results for some harder to reach groups, waiting time pressures in some services, and important limitations in routine outcome measurement and follow up data.[387]

Peer reviewed studies are somewhat more positive on short term outcomes. An early national analysis of routine headspace data found that more than one third of clients showed significant improvement in psychological distress and a similar proportion improved in psychosocial functioning, with 60 % improving significantly on one or both measures.[388] Improvement was most strongly seen in individuals who started with higher levels of distress and poorer functioning. Attending more sessions was also linked to better outcomes. However, factors like age, sex, and the primary issue the person sought help for did not seem to affect the level of improvement. More recent longitudinal analysis of headspace centre data has also pointed to improvements in psychological distress, psychosocial functioning and quality of life, with roughly seven in ten young

[383] S. Cross et al., *'Insights from fifteen years of real-world development, testing and implementation of youth digital mental health interventions'*, Internet Interventions, Vol. 41, 2025.

[384] Headspace, *Home*, 2026.

[385] Headspace, 2026.

[386] Australian Government Department of Health, Disability and Ageing, *National headspace Day: Funding boost to improve headspace services*, media release, 9 October 2025.

[387] Australian Government, Department of Health and Aged Care, 2022.

[388] D. J. Rickwood et al., *'Changes in psychological distress and psychosocial functioning in young people visiting headspace centres for mental health problems'*, Medical Journal of Australia, Vol. 202, No 10, 2015.

people improving on at least one measure.[389] These findings suggest that gains are often more visible when outcomes are assessed across several domains rather than distress alone.

The outcome evidence nonetheless remains qualified. The early national analysis was limited by the absence of a control group; incomplete follow up and variation across centres. The 2022 national evaluation likewise highlighted gaps in routine outcome data and uneven survey completion, which makes national subgroup analysis difficult to interpret consistently.[390]

Public evidence on economic performance is less developed than the evidence on access and outcomes, but it is not absent. The 2022 national evaluation included a cost effectiveness analysis and estimated an incremental cost effectiveness ratio of €27 330 per QALY gained, with sensitivity estimates ranging from €12 349 to €34 774 per QALY gained.[391] The evaluators concluded that headspace appeared cost effective against thresholds used for similar healthcare services. The same evaluation reported that 112 headspace services delivered 401 325 occasions of service in 2019–2020, at an average cost of around €188 per occasion of service.[392] However, it did not provide a simple headline ROI figure, and the evaluators noted uncertainty around the full cost base. headspace is therefore better described as a model with qualified cost effectiveness evidence than as one with a directly comparable public ROI estimate.

Implementation: Barriers and enablers[393]

A major strength of headspace is its integrated, youth friendly design, backed by sustained national investment. The 2022 evaluation found that this model makes services easier for young people to approach than more traditional clinical settings and helps connect mental health support with related needs. In 2019–2020, headspace services delivered more than 401 000 occasions of service to over 90 000 young people, showing both national scale and a high volume of repeat engagement. The network's spread across metropolitan, regional and remote areas also supports reach beyond major cities.

The main implementation challenges are: demand pressure, waiting times, workforce shortages and variation across sites. The evaluation found that waiting times were repeatedly raised as a barrier to access, particularly by school and university counsellors, and that pressure from supporting higher needs young people could reduce capacity for early intervention. Workforce shortages were identified as a key external constraint, especially for GPs, psychologists and psychiatrists, and particularly in regional, rural and remote areas. The evaluation also found variation in performance across centres and weaker results for some harder to reach groups, including Aboriginal and Torres Strait Islander young people, culturally and linguistically diverse young people, and young people with disability.

Stakeholder evidence points to a related system issue: a persistent 'missing middle', in which young people with mild to moderate needs often struggle to access timely support before difficulties escalate. This reinforces the value of headspace as an early intervention model but also shows that its effectiveness depends partly on the capacity of the wider system.

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389 Rickwood et al., 2015; D. Rickwood et al., *'Sixteen years of innovation in youth mental healthcare: Outcomes for young people attending Australia's headspace centre services'*, PLOS One, Vol. 18, No 6, 2023.

390 Rickwood *et al.*, 2015; Australian Government, Department of Health and Aged Care, 2022.

391 Australian Government, Department of Health and Aged Care, 2022.

392 Australian Government, Department of Health and Aged Care, 2022.

393 Australian Government, Department of Health and Aged Care, 2022.

Kids Helpline

Kids Helpline is Australia's national 24/7 counselling and support service for children and young people aged 5 to 25. It is free, confidential and available by phone and online. Children and young people can contact the service directly, without referral, making it a low threshold point of entry for those who need immediate support, do not want face to face care, or cannot access other services quickly.[394]

Kids Helpline combines early intervention; crisis support and digital mental health service delivery. It is not a substitute for specialist care, but it plays an important bridging role within the wider mental health system. The service provides immediate counselling, information and referral, and has a wider role through online support and school-based activity. It is therefore best understood as part of a broader help seeking pathway rather than as a standalone intervention.

Kids Helpline also operates at significant scale. yourtown's 2023 impact reporting recorded 122 356 counsellor responses and 70 618 counselling sessions, with emotional wellbeing, mental health concerns and suicide related concerns among the main reasons for contact.[395] Its 2024 reporting showed continued high demand, including 133 386 counsellor responses, a large website user base and substantial reach through the Kids Helpline @ School programme.[396] Together, these figures show substantial national reach across both immediate support and prevention activity.

Evidence of effectiveness and ROI

The strongest recent evidence specific to Kids Helpline concerns reach, accessibility and patterns of use rather than measured clinical outcomes. A 2021 peer reviewed study analysing 1 415 228 answered Kids Helpline contacts between 2012 and 2018 found a clear shift towards digital channels over time, with growing use of webchat and email alongside declining reliance on phone. Across all channels, the most common reasons for contact were emotional wellbeing and mental health concerns: 53.2 % of phone contacts, 57.3 % of webchat contacts and 58.2 % of email contacts. Social relationship issues and family relationship concerns were the next most common topics. While this was not an outcome evaluation, it shows that Kids Helpline was being used at scale as a mental health support pathway and that its format aligned with changing youth help seeking preferences.[397]

Recent service reporting points in the same direction. The 2023 Kids Helpline Impact Report, published in 2024, found that 49.7 % of all counselling sessions for children and young people aged 5–25 related to mental health and emotional wellbeing, and also highlighted an upward trend in suicide related concerns among Aboriginal and Torres Strait Islander children and young people over the previous five years.[398] The 2024 Kids Helpline Impact Report, published in 2025, reported that Kids Helpline responded to over 130 000 contacts in 2024, up from 122 356 the previous year, and that one in six counselling contacts related to suicidal thoughts.[399] Together, these reports provide strong recent evidence of high demand, substantial mental health relevance and growing crisis related activity.

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394 Kids Helpline, *Home*, website.

395 Yourtown, *Kids Helpline shines a light on priority needs of First Nations and gender diverse young people,* 8 March 2024.

396 Kids Helpline, *Kids Helpline Impact Report 2024: Revealing the top reasons children and young people reached out for help in 2024*, 2025.

397 D. Watling, J. Robinson, A. Graham, R. Tucker and D. Rickwood, *'Help-seeking from a national youth helpline in Australia'*, International Journal of Environmental Research and Public Health, Vol. 18, No 11, 2021.

398 Yourtown, *Kids Helpline acts to protect young lives*, 9 October 2025.

399 Kids Helpline, 2025.

Stakeholder evidence reinforces this picture. A Kids Helpline stakeholder described mental health and wellbeing as the leading reason for contact for at least the past decade, with increasing complexity in presentations and greater demand for crisis related support, particularly around suicide and self-harm. They also stressed the importance of anonymity, immediacy and continuity in virtual provision, describing Kids Helpline as 'the safety net for children and young people'. The published and stakeholder evidence indicates that Kids Helpline serves both preventive and crisis support functions.

The evidence base is therefore stronger on service use, accessibility and system relevance than on sustained clinical outcomes or comparative effectiveness. No robust published ROI estimate comparable to those available for some other interventions was identified. Kids Helpline is best understood as a service with high demonstrated demand, strong reach and stable policy relevance than as one with directly comparable economic evidence.[400]

Implementation: Barriers and enablers

A major enabling factor is Kids Helpline's multichannel, 24/7 design. This allows the service to provide immediate support at national scale and to reach young people who face stigma, privacy concerns or other barriers to help seeking.[401] Its national digital format also gives it broad geographical reach without requiring extensive physical infrastructure. Stakeholder evidence suggests that this model can work particularly well for groups facing additional barriers to help seeking, including culturally and linguistically diverse young people, Aboriginal and Torres Strait Islander young people, and LGBTQIA+ young people.

The main implementation challenges concern capacity, workforce and integration with wider care pathways. High demand creates pressure on response times and service coverage, while research and stakeholder evidence both suggest that young people often move between online and offline supports that are not always well connected.[402] Stakeholders also pointed to communication gaps across school systems, uneven access to devices and private spaces for support, and ongoing difficulty in reaching parents before problems escalate.

ReachOut

ReachOut is Australia's national digital mental health service for young people. It provides online information, self-help tools, peer support and pathways to further help in a format designed to be accessible, anonymous and youth friendly. It also supports parents and carers. ReachOut describes its youth service as free, anonymous, confidential, available 24/7 and without waitlists.[403]

ReachOut sits mainly within digital prevention and early intervention. Unlike a clinical treatment service or community hub model, it is built around self-directed online engagement at scale. It is particularly relevant for young people who may be reluctant to seek face-to-face support or who want an initial step before moving into more formal care. In this sense, it complements rather than replaces the wider youth mental health system.

ReachOut is delivered through a national online platform and related digital services. Its main youth offer is aimed at young people aged 12-25, with separate support for parents and carers. The model combines information, self-help resources, peer features and links to further support. It also remains part of Australia's digital mental health infrastructure: in February 2025, the Australian Government

400 Yourtown, 2024.

401 Kids Helpline, 2026.

402 Watling *et al.*, 2021.

403 ReachOut, *Support for young people*, 2025.

announced a three-year funding commitment under the Digital Mental Health Program, and ReachOut publicly confirmed that it was included in that commitment.[404]

Evidence of effectiveness and ROI

ReachOut has stronger evaluative evidence base than many comparable digital youth mental health services. A prospective cohort study published in *JMIR Mental Health* followed 1,982 ReachOut users over 12 weeks and reported an 81.18 % retention rate.[405] Over that period, users showed modest but statistically significant reductions in depression, anxiety and stress symptoms, as well as lower suicide risk and improved help seeking intentions. More recent service specific evaluation points in the same direction: ReachOut's 2024 developmental evaluation of PeerChat found that 74 % of users felt a little or a lot better after their chat, and 86 % experienced at least one positive outcome during the session, including reduced distress, feeling less alone, and greater confidence to talk about difficult issues.[406] Together, these findings suggest that ReachOut can contribute to short term improvements in mental health and help seeking, although the evidence remains encouraging rather than conclusive because it relies mainly on nonrandomised and developmental evaluation designs.

Public reporting adds useful context on scale and user need. ReachOut's 2024–2025 social impact reporting states that it supported over 1 million young people in Australia in the last year, and that 46 % of youth users met the K6 threshold for a possible serious mental illness.[407] Stakeholder evidence points in the same direction: a ReachOut stakeholder reported a 'really big uptake' in the organisation's anonymous peer support service over the past 12 to 24 months and said that young people valued having a space to explore their feelings before deciding what to do with them. This suggests that ReachOut is reaching a large user base with substantial mental health needs and is providing a form of early support that many young people find meaningful.

Public evidence on economic performance is more limited. ReachOut's public materials highlight reach, accessibility and user outcomes, but do not provide a directly comparable cost per user or return on investment figure. The service is therefore best understood as a digital intervention with promising outcome evidence and clear policy relevance, but without a directly comparable public ROI estimate.

Implementation: Barriers and enablers

A major enabling factor is ReachOut's service model. It is 100 % online, free, anonymous, confidential, available 24/7 and without waitlists, which supports broad access without the physical infrastructure required by face-to-face services. A second enabling factor is its emphasis on youth participation: stakeholder evidence indicates that young people are involved throughout the codesign process, and that ReachOut is trying to strengthen this further so that the service remains clearly human centred as AI generated information becomes more prominent.[408]

The main implementation challenges concern discoverability, long term impact measurement, service capacity, and escalation for users with more complex needs. The stakeholder interview highlighted that changing search behaviour and the rise of AI are making engagement harder to measure, because impressions and discoverability are becoming more important than clickthrough's

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404 Australian Government, Department of Health and Aged Care, 2025; ReachOut, *ReachOut welcomes Digital Mental Health Program funding commitment*, 19 February 2025.

405 Kahl B. L. *et al*., 2020.

406 ReachOut, *PeerChat evaluation*, 2024.

407 ReachOut, *Social Impact Report 2024–25*, 2025.

408 eSafety Commissioner, 2025.

alone. It also pointed to practical service limits: PeerChat is designed as in the moment support rather than ongoing care, users cannot return to the same peer worker by design, and continuity therefore depends on effective onward referral to more tailored services. The same interview described parts of the service as operating over capacity and noted that peer work remains a relatively new workforce model in Australia. ReachOut's implementation therefore appears strongest when it is embedded in a wider support system with clear referral pathways and sufficient downstream capacity.

eSafety Commissioner framework and under-16 social media restrictions

The eSafety Commissioner framework is Australia's main regulatory response to online harms affecting children and young people. Unlike headspace and ReachOut, it is not a service intervention but a governance framework for shaping the digital environment in which young people interact. Its relevance to youth mental health lies in its focus on reducing harmful online exposure and increasing platform accountability[409].

This intervention sits within digital regulation and online safety governance. It is rooted in the Online Safety Act 2021, which gives the eSafety Commissioner powers in relation to online harms, industry regulation and enforcement. It was extended by the *Online Safety Amendment (Social Media Minimum Age) Act 2024*, which requires age restricted social media platforms to take reasonable steps to prevent Australians under-16 from holding accounts. The obligation took effect on 10 December 2025.[410]

The policy case for the restrictions rests on evidence of widespread underage use, harmful content exposure and weak existing age checks. eSafety reported that 80 % of children aged 8-12 had used one or more social media services in 2024, suggesting that around 1.3 million children in that age group may have been using social media despite platform minimum age policies. Among 8-12-year-olds who had used social media, 54 % had accessed it through a parent's or carer's account. eSafety also reported that 96 % of children aged 10-15 had used at least one social media platform, that 7 in 10 had encountered content associated with harm online, and that three quarters most recently encountered such content on a social media service.[411]

The obligation falls on platforms, not on children, parents or schools. eSafety states that there are no penalties for under-16s or for parents and carers; instead, platforms may face penalties if they fail to take reasonable steps to comply. Rules made for the scheme also exclude some categories of services, including standalone messaging, voice and video calling, online gaming, and services whose main purpose is health or education support. This approach seeks to restrict broad social media access while preserving access to services that may have protective or functional value for young people.[412]

Evidence of effectiveness and ROI

Evidence is currently stronger on early compliance than on mental health outcomes. The minimum age obligation only took effect on 10 December 2025, so there is not yet mature public evidence on downstream effects on youth mental health, wellbeing or service demand. eSafety's March 2026 update covers only the first three months of implementation, and eSafety's formal evaluation is still under way, with initial findings due later in 2026.[413]

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409 Commonwealth of Australia, 2024; eSafety Commissioner, 2025.

410 eSafety Commissioner, *Industry regulation*, 23 December 2025; eSafety Commissioner, 2025.

411 eSafety Commissioner, 2025.

412 eSafety Commissioner, 2025; eSafety Commissioner, *Social media age restrictions evaluation*, 2026.

413 eSafety Commissioner, 2025.

There is, however, some early evidence of implementation effects. eSafety reports that platforms have taken steps to comply, resulting in a significant number of under-16 accounts being removed, deactivated or restricted from signing in since the law took effect. At the same time, eSafety also states that the restrictions will not eliminate every online risk children face, and its broader evaluation is needed before stronger claims can be made about effectiveness.[414]

Stakeholder evidence also cautioned against treating the online environment as the sole driver of worsening youth mental health. While eSafety evidence highlighted harms such as body image pressures, harmful online attitudes around relationships and consent, and algorithmically reinforced content pathways, the Kids Helpline stakeholder suggested that many contacts are also shaped by wider pressures including bullying, school stress, family difficulties and cost of living pressures.[415] This supports a broader view in which digital harms are important but interact with wider social and mental health pressures.

There is no robust public ROI or cost per user measure comparable to those used for service interventions. The economic dimension is therefore better understood in terms of regulatory burden, compliance design and implementation costs, rather than direct service efficiency.[416]

Implementation: Barriers and enablers

A major enabling factor is that Australia already had a dedicated online safety regulator. The eSafety Commissioner was able to move quickly from legislation to implementation by publishing regulatory guidance in September 2025, identifying 10 age restricted platforms, and using compulsory information gathering notices to monitor compliance in the first three months after the obligation took effect.[417]

Implementation has generated visible platform action, but not full compliance. eSafety reports that age restricted platforms removed access to 4.7 million under-16-year-old accounts across Australia by mid-December 2025. At the same time, eSafety's March 2026 compliance update was based on notices to 10 publicly identified platforms, which shows that active oversight is still needed[418].

The main barriers are age assurance, privacy and enforcement. OAIC guidance states that platforms and third-party age assurance providers may need to handle personal information for compliance purposes, and that steps taken under the scheme are not 'reasonable' unless they also comply with Part 4A, the Privacy Act and the Australian Privacy Principles.[419] This makes privacy compliance part of the core implementation task rather than a secondary issue.

Enforcement is also constrained by the need to draw workable boundaries around which services are covered. eSafety states that online gaming and standalone messaging apps are excluded, although messaging services with broader social media style features may still fall within scope. Platforms that fail to take reasonable steps can face court imposed civil penalties of up to 150 000 penalty units, currently equivalent to €30.1 million, while there are no penalties for under-16-year-olds or their parents or carers[420].

414 eSafety Commissioner, 2025.

415 eSafety Commissioner, 2025; Office of the Australian Information Commissioner, 2025.

416 eSafety Commissioner, 2025; Office of the Australian Information Commissioner, 2025.

417 eSafety Commissioner, 2025.

418 eSafety Commissioner, 2025.

419 Office of the Australian Information Commissioner, 2025.

420 eSafety Commissioner, 2025.

Stakeholder evidence also highlighted the practical importance of school preparedness, parent engagement and clear incident response pathways. This is especially relevant where schools may lack the confidence, training or communication systems needed to respond effectively to online safety incidents.

Transferability and EU policy lessons

The Australian experience offers valuable lessons for the European Union, demonstrating a dual track approach that combines the scaling of accessible early intervention services with the implementation of a robust, world leading regulatory framework for online safety. This combination of strengthening service delivery while actively shaping the digital environment provides a comprehensive blueprint for responding to the mental health needs of young people in a digital era.

Early intervention services and prevention

Australia's headspace network provides a highly transferable model for early intervention that is directly relevant to EU Member States seeking to address the 'missing middle' in mental healthcare. The integrated, youth friendly community hub design, which collates mental health support with physical health, drug and alcohol services, and work and study support, offers a blueprint for holistic, non-stigmatising care. For this model to be transferred successfully, several conditions are essential: sustained national public funding, a multidisciplinary workforce, and strong governance structures that ensure clear referral pathways between primary care hubs and specialist clinical services to manage demand and complexity.

Digital tools and governance

The Australian case study provides two distinct but complementary lessons on digital tools and governance. First, services like Kids Helpline and ReachOut demonstrate the value of delivering free, anonymous, and nationally scaled digital mental health support. These platforms effectively lower barriers to access for young people who may be reluctant to seek face-to-face help, offering a vital entry point into the care system. The conditions for transferring such models include robust national digital infrastructure, a trained workforce capable of delivering online counselling and peer support, and well-defined escalation pathways to ensure users with acute needs are connected to clinical care.

Second, and most distinctively, the eSafety Commissioner framework offers a powerful governance model for the EU and its Member States on how to operationalise digital regulation and enforce platform accountability. It provides a concrete example of how a well-resourced, independent national regulator can actively enforce safety by design principles, moving beyond reactive content moderation to proactively address systemic risks. The Commissioner's role in implementing the Online Safety Act, including the recent restrictions on social media for under-16-year-olds, is directly relevant to EU level debates on the enforcement of the Digital Services Act (DSA) and the protection of minors online. Transferability of this regulatory approach depends on strong legislative backing, political will to grant regulators meaningful enforcement powers, and careful navigation of the technical and privacy challenges associated with measures like age assurance.

Equity and access

Finally, the Australian experience underscores the importance of designing services to enhance equity and access. Digital interventions like Kids Helpline and ReachOut can improve access for young people in rural areas or for those who face stigma, but the headspace model highlights the ongoing challenge of effectively engaging harder to reach groups, including Indigenous and culturally diverse youth. The persistent focus on the 'missing middle' demonstrates a systemic commitment to ensuring that young people with mild to moderate needs can access timely support

before their difficulties escalate, a crucial lesson for any country aiming to build a more equitable and preventive mental health system.

Italy

Executive summary

Table 20 – Italy case study executive summary

Section	Details
National Context and Current Situation	Italy faces high youth mental health needs amid economic precarity, regional inequalities, and intense digital use. An estimated 16.6 % of 10–19-year-olds (≈956 000) had mental health problems in 2019, with worsening wellbeing among young people, especially girls. Self-harm, eating disorders, social withdrawal, and anxiety about the future are widespread; 'fear about the future' affects nearly a third of 11–19-year-olds and over half of 17–19-year-old girls. Digital access is almost universal, with problematic social media use and cyberbullying, and many youths turn to AI/chatbots for emotional support and advice. The regionally run public system is under-resourced (3.3–3.5 % of health spending), with workforce reductions and data gaps. COVID-19, high NEET rates, and climate anxiety have intensified distress while service capacity and equity remain limited.
Intervention 1: Fondazione Carolina	Fondazione Carolina provides group-based prevention in schools and communities, involving students, teachers, and parents as a 'comunità educante'. It uses workshops, peer testimonies, and discussions to build awareness and address risks such as screen addiction and poor sleep, framing digital spaces as 'places' designed for engagement rather than neutral tools. Its free centre 'Rete' collaborates with UONPIA to support youths whom public services cannot follow, offering integrated psychological, educational, and community pathways (e.g. volunteering). Evidence comes from pre/post assessments and wide reach (≈100 000 youths/year). Challenges include overflow from under-resourced public services, under-reporting of online harms, and the limits of bans without wider digital education. Enablers include whole-community engagement, peer testimonies, territorial hubs training local professionals, and alignment with calls for stronger EU platform regulation.
Intervention 2: Progetto Itaca	Progetto Itaca is a national NGO network (17 associations) offering information, prevention, support, and rehabilitation, in partnership with public services. Its 'Prevenzione nelle Scuole' delivers psychiatrist-led sessions to help adolescents understand mental health, recognise warning signs, and seek help. Supports include a national hotline, peer groups, and family courses ('Famiglia a Famiglia') that often trigger care-seeking. Digitally, Itaca Lab trains creators/influencers on responsible mental health communication, and 'Parole O_Stili' promotes non-stigmatising online language. Evidence shows substantial reach (15 000+ students in 2024) and qualitative indications of increased awareness and help-seeking, but no formal effect sizes or ROI. Barriers include stigma, reluctance to seek help, limited teacher role as relational support, parental uncertainty on technology, and digital pressures (screen use, body image, AI advice-seeking). Enablers include peer and lived-experience input, strong family engagement, links to public services and international models, and norm-shaping work with creators that complements regulation.

Section	Details
Intervention 3: C.O.P.E	C.O.P.E. is a social prescribing scheme for NEETs (age 16–34) offering a non-clinical pathway to better mental wellbeing and inclusion. Link workers build trust, co-create Individual Action Plans, and connect participants to tailored community and voluntary activities. Evaluations show significant improvements in wellbeing and reduced distress at about six months, with probable clinical depression rates nearly halved, especially for those with complex needs, though samples are small and lack controls and ROI estimates. The model is flexible and person-centred but resource-intensive; link worker time was underestimated, raising sustainability concerns. Barriers include the high support needs of NEETs, workforce/setting shortages, and regional inequalities. Enablers include low-stigma community activities, family/carer involvement for minors, and EU EaSI funding.
Transferability and EU Policy Lessons	Italy shows how civil society can innovate in youth mental health within a fragmented, underfunded public system. Fondazione Carolina's 'comunità educante' offers a transferable whole-school and family model for wellbeing and digital citizenship which seeks to understand the unmet relational needs of young people in relation to their digital consumption. This needs to be backed by supportive policy and teacher training. C.O.P.E. provides a replicable social prescribing approach for NEETs, dependent on trained link workers, strong community sectors, and stable funding. Progetto Itaca's Itaca Lab illustrates 'soft governance' in the creator ecosystem as a complement to EU digital rules (e.g. DSA, BIK+). The Italian case also warns against over-reliance on NGOs to fill systemic gaps, underscoring the need for adequately funded, equitable public services. EU lessons include pairing digital regulation with relational, community supports, investing in school-, community- and NEET-focused early intervention, and ensuring civil society complements rather than replaces public provision.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

Italy's National Prevention Plan (PNP) 2020–2025 explicitly recognises 'new technologies addiction,' including dependency on the internet, social networks, and video games, as a pathological addiction, and it calls for multi-component strategies that both build individual life skills and intervene in the environment (notably schools and families).[421] The PNP also places emphasis on the active involvement and training of General Practitioners (MMG) and Free Choice Paediatricians (PLS), as well as stronger interaction between the school and health systems.[422]

The National Action Plan for Mental Health (PANSM) 2025–2030 adopts a biopsychosocial and One Health model, flags the post-pandemic increase in youth anxiety and depression, and acknowledges systemic challenges, including reductions in facilities and personnel since 2020, stigma, and a resulting tendency for some people to forgo care.[423] It sets out actions on emotional-relational literacy for educators and young people, early identification in primary care, and social prescribing to connect individuals to community resources. The plan is accompanied by a dedicated funding

421 Ministry of Health (Italy), *Piano Nazionale della Prevenzione* 2020–2025, 2020.

422 Ibid.

423 Ministry of Health (Italy), *National Action Plan for Mental Health 2025–2030 (PANSM)*, 2025.

envelope through the state budget: €80 million (2026), €85 million (2027), €90 million (2028), and €30 million annually from 2029, plus €30 million annually for hiring healthcare and social-health personnel.[424] It also promotes the 'Health budget' to personalise integrated health, social, and community support.[425]

Italy's digital environment governance combines EU-aligned frameworks and national measures. Law 71/2017 defines and counters cyberbullying, empowering the Privacy Authority to order removal of offending content.[426] The 'Codice Rosso' criminalises non-consensual sharing of intimate images, SIMs registered to minors are preset to block 'inappropriate content', a draft age-verification regulation has been approved by the Communications Authority (Agcom), which is also designated as the Digital Services Coordinator under the Digital Services Act.[427] Guidelines have been adopted for influencers to ensure transparency and protect minors. The BIK+ strategy is identified as an important influence on national policy development.[428]

Baseline statistics

Italy has a population of 58.9 million (2024), with approximately 12 million young people under the age of 25, representing around 22 % of the total population.[429]

Mental health status indicators reveal considerable need. UNICEF-cited estimates indicate that 16.6 % of 10–19-year-olds—approximately 956 000—suffered mental health problems in 2019.[430] ISTAT's BES 2025 reports that, while the overall Mental Health Index is broadly stable year-on-year, it has worsened among young people, particularly girls, with the index for women and girls aged 14–34 falling by over two points since 2016.[431] The report links the deterioration of youth mental health to pandemic-related social restrictions and heightened uncertainty associated with conflicts and environmental crises.[432] Complementing this, Save the Children's 2025 Atlante highlights widespread issues including anxiety, depression, self-harm (+27 % for cutting/attempts compared to pre-pandemic), eating disorders, and social withdrawal (hikikomori[433]), with particularly low psychological wellbeing scores among 15-year-old girls versus European averages.[434]

National service-use data for 2023 show 70 550 users aged 18-24 engaged with specialist mental health services, with 34 817 first-ever contacts in that age group.[435] Among incident diagnoses, depression (11.3 per 10 000) and neurotic/somatoform syndromes (7.8 per 10 000) were most common.[436]

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424 Ibid.

425 Quotidiano Sanità, *Via libera al Piano nazionale per la Salute mentale 2025–2030. Obiettivo: riorganizzare l'assistenza di prossimità*, website.

426 Council of Europe, *Italy: Regulation for the safeguarding of minors and the prevention and tackling of cyberbullying*, website.

427 Better Internet for Kids, *Italy policy monitor country profile*, 2025.

428 Ibid.

429 Population Pyramids, *Italy Population Pyramid and Demographic Analysis*, 2025.

430 UNICEF Italy, *Salute mentale: dati e iniziative*, website.

431 ISTAT, *Rapporto BES 2025*, 2025.

432 Ibid.

433 Hikikomori is a condition, first identified in Japan, where individuals withdraw from society and remain largely confined to their home for extended periods, often avoiding work, education, and social interaction.

434 Save the Children Italia, *XVI Atlante dell'Infanzia: l'adolescenza tra solitudine, disuguaglianze e AI*, 2025.

435 Ministry of Health (Italy), *Rapporto sulla Salute Mentale,* 2023.

436 Ibid.

Wellbeing and expectations data point to vulnerabilities in transitions. Life satisfaction peaks among 14–19-year-olds (57.8 %) but drops sharply by 11 points to 46.8 % among 20–24-year-olds.[437] Fear about the future affects nearly a third of 11–19-year-olds (32.3 %), up by 5.5 points since 2021.[438] It is markedly higher among girls (42.1 % vs 23.1 % boys) and rises with age (43.5 % among 17–19; nearly 56 % among 17–19-year-old girls) and is associated with perceived family economic difficulties.[439]

Socio-economic context remains challenging relative to the EU. In 2024, 15.2 % of 15–29-year-olds in Italy were NEETs versus 11.1 % in the EU-27, with rates exceeding 20 % in Calabria (26.2 %), Sicily (25.7 %), Campania (24.9 %), and Puglia (21.4 %); the gap is larger for women (16.6 % in Italy vs EU women).[440]

Digital access and habits are pervasive. Regular weekly internet use reaches 95.1 % among 11–14-year-olds, 97.7 % among 15–19-year-olds, and 97.2 % among 20–24-year-olds. Among 11–19-year-olds, almost 85 % have a social media profile, rising to over 97 % among 17–19-year-olds, and girls are more likely than boys to have a profile (86.4 % vs 83.4 %).[441] Contact with friends online is frequent: 8.4 % report being continuously online, and 40.3 % are online multiple times per day, with higher rates among girls (54.6 % vs 43.2 %). [442]

HBSC 2021–2022 reports increases in problematic social media use (especially among girls) and in cyberbullying among 11 and 13-year-olds. AI/chatbot use among adolescents is widespread and includes emotional support-seeking.[443]

Save the Children's 2025 survey finds that around 42 % of 15–19-year-olds turn to AI when lonely/sad/anxious, with similar proportions seeking advice for important life decisions. [444]

Fondazione Carolina's 2025 study shows 27 % daily and 51 % weekly chatbot use; among under-15s, 27 % use chatbots to vent without judgment, 22 % to address difficult topics, and 20 % to reduce loneliness.[445]

An Ipsos Doxa survey for Telefono Azzurro (2025) reports that 35 % of 12–18-year-olds frequently use AI chatbots and 75 % use them overall; 14 % often seek personal advice and 34 % sometimes do so, with motivations including non-judgment (15 %), feeling less lonely (10 %), and lack of another person to turn to (7 %).[446]

Healthcare capacity figures depict a large, regionally administered network under strain. Mental health expenditure constituted 3.3 % of total health spending in 2022, and another national source noted 3.5% against an EU request of 6 %.[447] In 2023, there were 1 248 territorial services, 1 833 residential structures, and 689 semi-residential structures; public psychiatric services employed 29 114 staff, of whom 41.8 % were nurses and 17.2 % were doctors.[448] The average annual cost of

[437] ISTAT, *Rapporto BES 2025*, 2025.

[438] ISTAT, *Indagine bambini e ragazzi 2023*, 2024.

[439] Ibid.

[440] ISTAT, *Rapporto BES 2025*, 2025.

[441] ISTAT, *Indagine bambini e ragazzi 2024*, 2024.

[442] Ibid.

[443] HBSC, *Italian adolescents post-pandemic: mixed impact on mental health and relationships*, 2022

[444] Save the Children, Italy: *about 42% of teenagers turn to AI when they feel sad, anxious or for life decisions*, website.

[445] Fondazione Carolina, *Cuori e algoritmi. Capire l'IA emotiva per un'educazione affettiva nel tempo dei chatbot,* 2026.

[446] Ipsos, Safer Internet Day 2026: *un adolescente su tre usa chatbot di Intelligenza Artificiale,* website, 2025.

[447] WHO/European Observatory on Health Systems and Policies, Italy 2023 – *Towards a new model of mental health care in Italy: the National Mental Health Plan 2025–2030*, website.

[448] Ministry of Health (Italy), *Rapporto sulla Salute Mentale*, 2023.

psychiatric care per resident was €71.9 in 2022, and antidepressant spending through the national health system exceeded €400 million.[449]

On data systems, Italy's SISM (Mental Health Information System) underpins the Ministry's annual mental health report, while HBSC Italy became a national surveillance system in 2018 managed by the Ministry of Health/ISS, with around 90 000 students analysed in 2022 and the WHO-5 and loneliness added as core indicators enabling time series from 2022 onward.[450] However, significant national-level data gaps persist for child/adolescent mental health, a planned systemic database is not yet ready, and service datasets have high shares of 'unknown' socio-demographic variables.[451]

Crisis impacts

The COVID-19 pandemic had a highly negative impact on mental health across the population, with increased anxiety and depression particularly in young people.[452] The PNP underscores the need to strengthen prevention and health promotion via integrated service networks and population empowerment.[453] A researcher interviewed for this case study hypothesised that stricter Italian pandemic measures and increased digital use, notably gaming disorder, may have contributed to a spike in 2022 outcomes, although they emphasised the lack of analytical proof in their data.

Economic precarity and social uncertainty are significant. Italy's NEET rate is persistently higher than the EU average, while the share of youths afraid of the future rose by 5.5 percentage points since 2021, with much higher prevalence among those who rate their family's economic situation as 'not very or not at all good.'[454]

Climate-related distress is another driver of adolescent mental health challenges. A study validating the Climate Change Anxiety Scale in Italian adolescent's links climate anxiety to emotional distress, cognitive/functional impairments (sleep, concentration, social/academic functioning), and notes that modern digital information environments, often emphasising catastrophic outcomes, can exacerbate vulnerability and uncertainty particularly during adolescent identity formation.[455]

Deep dive: Featured interventions

This section examines three interventions that illustrate Italy's contribution to the study: Fondazione Carolina, Progetto Itaca, and C.O.P.E. (Capabilities, Opportunities, Places, and Engagement). Together, they show the breadth of Italy's response to youth mental health in a digital era, spanning school based and community prevention with a healthcare interface and digital literacy (Fondazione Carolina)[456], an integrated NGO ecosystem combining school prevention, family support and digital-sector engagement (Progetto Itaca)[457], and social prescribing pathways that connect NEET youth to community resources (C.O.P.E.).[458]

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449 Ibid.

450 Ibid.

451 Ibid.

452 Ministry of Health (Italy), *National Action Plan for Mental Health 2025–2030 (PANSM)*, 2025.

453 Ministry of Health (Italy), *Piano Nazionale della Prevenzione 2020–2025*, 2020.

454 ISTAT, Rapporto BES 2025, 2025; ISTAT, *Indagine bambini e ragazzi 2023*, 2024.

455 Innocenti M, Bocci Benucci S, Dockerty G, De Micco G, Lombardi GS, Perilli A, Congedo G, Di Russo M, Bruno S and Fioravanti G (2025) '*Exploring eco-anxiety in Italian adolescents: psychometric evaluation of the Climate Change Anxiety Scale and theoretical insights into the association with pro-environmental attitudes*'. Front. Psychol. 16:1601891.

456 Fondazione Carolina, *Home*, website.

457 Progetto Itaca, *Home*, website, 2026.

458 COPE Project, *Who We Are*, website, 2026.

These three interventions were selected because they:

- directly target adolescents and young adults where they live, learn, and spend time online;
- explicitly address digital-era risks (problematic social media/gaming, cyberbullying, and emergent AI-mediated help-seeking);
- operate at different levels of the system (school/family/community; creator ecosystem; healthcare/public services interface); and d) provide implementation learning relevant for EU-level transfer.

Other interventions are also relevant to the wider Italian landscape but are not examined here in the same detail. They are briefly noted below to illustrate the wider ecosystem of school-based, digital, and community initiatives that complement the three featured interventions.

Other examples of relevant interventions in the Italian ecosystem

An ISS universal school-based programme ('Establishing goals and problem solving') evaluated in 2015 with improvements in affect regulation self-efficacy, psychological well-being, and life satisfaction in its published evaluation.[459]

A MoH–financed psychoeducational programme (2021–2022) using 'serious games' to foster emotional self–regulation and conscious internet use in middle schools.[460]

'Cuori Connessi' (Unieuro + State Police) for cyberbullying awareness.[461]

The 'Rete senza fili' project monitoring IAD and promoting responsible internet use among 10–11-year-olds.[462]

'ChatContatto,' an online psychological support chat for 14–27–year–olds in Umbria (since 2020).[463]

'Diario della Salute' life-skills programme which found an unexpected increase in psychosomatic complaints—indicating reduced subjective well-being—showed a dose-response relationship (worse outcomes with more units) and concluded the programme should not be disseminated in its current form due to possible adverse effects.[464]

Fondazione Carolina

Fondazione Carolina delivers experiential, group-based prevention in schools and communities that always involves students, teachers, and parents. Activities include identity-building workshops (e.g., constructing a personal avatar with LEGO bricks), peer testimonies, and guided discussions that start from adolescents' perceptions of what influences mental health and then broaden to overlooked lifestyle risks (screen addictions, sleep) using engaging, youth-relevant content (e.g., a reel about quitting social media temporarily). The foundation frames digital as a 'place,' not a neutral tool, designed to maximise engagement, and argues that bans are effective only after suitable alternatives are in place; in care settings, relationship-building and group participation come first, with progressive limits such as switching off Wi-Fi at night. Its free Centre 'Rete' collaborates with UONPIA (public infant and adolescent neuropsychiatry) to take referrals for youths whom public services cannot follow due to budgetary and structural constraints. In its first year, about 60 families were

[459] Istituto Superiore di Sanità (ISS), *Salute Mentale: Obiettivi*, website; National Center for Biotechnology Information (NCBI), *Cyberbullying and Mental Health*, 2015.

[460] Istituto Superiore di Sanità (ISS), *Progetto Uso Consapevole di Internet*, website.

[461] Cuori Connessi, *Il Progetto Cuori Connessi*, website.

[462] Rete Senza Fili, *Home*, website, 2026.

[463] Istituto Superiore di Sanità (ISS), *Chat con Tatto (Umbria),* website, 2026.

[464] National Center for Biotechnology Information (NCBI), *Digital Media Use and Adolescent Mental Health*, 2019.

assessed, with around 40 in active support and others redirected to appropriate services. The foundation also authors *Cuori e algoritmi* (Hearts and algorithms) which documents the emotional use of AI chatbots among adolescents and sets out an '*onlife* affective education' approach that prioritises understanding over prohibition and involves the entire 'comunità educante'.[465]

Evidence of effectiveness and ROI

Fondazione Carolina reports using pre/post assessments in sampled settings, estimating very large prevention reach (~100 000 young people/year), and notes the efficiency gains of group formats, which can help mitigate workforce constraints.[466] Although the foundation does not report formal ROI, its approach aligns with reported evidence that whole-school and community engagement increases response and perceived impact compared to 'one-off' sessions (of 300 young people, around 250 respond to structured interventions compared to around 15 in one off sessions).

Implementation: Barriers and enablers

Delivery is workshop-based and relational, engaging whole school communities and families. The territorial implementation relies on three hubs (Milan, Perugia, Palermo), with local professionals trained by the foundation to deliver activities contextually. In care, the model integrates psychology and education with pathways that include community volunteering (e.g., assisting sports coaches, after-school support, public space care), helping youths convert their 'problem' into a 'resource' for others. Monitoring includes pre- and post-assessments (sometimes with universities). The foundation estimates reaching 'about one hundred thousand young people per year' through prevention trainings and emphasises the efficiency gains of group formats (e.g., ten youths per professional hour).

Barriers most relevant to Fondazione Carolina's model include the overflow from public services due to budgetary/structural constraints. The PANSM documents reductions in psychiatric facilities and staffing compared to 2020, with some individuals forgoing care.[467] For adolescents, there is a shortage of age-appropriate inpatient beds (NPIA) and a lack of community day/residential options post-acute. A clinician described how Fondazione Carolina's free Centre 'Rete' receives referrals from UONPIA due to budgetary and structural constraints in public services: '*It is a free centre… they cannot follow them for budgetary and structural reasons… Society creates distress; you must treat it at the individual level*.' They also highlighted long-term impacts of collective trauma from COVID-19 ('policy removed socialisation and forgot to reinsert it') and argued that digital spaces are not neutral tools but 'places' engineered to keep users engaged. According to stakeholders interviewed for this case study, digital harms are challenging to detect and address. Cyberbullying and online violence are likely underreported because victims are hard to reach and discourse tends to emerge only after extreme cases. Smartphone bans alone are judged 'necessary but insufficient' unless coupled with broader strategies for digital citizenship education, teacher training, parent involvement, and advocacy for stricter EU regulation of platforms targeting minors.[468] Italy's legislative proposals on social media age limits have faced gridlock.[469]

A youth representative interviewed for this case study also warned that cyberbullying and online violence are under-detected and under-reported, that some youths intensely engage with platforms without awareness of the risks, and that national psychological emergency support (1520) exists but

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465 Fondazione Carolina, *Cuori e algoritmi. Capire l'IA emotiva per un'educazione affettiva nel tempo dei chatbot*, 2026.

466 Interview with staff as part of this case study.

467 Ministry of Health (Italy), *National Action Plan for Mental Health 2025–2030 (PANSM)*, 2025.

468 Fondazione Carolina, *Commento al rapporto ENESET 'Mobile phone bans in schools across the EU' (2026)*, 2026.

469 Il Sole 24 Ore, *Social, in Francia off limits per gli under 15. Ecco a che punto siamo in Italia*, news article, 2026.

awareness and cultural/geographic barriers limit use. They also noted that social media are now the main competitor for youths' time and attention compared to volunteering and even sports.

Enablers include whole-community engagement (students, teachers, parents), which raises response and impact, peer testimonies that resonate with adolescents and can catalyse help-seeking. The territorial hubs and training of local professionals strengthen context-fit and sustainability. This is relevant as regional disparities are significant in the country: adolescent mental health care is largely concentrated in the North, and early smartphone exposure (age 6–7) is reportedly more common in the South.

Progetto Itaca

Progetto Itaca promotes information, prevention, support, and rehabilitation programmes for people with mental health disorders and their families across 17 local associations, collaborating with public services and international networks. The psychiatrist-led 'Prevenzione nelle Scuole' offers two-hour sessions for secondary schools to introduce mental health, foster self-listening, help adolescents recognise warning signs, and encourage help-seeking—recognising adolescence as a frequent onset period when problems often go unrecognised.[470] Supports include a national listening hotline, peer-to-peer groups, and 'Famiglia a Famiglia' (NAMI-based) to equip caregivers. Parents frequently report 'this meeting opened my eyes' and often seek orientation to care afterwards. Digital-sector initiatives include Itaca Lab, which trains content creators/influencers to communicate about mental health respectfully on social media,[471] and 'Parole O_Stili,' which sensitises students to inclusive, responsible online language regarding mental health.[472]

Evidence of effectiveness and ROI

Progetto Itaca presents robust activity reach and qualitative indications of impact rather than formal effect size. In 2024, 15 336 students were trained via school prevention, with parent/staff sessions (e.g., 'Ending The Silence') and family courses scaled across local associations.[473] Parents frequently reported that '*this meeting opened my eyes*,' often seeking guidance and orientation afterwards, and anecdotal help-seeking was triggered (e.g., a student recognising distress through the programme, seeking help at UONPIA, and showing improvement). Formal effect sizes and ROI were not reported.

Implementation: Barriers and enablers

Delivery combines live school sessions co-facilitated by psychiatrists and trained volunteers, helpline access, peer and family courses, and day-programme/assisted remote work rehabilitation models.-Itaca Lab cohorts are small (around 10–15 participants per year), open to motivated creators, and designed to grow; creators often operate within algorithmic/engagement pressures that can harm their own wellbeing – making reflective practice and safer content norms doubly important.

Barriers most relevant to Progetto Itaca include the persistent stigma and internal barriers to help-seeking (from interviews: '*difficult to admit having a problem*,' '*fear of not being believed/minimisation*'), which prevention must explicitly address.

A volunteer coordinator reported strong correlations between problematic screen use and mental health (including time-perception changes and study procrastination), pervasive body-image

[470] Progetto Itaca, *Progetto Prevenzione nelle Scuole*, website.

[471] Progetto Itaca, *Itaca Lab,* website.

[472] Parole O_Stili, *Home*, website.

[473] Fondazione Progetto Itaca, *Relazione annuale 2024 (Bilancio di missione)*, 2024.

pressures via social comparison, and a recent trend of youths attempting to self-manage social media exposure. Teachers, however, are seldom seen as help sources ('*at the end of year polls they are at 0%*') and many view relational support as outside their role. Parents frequently request guidance on managing technologies at home, with community 'digital pacts' among parents to set consistent rules.

An economist interviewed corroborated that stricter COVID-19 measures likely contributed to worse outcomes in 2022 (as a hypothesis), and that many indicators show sharper deterioration among girls in mental health, hyper connection, and problematic social media use, partly linked to exposure to 'perfect' body models. They also reported that only about 3 % of adolescents say they have never used AI in any modality, that a significant minority use AI for concrete life advice and to feel less alone, and that adolescents often value AI's 'non-judging' stance (indicating poor disclosure that they are interacting with AI). They underscored Italy's digital-skills gaps by EU comparisons among 15–19-year-olds and observed that creative digital-education projects 'limit risks very much' for adolescent mental health.

Enablers include peer-led components and lived-experience testimonies that increase courage to seek help, strong family activation which facilitates early, supportive responses at home, and integration with public services and international evidence-based networks (e.g. NAMI), which supports quality and scalability.[474] In the digital sphere, Itaca Lab complements regulatory enablers (such as influencer guidelines, SIM presets, parental controls) by shifting creator norms and student online language towards safer, more inclusive communication.[475]

C.O.P.E.

C.O.P.E. supports NEETs (16–34) through a social prescribing model in which a link worker builds a trusting relationship, co-creates an Individual Action Plan (IAP) with the young person, and, when ready, refers them to mainly non-clinical VCSE activities (e.g., volunteering; creative workshops) matched to needs and goals.[476]

Evidence of effectiveness and ROI

C.O.P.E. social prescribing evaluations found statistically significant improvements in mental well-being and reduced psychological distress.[477] Quantitative follow-up indicates these improvements at six months, with the share of probable clinical depression nearly halved. Effects that were especially salient for participants with more complex mental health issues. Qualitatively, participants reported increased self-esteem, confidence, social skills, and agency; for some, changes were 'transformational,' while for others still 'useful,' underlining the model's person-centred flexibility. ROI was not estimated, and limitations include the absence of control groups and small sample sizes. Feasibility insights indicate that community-based services can be less stigmatising and serve as a buffer while waiting for formal mental health support.[478]

Implementation: Barriers and enablers

Delivery is holistic, informal, and flexible, granting agency to the young person and adapting to complexity and readiness. Link workers invest significant time and effort, a factor initially underestimated and flagged as a sustainability risk when balanced with other duties. Family

474 Ibid.

475 Better Internet for Kids, *Italy policy monitor country profile*, 2025; Fondazione Progetto Itaca, *Relazione annuale 2024 (Bilancio di missione),* 2024.

476 COPE Project, website.

477 National Center for Biotechnology Information (NCBI), *Cyberbullying and Mental Health*, 2015

478 ibid.

relationships matter for minors, and some contexts adopted integrated strategies engaging parents/carers. The project was largely funded by the European Commission's EaSI programme.

Barriers most relevant to C.O.P.E. include the considerable time and effort required from link workers, initially underestimated and seen as unsustainable when combined with other duties—highlighting resource and staffing requirements for durable scale; the 'doubly disadvantaged' nature of NEET status (social exclusion plus missed early intervention), which raises the intensity of support needed; and broader system constraints (workforce/setting shortages; regional inequalities) that shape referral ecosystems and access to complementary services.[479]

Enablers include the link worker's holistic, informal, flexible approach that centres youth agency; active family/carer engagement for minors to reinforce change in home settings; and EU-level funding (EaSI) that underpinned implementation. The intervention's community focus complements school-embedded and NGO prevention by catching those out of education/employment/training and providing non-clinical pathways that reduce stigma and support re-engagement.

Transferability and EU policy lessons

The Italian experience provides valuable lessons for the EU, primarily demonstrating how a vibrant civil society can drive innovation in a context of a strained and fragmented public mental health system. The featured interventions offer transferable models for prevention and early intervention that are deeply embedded in communities and are highly attuned to the cultural and relational nuances of the digital era.

Prevention in schools and early intervention services

Italy's school-based interventions offer a transferable blueprint for creating a supportive ecosystem around young people. The 'educating community' (comunità educante) approach, central to Fondazione Carolina, which systematically involves students, teachers, and parents together, is a powerful model for moving beyond one-off lessons to foster a whole school culture of wellbeing. For this to be transferred, it requires not only structured materials and teacher training but also a policy environment that encourages schools to take an active role in mental health promotion. For young people outside the education system, the C.O.P.E. project provides a transferable social prescribing model for early intervention. It demonstrates a structured, nonclinical pathway to reengage vulnerable NEETs, a key priority group for social inclusion across the EU. The conditions for its success elsewhere would include a trained workforce of 'link workers,' a rich local ecosystem of voluntary and community sector activities, and dedicated funding streams.

Digital tools and governance

The Italian case study offers specific and highly relevant insights for EU level debates on digital governance, focusing on shaping the digital environment rather than just reacting to it. Progetto Itaca's Itaca Lab is a standout transferable model. By training content creators and influencers to communicate responsibly about mental health, it demonstrates a 'soft governance' approach that complements formal regulation like the DSA. It offers a proactive strategy for shaping healthier online norms from within the digital ecosystem. Secondly, the research from Fondazione Carolina into adolescents' emotional use of AI chatbots provides a critical insight for the EU: the need to understand the unmet relational needs (e.g., for nonjudgmental support) that are driving this behaviour. This suggests that EU policy on AI and digital mental health tools must go beyond technical safety to prioritise human centred design and address the underlying reasons for this trend.

[479] Ministry of Health (Italy), *National Action Plan for Mental Health 2025–2030 (PANSM),* 2025

Equity and access

Finally, the Italian experience serves as a cautionary tale regarding equity and system fragmentation. The heavy reliance on innovative NGOs to fill the gaps left by an underfunded and regionally disparate public system highlights a potential risk for other Member States. While civil society is a vital partner, the Italian context underscores that it cannot be a substitute for adequately funded, accessible, and equitable public services. The work of Fondazione Carolina and Progetto Itaca in providing free support where the state cannot is crucial, but it also points to the systemic challenge. Models like C.O.P.E. offer a targeted solution for improving equity and access for marginalised groups, but their sustainability depends on consistent funding and integration with the broader health and social care system.

Norway

Executive summary

Table 21 – Norway case study executive summary

Section	Details
National Context and Current Situation	Norway's youth mental health system is municipality-led and guided by the 2023 Mental Health Escalation Plan, which prioritises early intervention, accessibility, and cross-sector coordination. Despite high investment, demand exceeds capacity, with workforce shortages, long waiting times, and a persistent treatment gap. Mental health challenges remain high, particularly among girls, with social media use, loneliness, and digital harms contributing to poorer wellbeing. The COVID-19 pandemic and wider pressures, including inequality and climate anxiety, have further increased demand for services. For example, 38 % of adolescents report being worried about climate change.
Intervention 1: Prompt Mental Health Care (PMHC)	PMHC provides low-threshold, rapid access to evidence-based psychological therapies for mild to moderate anxiety and depression without GP referral. Delivered through municipal services, it combines face-to-face and digital care, improving access and reducing the treatment gap. Strong evidence demonstrates significant symptom reduction, high recovery rates, and cost-effectiveness. Key enablers include ease of access and integration into primary care, while challenges include workforce shortages, regional inequalities, and limited provision for more complex or subthreshold cases.
Intervention 2: YAM	YAM is a school-based universal prevention programme aimed at improving mental health literacy and reducing suicide risk among adolescents. Delivered through structured sessions combining education and peer interaction, it has strong RCT evidence showing significant reductions in suicide attempts and ideation. Its success is driven by its universal, non-stigmatising approach and strong evidence base. However, implementation is inconsistent due to school autonomy, curriculum pressures, and reliance on external trained facilitators.
Intervention 3: Spillsonen	Spillsonen is a digital outreach initiative targeting young men through gaming platforms such as Twitch and Discord. It embeds mental health discussions within entertainment contexts, reducing stigma and engaging users who are unlikely to seek traditional support. The programme has demonstrated strong reach and increased willingness to seek help among participants. Its success is driven by accessibility, peer engagement, and use of trusted influencers, while challenges include measuring long-term impact, platform dependency, and sustainability due to reliance on volunteers.
Intervention 4: FACT ung	FACT ung provides intensive, multidisciplinary, community-based support for young people with complex mental health needs up to age 25, bridging the transition between child and adult services. It integrates clinical, social, and practical support delivered through outreach in everyday settings. Evidence shows substantial reductions in hospitalisation and strong long-term economic returns. Key strengths include flexibility and integrated care, while barriers include high costs, workforce demands, and scalability limitations.

Section	Details
Transferability and EU Policy Lessons	Norway demonstrates the importance of integrated, multi-level mental health systems combining early intervention, prevention, and intensive support. Transferable lessons include the effectiveness of low-threshold services like PMHC in reducing treatment gaps, the value of school-based prevention (YAM) when structurally embedded, and the potential of digital engagement models like Spillsonen to reach underserved groups. FACT ung highlights the importance of addressing transitions to adulthood for complex cases. However, successful transfer requires strong primary care infrastructure, cross-sector governance, and sustained workforce investment. The case underscores that funding alone is insufficient without capacity and coordination and highlights the need for EU-level action on digital environments and equitable access.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

Norway has developed a comprehensive mental health framework, most recently articulated in its new ten-year Mental Health Escalation Plan.[480] This long-term strategy, which was launched in 2023, succeeds the previous national plan[481] and emphasises cross sectoral coordination, early intervention, and accessible services through municipalities. The plan is built on three core pillars: health promoting and preventative work; good and accessible services where people live and improved support for those with long term, complex needs. It reflects a whole government approach and as highlighted by a stakeholder from the Norwegian Directorate of Health, has a specific pillar focused on digitalisation to improve access, patient satisfaction, and quality across the healthcare sector.

This strategic direction is underpinned by the suicide prevention action 'Ingen å miste' (2020-2025). This plan is significant as it provides the political support and framework for the nationwide implementation of evidence-based programmes. It has, for example, enabled the systematic recommendation and rollout of interventions like the Youth Aware of Mental Health (YAM)[482] programme.

Mental health services for young people operate through a tiered system. Municipalities are responsible for primary care and low threshold services, which are central to the new Escalation Plan's focus on local support. Specialist Child and Adolescent Mental Health Services (BUP) handle more complex cases referred by GPs. A key structural challenge is the transition between child and adult services at age 18. This is explicitly addressed through initiatives like the Flexible Assertive Community Treatment (FACT ung) model, which extends its intensive support for youth up to the age of 25. Stakeholders confirm this model is considered a success precisely because it bridges the service gap between municipalities and hospitals and prevents vulnerable young people from falling through the cracks during this critical life stage.

480 Norwegian Ministry of Health and Care Services, *Escalation Plan for Mental Health (2022-2033)*, 2022

481 Ibid.

482 Mental Helse, *YAM*, website.

Baseline statistics

Norway has a population of 5.572 million (2024), with approximately 2.36 million young people under the age of 25, representing around 42.4 % of the total population.[483]

Self-reported mental health problems among Norwegian youth have increased continually since the early 1990s. However, one stakeholder with expertise in longitudinal youth data noted that the most recent surveys suggest a sharp increase in internalising problems (like anxiety and depression) may have plateaued or even slightly decreased in the last few years. Despite this potential plateau, the prevalence remains high. One stakeholder highlighted that in student health surveys, almost half of the student population reports mental health issues at a level that would typically require treatment. This figure has caused professional debate, with some suggesting that younger generations may be more inclined to verbalise normal life challenges using diagnostic terms (e.g., calling shyness 'social anxiety').

Norwegian longitudinal research indicates that girls' mental health deteriorates faster from age 13, with social media use explaining 15 to 20 % of the gender gap in depressive symptoms. This is reflected in national survey data: the prevalence of depressive symptoms among adolescents increased from 18 % to 22 % among girls (2014–2024), compared to 5 % to 8 % among boys.[484] Furthermore, around 31.7 % of girls aged 13–19 report high levels of depressive symptoms, compared to 12.3 % of boys,[485] highlighting a substantial gender gap. Earlier research also suggests that around one in four girls aged 15–16 report depressive symptoms, with lower rates among boys.[486] Stakeholders agree this is accurate but suggest it is a pattern common to most industrialised countries and may be partly explained by boys being less inclined to formulate and report their challenges due to stigma.

Digital engagement among Norwegian youth is ubiquitous, and its impact is a major topic of concern and debate. Rather than mirroring vague European patterns, the Norwegian context is specific: stakeholders expressed deep concern about the passivizing effect of screen time, which displaces physical activity and real-world social interaction. One academic stakeholder argued that while it is difficult to find definitive evidence of causation in studies, there is a strong belief that the current form of social media is not healthy for youth development, particularly due to its focus on social comparison. In response, there is a growing movement in Norway towards tighter regulation, with active discussions around smartphone free schools and a desire for stronger EU level regulations on social media companies.

In addition to this, the Spillsonen project research reveals that 42 % of young male gamers report feeling lonely, with many experiencing sleep disruptions due to excessive screen time.[487] Young people face significant exposure to harmful online content. Data from the national Ungdata[488] surveys show that around 3 % of adolescents report being victims of cyberbullying, with additional groups involved as perpetrators or both, and that involvement is consistently associated with poorer

[483] Population pyramids, *Norway Population Pyramid and Demographic Analysis*, 2025.

[484] European Journal of Public Health, *Trends in Norwegian adolescents' mental health (2014–2024): socioeconomic and rural–urban differences*, 2025.

[485] Kleppang et al., *Lifestyle habits and depressive symptoms in Norwegian adolescents: a national cross-sectional study,* 2021.

[486] UiT Norges arktiske universitet, *Ungdata, mental health and gender differences. A study of gendered mental health re-enactments in Ungdata's dLTC youth surveys,* 2017.

[487] Mental Helse Ungdom, *Spillsonen*, website.

[488] International Journal of Epidemiology, *Data Resource Profile: Ungdata—National Norwegian Youth Surveys,* 2026.

mental health, loneliness, and reduced school wellbeing.[489] While earlier analyses suggested relatively stable levels of cyberbullying (2014–2016), more recent national monitoring indicates growing concern about digital harassment and online exclusion among children and adolescents, particularly in parallel with increased social media use.

The health system is under significant pressure. While Norway has high levels of investment in mental health, employing approximately 400 therapists across 52 municipalities through the Prompt Mental Health Care (PMHC) programme alone,[490] demand continues to outpace provision. National data indicates that average waiting times for mental health services are approximately 54 days, exceeding policy ambitions for timely access. A Directorate stakeholder clarified that the primary challenge is not a lack of money, but a lack of people and capacity. This is compounded by evidence that a substantial proportion of referrals to specialist services are rejected, often because individuals are assessed as 'not meeting severity thresholds,' contributing to a persistent treatment gap.[491]These pressures reinforce the strategic importance of scalable, early intervention approaches within Norway's stepped care model.

Crisis impacts

The COVID-19 pandemic significantly exacerbated existing mental health challenges among Norwegian youth. Population wide registry data from the Norwegian Institute of Public Health (FHI) showed an increase in service use: primary care consultations related to mental health among 13- to 15-year-olds rose by approximately 38 % in 2021 compared to pre pandemic levels, with the largest increase observed for anxiety and depression.[492]

Economic uncertainty and social inequality have emerged as compounding risk factors. Stakeholders strongly emphasised this connection, with one academic expert describing a clear 'social gradient' in mental health, where young people from families with financial problems are at a much higher risk. There is significant national concern about the increasing number of young adults (aged 1830) on disability pensions due to mental health problems, who never fully integrate into the workforce. This issue of youth labour market marginalisation has profound long-term consequences for both the individual and the national economy.

As well as this, concern about climate change has also become increasingly more common amongst young people in Norway. National survey data from the Ungdata study indicates that approximately 38 % of adolescents report being worried about climate change – this emerging evidence also shows that climate related worry is associated with higher levels of depressive symptoms, lower wellbeing and more pessimistic expectations about the future, suggesting links to broader experiences of stress and reduced life satisfaction.[493]

Taken together, these crises have intensified demand for youth mental health services in Norway and reinforced the need for scalable, preventive, and digitally delivered interventions.

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489 Behavioral Sciences, *Cyberbullying Among Adolescents in Norway: Time Trends and Factors Associated with Perpetration and Victimization,* 2024.

490 Goldblatt et al., *Rapid review of inequalities in health and wellbeing in Norway since 2014,* 2023.

491 Types of waiting times for investigation and treatment.

492 European Child & Adolescent Psychiatry, *Impact of the COVID-19 pandemic on mental healthcare consultations among children and adolescents in Norway: a nationwide registry study,* 2022.

493 European Child & Adolescent Psychiatry, *Associations between Mental Health, Lifestyle Factors and Worries about Climate Change in Norwegian Adolescents,* 2022.

Deep dive: Featured intervention(s)

This section focuses on four interventions selected to represent Norway's contribution to the study: Prompt Mental Health Care (PMHC),[494] Youth Aware of Mental Health (YAM),[495] Spillsonen,[496] and Flexible Assertive Community Treatment for Youth (FACT ung). These interventions were chosen to reflect the breadth and reality of the Norwegian response. They cover the full spectrum of care, from established, state backed models being scaled with digital technology (PMHC, FACT ung) to innovative, NGO led digital outreach (Spillsonen) and evidence-based prevention programs facing real world implementation hurdles (YAM).

PMHC offers a mature model of accessible psychological therapy with robust outcome data and economic evidence. YAM provides an example of universal prevention with strong randomised controlled trial evidence on suicide prevention. Spillsonen represents an innovative approach to reaching underserved young men through digital platforms where they naturally congregate. FACT ung demonstrates how intensive, flexible support can address complex needs whilst maintaining young people in their communities.

Other interventions remain relevant to the broader Norwegian landscape but are not examined here in the same level of detail. They are briefly noted below to illustrate the wider ecosystem of school based, digital, and community initiatives that complement the four featured interventions.

Other relevant interventions in the Norwegian ecosystem

MOT programmes:[497] operating in 300+ Norwegian schools since 1997, MOT focuses on building resilience and courage through local role models and youth to youth approaches. Longitudinal studies show 32 % lower dropout rates and 28 % higher upper secondary completion among participants.

Digital self-help tools: Norway has developed multiple evidence-based apps including Opp[498] (universal mental health promotion), NettOpp[499] (addressing negative online experiences), UngSpotlight[500] (presentation anxiety), and Hjelpehånda[501] (emotional regulation through gamification). These complement face to face services and extend reach to rural areas.

Alarmtelefonen[502] (116 111): a 24/7 telephone and chat helpline for children and young people, offering anonymous support in Norwegian and English. This provides an essential safety net for immediate crisis support outside office hours.

Regional Knowledge Centres (RKBU[503]/RBUP[504]): four regional centres provide training, research, and quality assured resources for professionals working with children and youth mental health, strengthening workforce capacity across the country.

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494 Norwegian Ministry of Health and Care Services, *Escalation Plan for Mental Health (2022-2033).*

495 Mental Helse, *YAM*, website.

496 Mental Helse Ungdom, *Spillsonen*, website.

497 MOT Norge, *Home*, website.

498 Opp, *Home*, website.

499 NetOpp, *Home*, website.

500 UngSpotlight, *Home*, website.

501 Hjelpehånda, *Home*, website.

502 Alarmtelefonen, *Home*, website.

503 RKBU, *Home*, website.

504 RBUP, *Home*, website.

Prompt Mental Health Care (PMHC)

Overview

Prompt Mental Health Care represents Norway's national programme for accessible psychological therapy, adapted from the UK's Improving Access to Psychological Therapies model. It provides immediate access to evidence-based treatment for mild to moderate anxiety and depression without requiring general practitioner referral, thereby removing a significant barrier that often delays or prevents help seeking. The programme has expanded rapidly since initial pilots, now operating across 52 municipalities and serving as a cornerstone of Norway's mental health strategy.[505]

In typological terms, PMHC sits within the healthcare and community-based intervention space, with integrated digital components that extend reach and flexibility. The model represents a shift from specialist centred care to accessible, evidence based psychological therapy delivered in primary care settings. This positioning is significant because it addresses the 'treatment gap' where many young people with mild to moderate symptoms receive no support, potentially allowing conditions to deteriorate.

Operationally, PMHC functions through municipal health centres with multidisciplinary teams comprising psychologists, psychiatric nurses, and social workers trained in specific therapeutic approaches. Young people aged 16 and above can self-refer through online portals, telephone, or walk in arrangements, with treatment typically beginning within two weeks. The standard treatment package consists of cognitive behavioural therapy or metacognitive therapy, delivered individually or in groups, with an average of 5.5 sessions per client.[506] Digital consultations have become increasingly integrated, particularly for reaching rural populations where travel distances pose barriers. As a stakeholder explained, this digital delivery, often through an app, is a key part of the strategy to make therapy more effective, less dependent on travel, and more scalable.

The programme is funded through municipal health budgets with national coordination and quality standards set by the Norwegian Directorate of Health.

Evidence of effectiveness & ROI

The evidence base for PMHC is strong, with multiple studies demonstrating both clinical effectiveness and economic value. A randomised controlled trial comparing PMHC to treatment as usual found substantially greater symptom reduction and recovery rates at six months, with effects sustained at 12-month follow up.[507] The model is considered a success by government stakeholders, who advocate for its wider adoption combined with digital delivery as a cost-effective way to scale up access to care.

Observational studies across multiple sites reinforce these findings, showing large reductions in symptoms of anxiety and depression and recovery rates comparable to, or exceeding, those observed in similar programmes such as Improving Access to Psychological Therapies.[508] Importantly, these outcomes have been replicated across diverse municipalities, suggesting that the model is robust to local implementation variation.

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505 Goldblatt et al., *Rapid review of inequalities in health and wellbeing in Norway since 2014,* 2023.

506 OECD, *Promoting good mental health in children and young adults,* 2025.

507 M. Knapstad, T.Nordgreen and O. Smith, *Prompt mental health care, the Norwegian version of IAPT: clinical outcomes and predictors of change in a multicenter cohort study,* 2018.

508 Ibid.

PMHC also performs well in terms of access and equity. Around one-third of users self-refer, and the programme reaches a substantial proportion of individuals who have not previously received mental health treatment, indicating success in addressing the treatment gap. There is also evidence that PMHC reduces symptoms of mild to moderate depression in young adults specifically, supporting its relevance for youth focused mental health strategies.

On economic performance, Norwegian evaluations estimate treatment costs of approximately €600-€700 per client, substantially lower than specialist mental health services[509] -cost effectiveness analyses suggest a cost per quality adjusted life year (QALY) gained in the range of €9 000-€14 000, well below commonly accepted thresholds.

Implementation: Barriers & enablers

Key enablers of PMHC's success include the removal of referral requirements, which research indicates was a critical factor in improving access for young people who might otherwise not seek help.[510] The integration with existing municipal services ensures sustainability and local ownership, whilst flexible delivery modes accommodate different preferences and circumstances.

The main implementation challenges centre on workforce capacity and geographic equity. Despite employing approximately 400 therapists nationally, demand continues to exceed supply in many areas, with particular pressures in urban centres and recruitment difficulties in rural regions.[511] A stakeholder confirmed this dynamic, noting that recruitment is particularly difficult in Norway's many small, rural municipalities, making consistent implementation a key challenge.

Municipality based implementation has led to variations in service quality and availability, suggesting need for stronger national coordination. The model's focus on mild to moderate symptoms, whilst ensuring efficiency, creates gaps for those with subthreshold symptoms or more complex presentations who fall between PMHC and specialist services. Maintaining treatment fidelity whilst allowing local adaptation remains an ongoing balance.

Youth Aware of Mental Health (YAM)

Overview

The YAM programme represents Norway's adoption of an internationally validated universal prevention approach, delivered through schools to promote mental health literacy and reduce suicide risk. Developed by the Karolinska Institute and Columbia University, YAM employs a distinctive model combining professional facilitation with peer education elements, creating safe spaces for adolescents to explore mental health topics. The programme's integration into Norway's national suicide prevention strategy 'Ingen å miste' demonstrates political commitment to evidence-based prevention.

YAM is classified as a school based universal prevention programme, meaning it is delivered to all students regardless of risk status. This approach is significant because it avoids stigmatisation whilst reaching young people who might not be identified through targeted screening. The programme's focus on mental health promotion rather than problem identification aligns with Norwegian educational values emphasising whole child development and wellbeing.

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509 OECD, *Promoting good mental health in children and young adults,* 2025

510 M. Knapstad, T.Nordgreen and O. Smith, *Prompt mental health care, the Norwegian version of IAPT: clinical outcomes and predictors of change in a multi cohort study,* 2018.

511 Ibid.

The programme operates through a standardised five session format delivered over three weeks to students aged 13 to 17.[512] Each one-hour session covers specific topics including mental health awareness, stress and crisis management, depression and suicidal thoughts, helping behaviours, and knowledge about professional help. Delivery involves certified instructors who complete a two-day training course, with teachers and school staff trained alongside mental health professionals to ensure sustainability.[513] Youth helpers drawn from older students receive separate training to facilitate peer discussions and roleplays. Since 2019, Mental Helse Norge, an NGO, has coordinated national implementation, with over 2 000 students reached to date. Schools typically integrate YAM into health education curricula, though scheduling remains flexible to accommodate local timetables.

Evidence of effectiveness & ROI

YAM's effectiveness is established through one of the largest randomised controlled trials in suicide prevention. The SEYLE study,[514] involving over 11 000 students across ten European countries, demonstrated a 50 % reduction in suicide attempts and 55 % reduction in severe suicidal ideation at 12-month follow up. These effects emerged after a 'silent period' of several months, highlighting the importance of long-term evaluation in prevention research. The programme also showed positive effects on help seeking attitudes and reduced stigma, important intermediate outcomes for mental health promotion.

A cost effectiveness analysis of school-based suicide prevention programmes indicates programme costs for YAM of €34.83 per student, with a cost per life year saved of €45 468, considered highly cost effective by WHO standards.[515] When broader benefits are considered, including improved classroom climate and reduced need for specialist services, the economic case strengthens further. Norwegian implementation costs appear similar, though comprehensive local economic evaluation is pending. The National Forum for Suicide Prevention's recommendation for nationwide rollout was based on this compelling evidence base combined with positive implementation experiences.

Implementation: Barriers & enablers

While integration with the national suicide prevention strategy provides political support, stakeholders report that implementation has been challenging and not systematic across the nation. A key barrier is the autonomy of Norwegian schools; they are not obligated to adopt such programmes and can be resistant to perceived interference from the healthcare sector. A Directorate stakeholder noted that securing curriculum time amidst competing priorities is a constant struggle, and there is professional disagreement on whether standalone programs like YAM should be prioritised over more integrated curricular approaches. Furthermore, the model often requires trained people from outside the school to deliver it, which presents significant logistical and resource challenges to manage on a national scale.

Spillsonen (Game Zones)

Overview

Spillsonen, a project run by the NGO Mental Helse Ungdom, represents an innovative digital outreach initiative that meets young men where they naturally congregate online gaming platforms. Recognising that young males are significantly less likely to seek traditional mental health support,

512 Mental Helse, *YAM*, website.

513 YAM – *Youth Aware of Mental health*, website.

514 Wasserman et al., *Saving and empowering young lives in Europe (SEYLE): a randomized controlled trial*, 2010.

515 Ahern et al., *A cost effectiveness analysis of school-based suicide prevention programmes,* 2018.

the project uses Twitch streams and Discord servers to facilitate mental health discussions within gaming contexts. This approach is particularly significant given project findings that 42 % of young male gamers report feeling lonely, yet many have never sought professional help due to shame or perceiving their struggles as 'not serious enough'. The intervention is classified primarily as a digital/technology-based outreach model with strong community engagement elements. Unlike clinical digital interventions that replicate therapy online, Spillsonen embeds mental health content within entertainment and social connection. This positioning is crucial because it reaches young men who would not actively seek mental health information or support, addressing the gender gap in help seeking that contributes to higher male suicide rates.

Operationally, Spillsonen works through partnerships with established gaming influencers who integrate mental health discussions into their regular streaming schedules. The project has conducted 60 Twitch streams featuring conversations about mental health alongside gameplay, creating a nonthreatening context for exploring emotional topics. Professional support is available through trained moderators in chat functions, though the primary model is peer to peer discussion facilitated by streamers. Mental Helse Ungdom[516] coordinates the initiative with funding from public health grants and private foundations. The target demographic is males aged 16 to 25, though streams are publicly accessible and attract broader audiences. Content remains available on demand, extending reach beyond live participation.

Evidence of effectiveness & ROI

Spillsonen has achieved significant reach, with over 45 000 unique viewers across 60 streams and sustained engagement throughout stream durations averaging two to three hours. Project evaluation reveals that 23 % of viewers reported increased willingness to seek help after watching streams, a meaningful shift given baseline reluctance among this demographic. Qualitative feedback highlights that participants value the normalisation of mental health discussions and the authenticity of streamers sharing their own experiences.

The project's research component provides valuable insights into the mental health needs of young male gamers. Surveys reveal high rates of loneliness, sleep disruption related to gaming, and significant barriers to help seeking including shame and minimisation of problems. These findings inform both content development and demonstrate the initiative's value in reaching an underserved population.[517] Whilst comprehensive economic evaluation is pending, the low-cost model utilising existing platforms and volunteer networks suggests strong value for money compared to traditional outreach methods.

Implementation: Barriers & enablers

The initiative's primary strength lies in meeting young men in their natural digital habitat, removing geographical, psychological, and practical barriers to mental health engagement. Partnerships with trusted streamers provide credibility that institutional messaging lacks, with parasocial relationships developed through regular viewing creating openness to mental health content. The entertainment first format reduces stigma whilst normalising emotional expression among male peers. Anonymous participation through chat functions allows graduated engagement, from passive viewing to active discussion.

Significant challenges include measuring impact beyond engagement metrics, with conversion to help seeking behaviour difficult to track given the anonymous, distributed nature of participation. Platform dependency creates vulnerability to policy changes, algorithm modifications, or streamer

[516] Ibid.

[517] Ibid.

availability. Quality control across multiple streamers requires ongoing training and support to maintain appropriate boundaries whilst preserving authenticity. The model's reliance on volunteer streamers and moderators raises sustainability questions, particularly as mental health content can be emotionally demanding. Balancing entertainment value with mental health messaging requires careful navigation to maintain audience engagement whilst ensuring appropriate support for those experiencing distress.

Flexible Assertive Community Treatment for Youth (FACT ung)

Overview

FACT ung adapts the evidence based Dutch FACT model for Norwegian youth experiencing complex mental health challenges alongside substance use, social difficulties, and functional impairment. The programme addresses a critical service gap for young people whose needs exceed traditional outpatient capacity, but who can be maintained in the community with intensive support. By extending services to age 25, FACT ung explicitly addresses the 'transitional cliff' when young people age out of child services at 18, often experiencing service disruption at a vulnerable developmental stage. A stakeholder confirmed it is seen as a success because it effectively bridges the gap between municipal level services and specialist hospital services, forcing them to work together.

The model represents intensive community-based healthcare with strong social prescribing elements. Teams work across traditional service boundaries, providing psychiatric treatment, psychological therapy, social support, educational assistance, and family intervention within an integrated package. This comprehensive approach recognises that mental health, substance use, and social functioning are interconnected, particularly for youth experiencing multiple adversities.

FACT ung operates through multidisciplinary teams comprising psychiatrists, psychologists, nurses, social workers, occupational therapists, substance abuse counsellors, and peer support workers. Teams maintain small caseloads of 10 to 15 clients per practitioner, enabling intensive, personalised support. The assertive outreach model means teams actively engage clients in their natural environments like their homes, schools, workplaces, and community settings, rather than requiring office attendance. This flexibility is crucial for engaging youth who struggle with traditional appointment-based services. The National Competence Centre for Concurrent Substance Abuse and Mental Health Disorders (NKROP) provides training, quality assurance, and coordination, whilst services are delivered through partnerships between specialist mental health services and municipalities. Approximately 2 000 young people are currently served nationally, with government pilots supporting expansion.

Evidence of effectiveness & ROI

Stakeholders from both government and academia confirm that FACT ung is widely considered a success in Norway, with one describing it as 'something that has come to stay' and is working well where implemented. Norwegian evaluation data demonstrates substantial impacts across multiple domains with 68 % reduction in inpatient days representing both improved client outcomes and significant system savings, given that psychiatric hospitalisation is the most expensive form of mental health care.[518]

Whilst comprehensive Norwegian cost effectiveness analysis is ongoing, international evidence suggests returns of €3 to €5 for every euro invested in intensive community based mental health

[518] Guidance on community mental health services: *Promoting person-centred and rights-based approaches,* 2021.

models.[519] These returns accrue through prevented hospitalisations, reduced criminal justice involvement, improved educational outcomes, and decreased long term disability. The model is particularly cost effective in preventing the accumulation of disadvantage when complex needs are not addressed during the transition to adulthood.[520] Norwegian stakeholders suggested similar economic benefits, with costs partially offset by reduced use of inpatient and crisis services over time.

Implementation: Barriers & enablers

Success factors centre on the model's flexibility in meeting clients 'where they are' both literally and metaphorically. The assertive outreach approach overcomes practical barriers like transport and scheduling whilst building trust through consistent, reliable presence. The extended age range to 25 acknowledges that developmental transitions do not align with administrative boundaries. Multidisciplinary teams enable real time coordination, avoiding the fragmentation that often characterises complex cases. Strong family involvement, where appropriate, mobilises natural support systems whilst addressing family dynamics that may perpetuate difficulties.

Implementation challenges are substantial, beginning with high per client costs that limit scalability despite economic returns. Recruiting and retaining qualified staff for intensive work with complex cases proves difficult, particularly for psychiatrist positions in rural areas. The model requires significant investment in cross sector relationships, information sharing agreements, and joint funding arrangements between health and social services. The intensity of support means the model can only serve those with the most complex needs, leaving gaps for young people with moderate complexity who exceed standard service capacity but do not meet FACT ung thresholds. Maintaining model fidelity whilst adapting to local contexts and resources requires ongoing supervision and quality monitoring that smaller municipalities struggle to provide.

Transferability & EU policy lessons

The Norwegian experience offers valuable lessons for the EU on how to structure and refine a mature, multilayered mental health system. While Norway benefits from high levels of public investment, its key insights for other countries lie not in the level of spending, but in its strategic focus on system integration, workforce capacity, and innovative models for early intervention and prevention.

Early intervention services

Norway provides two highly transferable models for early intervention that address different ends of the need spectrum. For mild to moderate difficulties, Prompt Mental Health Care (PMHC) offers a blueprint for a low threshold, evidence-based service that relieves pressure on specialist care. Its success in removing the need for a GP referral is a key lesson in improving access. For this model to be transferred, it requires a strong primary care infrastructure at the municipal level, a trained workforce in therapies like CBT, and national coordination to ensure quality. At the other end of the spectrum, FACT ung provides a robust model for supporting young people with complex needs through the critical transition to adulthood (up to age 25). This is directly relevant for EU countries struggling to prevent vulnerable youth from falling through the gap between child and adult services. However, its transferability is dependent on significant per client funding and the availability of a highly skilled, multidisciplinary workforce.

[519] European Commission (2018). *Mental health and wellbeing in Europe: economic case.*

[520] Guidance on community mental health services: *Promoting person-centred and rights-based approaches*, 2021.

Prevention in schools

The Norwegian experience with the Youth Aware of Mental Health (YAM) programme demonstrates both the value of implementing evidence based universal prevention and the practical challenges involved. While the programme has a strong international evidence base for reducing suicide risk, its rollout in Norway highlights a critical governance lesson: even with national strategic backing, implementation can be patchy if schools have high levels of autonomy. For such models to be successfully transferred elsewhere, it requires formalised, cross sectoral agreements between health and education authorities to ensure that prevention is structurally embedded in the curriculum, rather than being an optional addon.

Digital tools and governance

The Norwegian case study provides specific insights into using digital tools for engagement rather than purely for clinical delivery. Spillsonen is a standout transferable model for reaching underserved populations, particularly young men. By embedding mental health conversations within gaming platforms and leveraging trusted influencers, it offers a blueprint for how to destigmatize help seeking and build supportive peer communities in digital spaces where young people naturally congregate. The conditions for its success include partnerships with digital creators and a trained workforce of online moderators. This approach is highly relevant for EU level discussions on how to design youth friendly digital mental health supports that go beyond traditional app-based therapy.

Equity and access

Finally, the Norwegian experience underscores that funding alone does not guarantee equitable access. The primary constraint identified in Norway is workforce capacity, especially in rural areas. This serves as a crucial lesson for all Member States: any strategy to scale up mental health services must be accompanied by a long-term plan for recruiting, training, and retaining a skilled workforce. Furthermore, interventions like PMHC (by removing referrals), Spillsonen (by targeting young men), and FACT ung (by supporting complex cases) all offer concrete strategies for improving equity and access for different groups who are often missed by traditional service models.

Poland

Executive summary

Table 22 – Poland case study executive summary

Section	Details
National Context and Current Situation	Poland's youth mental health system is guided by the National Mental Health Protection Programme (2023–2030) and is transitioning from hospital-based to community-based care. Despite reforms, the system faces significant underfunding, workforce shortages, long waiting times, and regional inequalities. Youth mental health outcomes are poor, with high levels of stress, anxiety, and suicidal ideation, alongside growing digital risks such as excessive screen time, harmful content exposure, and cyberbullying. The COVID-19 pandemic, economic pressures, and the impact of the war in Ukraine have further increased demand and complexity of need.
Intervention 1: 'An Hour for YOUNG HEADS' (UNAWEZA Foundation)	This school-based prevention programme delivers monthly, low-intensity lessons focused on emotional literacy, digital hygiene, and help-seeking among pupils aged 10–18. It operates at national scale and is free for schools, using accessible digital materials. Evaluation shows significant improvements in emotional knowledge, communication, and digital competencies. Key strengths include scalability, strong acceptability, and practical applicability, while challenges include variation in delivery and limited impact on some behaviours such as external help-seeking.
Intervention 2: Project SOLVE	SOLVE is a brief, digital, single-session intervention teaching structured problem-solving skills to reduce anxiety and depression. Delivered in classrooms via pupils' own devices, it is highly scalable and suitable for low-resource settings. Evidence from a randomised controlled trial shows small but meaningful reductions in internalising symptoms, particularly among more vulnerable groups such as Ukrainian refugee youth. Strengths include low cost and ease of implementation, while challenges include modest effect sizes, follow-up attrition, and the need for complementary support systems.
Intervention 3: Polish Health Education Curriculum	Introduced in 2025, this curriculum integrates mental health, digital literacy, and wellbeing into school education through weekly lessons. It covers topics such as digital hygiene, online safety, emotional regulation, and critical thinking. While early implementation shows variable uptake (around 30 % attendance), it represents a systemic approach to prevention. Key enablers include strong demand and teacher training, while challenges relate to its initially non-obligatory status, political contestation, and regional disparities in participation.
Intervention 4: State Programme for Prevention of Suicidal Behaviours (KPZZS)	KPZZS is a national, multi-sector suicide prevention framework combining workforce training, crisis support (including 24/7 helplines), public awareness, and media regulation. Early results indicate improved awareness, large-scale training (over 50 000 individuals), and a potential decline in suicide rates. Strengths include its comprehensive, system-level approach and digital components, while challenges include uneven regional implementation and the need for stronger targeting of high-risk groups.

Section	Details
Transferability and EU Policy Lessons	Poland highlights how large-scale, low-cost interventions can strengthen prevention in resource-constrained systems. Transferable lessons include the effectiveness of light-touch school programmes ('YOUNG HEADS'), scalable digital tools (SOLVE), and national suicide prevention frameworks (KPZZS). The new health curriculum illustrates how mental and digital health can be embedded structurally in education, though sustained political support is essential. The case also underscores persistent challenges around equity, workforce capacity, and regional disparities, emphasising that innovation must be paired with sustained public investment and coordinated governance.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

The Polish mental health protection system relies on the 1994 Mental Health Protection Act[521] while the 2019 Regulation on Guaranteed Benefits in Psychiatric Care/Addiction Treatment defines service entitlements.[522] The flagship programme is the National Mental Health Protection Programme ('NPOZP') for 2023-2030, coordinated by the Ministry of Health, and financed by the National Health Fund, based on the 3tier care model.[523] One of the goals of the Programme is to: 'disseminate recommended assumptions for therapeutic programs for children and youth problematically using new digital technologies.'

The Polish public mental health services system has been undergoing major reform in recent years, transitioning from hospital-focused services to a community-based, three-tier system for children and adolescents. [524] The 2024 report, the Polish Supreme Chamber of Control report pointed to disparities in service coverage.[525] The report summarising the progress in reforms has been recently published by the Ministry of Health[526] and the decisions are due on the future of the reform.[527]

Poland does not yet have a comprehensive law regulating smartphone and social media use by adolescents, yet several major legislative initiatives are underway. As suggested in the stakeholder interviews, that Poland's youth mental health challenges in the digital era mirror those seen across the EU. Namely, the Ministry of Education informed smartphone use will be banned in primary

521 Ustawa z dnia 19 sierpnia 1994 r. o ochronie zdrowia psychicznego, *Ochrona zdrowia psychicznego*, website

522 Rozporządzenie ministra zdrowia z dnia 19 czerwca 2019 r. *w sprawie świadczeń gwarantowanych z zakresu opieki psychiatrycznej i leczenia uzależnień*, akty prawne do ISAP-u, 2019.

523 Najwyższa Izba Kontrol. *Informacja o wynikach kontroli: Opieka psychiatryczna nad dziećmi i młodzieżą* (LPO.430.5.2023; Nr ewid. 11/2024/P/23/077/LPO). Warszawa: Najwyższa Izba Kontroli, 2019.

524 Serkowska, M., Robakowska, M., Rystwej, D. A., & Brzeziński, M. 'Child and Adolescent Mental Health Service (CAMHS) in Poland—From the perspective of the current state and new reform'. *Healthcare*, 13(16), 2078, 2025.

525 Kaźmierczyk, P., Partyka-Opiela, A., Papis, M., Nowosielska-Łaskawiec, J., & Bednarski, J. *Raport regulacyjny: Poprawa ochrony zdrowia psychicznego dzieci i młodzieży w Polsce. Kancelaria Rymarz Zdort Maruta we współpracy z UNICEF Polska*, 2025.

526 Taskforce for Systemic Changes in Mental Health Centres. *Raport końcowy Zespołu do spraw zmian systemowych w centrach zdrowia psychicznego,* 2025.

527 Oko Press. *Niechciany raport na temat reformy psychiatrii. Czy utrzymają się centra zdrowia psychicznego?*, website.

schools from the 2026/2027 school year, while high schools will regulate it by school statutes. The Ministry informed also of the plans to ban social media for adolescents below the age of 15.[528]

Baseline statistics

The population segment aged 0–24 years constitutes close to 25 % of the total Polish population of close to 37.5 million (2024).[529] There are approximately 6.7 million minors, and 2.5 million individuals aged 18–24.[530] The source literature clearly points to a mental health crisis affecting the Polish youth. 45 % of Poles aged 18–24 rate their mental health as bad or very bad, and 70 % of young Poles feel stress.[531] According to UNAWEZA Foundation's 2023 research, almost 81 % of young people in Poland felt overcome by daily stress, half of students had extremely low self-esteem. Many young people pointed to trouble focusing (38.1 %), difficulties with studying/schoolwork (30.6 %), or sleep issues (37 %).[532]

Regarding suicide data, approximately 13 people die by suicide daily in Poland–with 11 of them being men. The number of suicides per year decreased between 2014 to 2024 by 21.4 %, and 2024 saw 7.4 % with the largest 10-year drop (7.4 %) between 2023 and 2024.[533] Regarding youths, as of 2023, close to 40 % students thought about attempting suicide, roughly 25 % admitted having talked about suicide, and slightly above 20 % stated the lack of willingness to live.[534] The number of suicides and suicidal attempts were on the rise from 2020 (the number of reported attempts increased more than 2.5 times between 2020 and 2022), with the biggest increases among girls, 215 % between 2020 and 2023. Between 2023 and 2024, the increasing trend slowed down.[535] A sustained decline had been recorded for 24 months despite a 3 % increase in police recorded attempts,[536] however underreporting is likely.[537] Polish adolescents are strongly exposed to suicide related contents in social media. Suicidal/self-harm content appears in social-media feeds for 40 % of 7th-grade primary students and 55 % of 3rd-year upper-secondary students.[538]

When it comes to depression and anxiety, treatment services have historically been under resourced, particularly in the rural areas, with stigma delaying diagnosis/treatment.[539] Estimated 2 % of children and 20 % of adolescents suffer from depression.[540] In a study with Polish students, 41.9 %

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528 BBC News Polska, Polska przedstawia plany ograniczenia dostępu dzieci do mediów społecznościowych', website, 2026.

529 Statistics Poland. *Poland in Figures 2025*. Statistical Products Department, Statistics Poland, 2025

530 Statistics Poland. Size and structure of population by age groups in 2989–2024, 2025.

531 Gagatek, K., Karaś, U. and Kelsz, J.*, Stan młodych 2025: Raport ważnych spraw*, Fundacja ważne sprawy.

532 UNAWEZA Foundation, Młode głowy – raport z badania, 2023.

533 Czabański, A., Samobójstwa i próby samobójcze w Polsce w latach 2020–2024: Na podstawie danych KGP na dzień 17.01.2025, Biuro do Spraw Zapobiegania Zachowaniom Samobójczym, 2025.

534 Flis, J. and Dębski, M., Młode Głowy. *Raport z badania dotyczącego zdrowia psychicznego, poczucia własnej wartości i sprawczości wśród młodych ludzi*, Fundacja Unaweza, 2023.

535 Dębski, M., Pyżalski, J., Borchet, J. and Witkowska, H., Dobre i złe wiadomości – życie online i offline a zdrowie psychiczne polskich nastolatków: Raport z badań, Fundacja Dbam o Mój Zasięg, 2025

536 *Samobójstwa i próby samobójcze w Polsce w latach 2020–2024: Na podstawie danych KGP na dzień 17.01.2025,* Komenda Główna Policji, *2025.*

537 Zięba-Kołodziej, B. and Kołodziej, P., 'Mental health of children and adolescents in Poland: Needs and opportunities', *International Journal of Social and Educational Innovation*, Vol. 11(Special Issue), 2024, pp. 111-126..

538 *Dobre i złe wiadomości – życie online i offline a zdrowie psychiczne polskich nastolatków: Raport z badań,* Fundacja Dbam o Mój Zasięg, 2025

539 Czech, M., Hołownia-Voloskova, M., Bliźniewska-Kowalska, M., Zakrzewski, M., Roubinek, P., Mosiołek, A. and Silczuk, A., 'Depressive and anxiety disorders in Polish children across the COVID-19 pandemic: a nationwide registry-based time-trend analysis', Frontiers in Psychiatry, *Vol. 16, Frontiers Media*, 2026

540 Zięba-Kołodziej, B. and Kołodziej, P., 'Mental health of children and adolescents in Poland: Needs and opportunities', *International Journal of Social and Educational Innovation (IJSEIro)*, Vol. 11, No 21, 2024.

of student participants' answers indicated that an individual could suffer from depression.[541] An estimated 7.3 % of 7–17-year-olds experienced internalising disorders such as withdrawal, somatic symptoms, depression, anxiety, and phobias. The helpline data points to a sustained rise in anxiety related concerns: young customers often described persistent fear and anxiety that impaired everyday functioning, with females reporting these problems relatively more often (69 % vs 30 %).[542] Prior to COVID-19, Poland saw an upward trend in the number of patients under the age of 21 treated for major depression (from 1.9 % to 4.1 % between 2005 and 2016). Use of subsidized depression medicines among adolescents nearly quintupled between 2014 and 2024, from 18 500 to 88 400 annual purchasers.[543] The pandemic years intensified this trend.[544] In the population who received medical treatment with main or coexisting diagnosis of depression, the share of people below under the age of 17 increased from 1.4 % to 3.7 % between 2014 and 2024, and the share of those between 18 and 34 years old from 12.7 % to 15.0 %.[545,546]

Turning to digital habits: 96 % of male and 96 % of female Polish youths declare smartphone usage, and 65 % that they 'almost never part' with their devices.[547] The average adolescent gets their first Internet enabled phone at the age of just over 8.[548] Among primary school's 7th graders 88 % participants reported having a social media account, and among teenagers in their 3rd year of high school, 96 % have such an account. Before they turned 13, 81.6 % set up their social media accounts.[549] Screen time increased for the Polish teenagers increased by approximately 52.73 % from 2014 to 2022, up to 5 hours and 36 minutes on workdays, and 6 hours and 16 minutes on average on Saturdays and Sundays.[550]

As of 2023, one in five Polish students (22.7 %) felt addicted to new technologies and one in three (33.3 %) experienced a strong anxiety related to being disconnected from the internet. Additionally, 86 % of young people in Poland regularly accessed harmful contents online.[551] In 2024, 66 % of 15–24-year-olds encountered online hate, 33 % of students were insulted online by people from school/class, and 31 % received unwanted erotic content. Nearly 40 % of young people viewed contents depicting violence online.[552] Another serious problem was widespread youths'

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541 Dębski, M. and Flis, J., *MŁODE GŁOWY. Otwarcie o zdrowiu psychicznym. Raport z badania dotyczącego zdrowia psychicznego, poczucia własnej wartości i sprawczości wśród młodych ludzi w Polsce*, Fundacja UNAWEZA, 2023

542 Zięba-Kołodziej, B. and Kołodziej, P., 2024.

543 Narodowy Fundusz Zdrowia, *NFZ o zdrowiu. Depresja, Wykres 2.12: Liczba pacjentów (w tys.) poniżej 18 r.ż., którzy zrealizowali receptę na refundowane leki przeciwdepresyjne (2013–2024)*, Centrala Narodowego Funduszu Zdrowia, 2025.

544 Czech, M., Hołownia-Voloskova, M., Bliźniewska-Kowalska, K., Zakrzewski, K. M., Roubinek, O., Mosiołek, A. and Silczuk, A., 'Depressive and anxiety disorders in Polish children across the COVID-19 pandemic: A nationwide registry-based time-trend analysis', *Frontiers in Psychiatry*, Vol. 16, Art. 1728383, Frontiers Media, 2026.

545 Narodowy Fundusz Zdrowia, *NFZ o zdrowiu. Depresja, Tabela 2.1: Struktura wieku i płci pacjentów…* (2013–2024).

546 Narodowy Fundusz Zdrowia, *NFZ o zdrowiu. Depresja, Wykres 2.1: Liczba osób, którym udzielono świadczenia…* (2024).

547 Potęga vel Żabik, K. and Sadowska, S., *Urządzenia mobilne w uczeniu się i nauczaniu: Raport z badań ilościowo-jakościowych*, Centrum Nauki Kopernik and Samsung, 2024.

548 Zięba-Kołodziej, B. and Kołodziej, P., 2024.

549 Dębski, M., Pyżalski, J., Borchet, J. and Witkowska, H., Dobre i złe wiadomości – życie online i offline a zdrowie psychiczne polskich nastolatków: Raport z badań, Fundacja Dbam o Mój Zasięg, 2025.

550 Lange, R., Wrońska, A., Ładna, A., Kamiński, K., Błażej, M., Jankiewicz, A. and Rosłaniec, K., *Nastolatki 3.0: Raport z ogólnopolskiego badania uczniów i rodziców*, NASK – Państwowy Instytut Badawczy, 2023.

551 Wójcik, S., Wojtasik, Ł., Kępka, M., Makaruk, K., Dziemidowicz, E., Nawarenko, A. and Podlewska, J., *Patotreści w internecie: Raport o problemie*, Fundacja Demy Dzieciom Siłę, 2019.

552 Dębski, M. and Flis, J., *MŁODE GŁOWY. Otwarcie o zdrowiu psychicznym. Raport z badania…*, Fundacja UNAWEZA, 2023

consumption of so called 'trash streams' (in Polish referred to as 'patotreści', or 'patostreaming') – broadcasts entailing violence, abuse of substances, humiliation, or display of unethical behaviours.[553]

The research from Dębski et al. (2025) linked compulsive internet behaviour usage among Polish students and worsened wellbeing (i.e. lower life satisfaction, more frequent experiencing of thoughts 'not to wake up'. Those with low compulsivity were three times as likely to feel very happy and much more likely to report excellent or good wellbeing.

Healthcare capacity

As of 2023, total healthcare spending was €57 billion (7.1 % of GDP), while merely 3.7 % of this budget was channelled to mental healthcare (adults and children combined), which indicates constrained financing.[554] Although between 2019 and 2023 the investments in psychiatric support for children and youth quadrupled, up to more than €236 million,[555] the available resources are described as insufficient across the literature.[556]

Overall, the capacity of the Polish mental healthcare system is constrained by workforce shortages and underfunding, producing long waits, territorial inequities, and emergency-driven admissions.[557] Recent reforms (three-tier model with Level-I centres and telemedicine uptake) aim to improve early access, but persistent staffing gaps, uneven, and coordination barriers limit impact.[558, 559, 560, 561] Limited capacity results in long waits (2025: inpatient care-105 days wait, daycare units-61;-outpatient clinic-257).[562] The number of available facilities and waiting time across 16 Polish provinces vary considerably. Lack of inpatient ward capacity was noted across the provinces, resulting in admissions on an emergency basis, and insufficient number of beds leading to patients sometimes treated in other provinces or at paediatric wards, sometimes such that specialise in areas of medicine other than mental health.[563] Bed occupancy regularly exceeded 100 %, with occupancy rate at psychiatric wards for children and youth averaging 110 % between 2019 and 2022. More than a thousand of under18s were hospitalised on adult wards between 2020 and early 2023.[564]

The number of practicing psychiatrists increased between 2019 and 2024 by close to 8 %: up to 4 141 in 2024 – including 23 % past the retirement age, with the average age of a practitioner exceeding 50 in each of the Polish regions. The ratio of psychiatrist per 100 000 population was 11.0, with significant interregional disparities.[565] As of 2024, there were 516 practicing child and adolescent

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553 Polish Safer Internet Centre, *Patostreaming – A new concern for Polish parents and educators*, European Union, Better Internet for Kids, 2020.

554 Czech, M., Hołownia-Voloskova, M., Bliźniewska-Kowalska, K., Zakrzewski, K. M., Roubinek, O., Mosiołek, A. and Silczuk, A., 'Depressive and anxiety disorders in Polish children across the COVID-19 pandemic: A nationwide registry-based time-trend analysis', *Frontiers in Psychiatry*, Vol. 16, Art. 1728383, Frontiers Media, 2026.

555 Raport regulacyjny: *Poprawa ochrony zdrowia psychicznego dzieci i młodzieży w Polsce (Stan na 17.06.2024)*, 2024.

556 Gmitrowicz, A. and Rabe-Jabłońska, J., 'Child and Adolescent Mental Health Service (CAMHS) in Poland — From the perspective of the current state and new reform', *Archives of Psychiatry and Psychotherapy*, Vol. 25, No 2, 2023.

557 Ibid.

558 Raport regulacyjny*: Poprawa ochrony zdrowia psychicznego dzieci i młodzieży w Polsce...* (Stan na 17.06.2024).

559 Czech, M. et al., 'Depressive and anxiety disorders in Polish children across the COVID-19 pandemic...', 2026

560 Zięba-Kołodziej, B. and Kołodziej, P., 'Mental health of children and adolescents in Poland: Needs and opportunities', *International Journal of Social and Educational Innovation (IJSEIro)*, Vol. 11, No 21, 2024.

561 UNICEF Polska, *Zdrowie psychiczne dzieci i młodzieży w Polsce – jak poprawiać sytuację najmłodszych i polepszać ich komfort oraz samopoczucie?*, press release, 17 June 2024.

562 Gmitrowicz, A. and Rabe-Jabłońska, J., 'Child and Adolescent Mental Health Service (CAMHS) in Poland...', 2023.

563 Ibid.

564 Najwyższa Izba Kontroli, *Informacja o wynikach kontroli: Opieka psychiatryczna nad dziećmi i młodzieżą*, NIK, 2020.

565 Ministerstwo Zdrowia, *Kadry medyczne – Mapy potrzeb zdrowotnych*, website, consulted on 22 March 2026.

psychiatrists in Poland: approximately 10.49 per 100 000 children.[566] By 2024, 22 % among them had reached pension age. In all but 2 regions of Poland, the average age of a doctor practicing in this area exceeded 50. Several reviewed sources emphasise continued shortages and uneven distribution affecting access despite incremental increases.[567, 568] Acute interregional differences in availability persist.

From the 2022/2023 school year, Poland made it obligatory to employ psychologists in educational institutions. However, many schools lacked filled posts, and in other cases conversion of posts to pupil numbers resulted in unsustainable parttime allocations. As of 2023/24 school year, 450 schools reported no posts filled, and in some provinces more than 52 % of posts remained unfilled.[569]

Crisis impacts

The COVID-19 pandemic exposed and intensified existing mental healthcare issues in Poland. Isolation, anxiety, and instability negatively impacted wellbeing of many, and the problems challenges witnessed in the mental health services system became more acute.[570] The increased demand on psychological services resulted in telepsychiatry projects being implemented, however the need for integrated support systems at all levels and improved access persisted.[571]

Regarding the youth specifically, the closing of schools and sports facilities led to decreased physical activity in children, heightening risks for depression and exacerbating mental health conditions due to decreased exercise and social interaction.[572] Moreover, during remote learning, internet use dramatically increased both on weekdays and weekends, which may have entrenched high online activity levels, potentially aggravating mental health issues due to prolonged digital exposure.[573] There was a surge in psychotropic prescriptions among Polish children and adolescents during COVID-19. In one stakeholder interview it was noted that the publicly funded child and adolescent mental health service use rose approximately threefold after pupils returned from remote learning.

Then, when it comes to the Russian aggression against Ukraine, new stressors emerged since 2022, notably: fears of the war spreading, distress from the humanitarian crisis, and economic anxieties linked to the influx of refugees. One study from Gambin et al. (2023), based on a Polish teen sample tracked from late 2021 to May 2022, found the war showing up in the concerns held by adolescents with persistently high symptoms: those with chronic anxiety (25 %) reported greater worry about war-driven economic difficulties, while those with chronic depression (11 %) concerns about challenges linked to responsibilities related to Poland hosting many refugees.[574]

As a separate issue, one should consider the impact of the war on the mental health of young Ukrainians in Poland. Following the influx of Ukrainians related to the Russian aggression, in 2025 Ukrainians constituted 78 % of all foreigners settling in Poland. One in two people in this group were

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566 *Raport regulacyjny: Poprawa ochrony zdrowia psychicznego dzieci i młodzieży w Polsce...* (Stan na 17.06.2024)

567 Zięba-Kołodziej, B. and Kołodziej, P., 'Mental health of children and adolescents in Poland: Needs and opportunities', *International Journal of Social and Educational Innovation (IJSEIro)*, Vol. 11, No 21, 2024

568 *Raport regulacyjny: Poprawa ochrony zdrowia psychicznego dzieci i młodzieży w Polsce...* (Stan na 17.06.2024).

569 *Mental health of children and adolescents in Poland: Needs and opportunities.*

570 Zięba-Kołodziej, B. and Kołodziej, P., 'Mental health of children and adolescents in Poland...', 2024.

571 Ibid.

572 Gmitrowicz, A. and Rabe-Jabłońska, J., 'Child and Adolescent Mental Health Service (CAMHS) in Poland...', 2023

573 Dębski, M., Pyżalski, J., Borchet, J. and Witkowska, H., *Dobre i złe wiadomości – życie online i offline a zdrowie psychiczne polskich nastolatków...*, 2025.

574 Gambin, M., Wnuk, A., Oleksy, T., Sękowski, M., Kubicka, K., Woźniak-Prus, M., Sharp, C. and Bonanno, G. A., 'Depressive and anxiety symptom trajectories in Polish adolescents during the COVID-19 pandemic and the outbreak of war in Ukraine: Uncovering the role of family relations', *Development and Psychopathology*, Cambridge University Press, 2023, pp. 1–11.

minors, and 61 % women.[575] Ukrainian youths in Poland witnessed challenges stemming from displacement, trauma, and integration pressures. The UNICEF's report (2024) hints at the findings from earlier study (UNICEF et al., 2023, 'It is cool here, no doubt about it... but home is home.'), noting that many Ukrainian refugees felt nostalgic for the people, pets and places that they had to leave, while 'many children and adolescents became apathetic and resorted to excessive sleeping and eating when overwhelmed by stress'.[576] Almost half of the adolescents reported loneliness most of the time after arrival.[577] Despite these hurdles, the 2024 survey found that 74 % were not engaging with any MHPSS service, and 53 % had never used any MHPSS service previously.[578]

Regarding climate change, the study of Polish adolescents and university students by Błaszczak et al. (2025) found that climate related emotions meaningfully predict poorer mental health in that cohort: higher levels of climate anger, contempt, and especially guilt is associated with higher generalized anxiety and depression in both groups. Cited evidence also shows climate change undermines wellbeing, daily functioning, and fuels future related worries (e.g., hesitancy about having children).[579]

On top of that, the economic downturn, showcased by high inflation and related financial stressors, adversely affects mental health in Poland. There was a noticeable downward trend in reported life satisfaction, especially among younger age groups, linked to macroeconomic stressors, such as inflation and energy crisis, evident in worsening assessments of future prospects and the material situation.[580]

Deep dive: Featured intervention(s)

UNAWEZA Foundation's prevention programme: 'An Hour for YOUNG HEADS' ['Godzina dla MŁODYCH GŁÓW'].

The programme has been designed and implemented by the experts in the area of mental health, on behalf of the UNAWEZA Foundation, as a follow up to the study„ MŁODE GŁOWY. Otwarcie o zdrowiu psychicznym'.[581] The target population is school students in Poland aged approximately 10–18 years. It delivers one 45-minute class per month throughout one school year. The classes are run according to the scenarios provided by the authors of the programme. It is free for schools, with resources accessible online via an online platform: digital tools for easy download and implementation.

By integrating free, age-appropriate lessons, the programme reinforces students' psychological conditions and improves relationships in classrooms and with adults, establishing a school 'safety net.' The areas where it provides practical education include emotions, digital hygiene, or critical thinking. The programme also focuses on prevention of self-destructive behaviours through

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575 *Note on exclusions:* This data excludes individuals staying in Poland under the visa-free movement or based on visas.

576 UNICEF Refugee Response Office in Poland, *Understanding Ukrainian adolescents' attitudes to mental health and psychosocial support in Poland*, UNICEF, 2024.

577 UNICEF Refugee Response Office in Poland, *Understanding Ukrainian adolescents' attitudes to mental health...*, 2024.

578 Ibid.

579 Błaszczak, A., Gawda, B., Jach-Salamon, N., Ludwikowska-Świeboda, K. and Tychmanowicz, A., 'Climate emotions among Polish adolescents and students: Increase in emotional resources with age', *Psychiatria i Psychologia Kliniczna*, Vol. 25(1), 2025, pp. 31–38.

580 Marchlewska, M., Rogoza, M., Adamczyk, D., Molenda, Z., Bagrowska, P., Gawęda, Ł., Pochwatko, G. and Grzeszczuk, M., *Dobrostan psychiczny w Polsce. Co myślimy o pomocy psychologicznej? Raport z badania ilościowego 'Psychologia dla społeczeństwa'*, Instytut Psychologii Polskiej Akademii Nauk, 2025.

581 Dębski, M. and Flis, J., *MŁODE GŁOWY. Otwarcie o zdrowiu psychicznym. Raport z badania...*, Fundacja UNAWEZA, 2023.

education and targeted preventive activities, and positions school as a place that can teach Psychological First Aid when provided with simple, easy-to-use resources.

In addition to running the school-based programme, the Foundation offers specific mental health aid materials, namely: the 'PPP Lesson First Aid for Mental Health', based on the WHO recommended model of provision of support to individuals experiencing emotional crisis. On the one hand, materials are offered to school staff via the Foundation's website, thereby enabling teachers to gain skills to run a classroom lesson about mental health first aid. On the one hand, a set of visually attractive and concise learning materials is offered via the Foundation's website to anyone – including students who wants to gain skills in supporting anyone who experiences emotional distress.

Results

In the 2024/2025 edition, the programme operated at national scale in schools enrolling an estimated 1.19 million pupils, with about 700 000 completing eight one-lesson sessions across eight months. Compared with a control group in the same schools, participants showed statistically significant gains in help-seeking literacy and emotional knowledge, reported stronger skills and behaviours (feeling able to talk about feelings, actually holding such conversations more often). Digital era competencies improved too: more pupils said they could protect themselves online and verify information, and more several times chose to forgo using a smartphone/computer when it was not necessary, while controls showed little change or small declines.

Teacher-leaders corroborated these patterns, with large majorities reporting more open communication, clearer expression of emotions/needs, better relationships and more critical appraisal of information; 72 % of pupils said they would recommend the programme, and the evaluation noted no elevation in anxiety during sessions.

A shortcoming identified by the evaluation was that some target behaviours did not move in a follow up to programme participation. For example, asking at home to seek external therapy did not increase among participants, and some information-seeking behaviours showed minimal change.

Success factors and challenges

Regarding success factors, the cited evaluation[582] points to the format being light-touch and school-friendly (only eight 45-minute sessions over eight months), and no financial cost for schools. Second, acceptability was strong across students. Third, safety signals were reassuring: the evaluation explicitly noted that sessions did not elevate anxiety, with discomfort levels comparable to general-population studies and nearly half of pupils reporting little or no discomfort, which supports safe delivery at scale. Finally, the content appears practically usable: participants were not only more confident in what to do (help-seeking, recognising needs and emotions), but also more likely to put skills into action, indicating that classroom learning translated into everyday behaviours.

Regarding challenges, delivery itself varied: some classes completed all elements while others did not, and tight fieldwork windows for baseline and follow-up added operational pressure. Finally, older cohorts reported social-situation worries more often than younger pupils, suggesting that sustaining engagement in later years may require additional supports to address concerns about judgement or peer reactions.

[582] Tak LEKKO, *Wyniki ewaluacji. Oddziaływanie programu profilaktycznego „Godzina dla MŁODYCH GŁÓW" w roku szkolnym 2024/2025*, PowerPoint presentation, 2025.

Project SOLVE

Overview

Project SOLVE is a digital, school based single-session intervention designed to reduce adolescents' internalising symptoms (depression and anxiety) by teaching a concrete, step-by-step problem-solving strategy: define the problem, set a goal, generate options, weigh pros and cons, and try and iterate. Its core aim is to provide a scalable, acceptable, and easily delivered tool that pupils can complete in a single class (around 30 minutes) on their own devices, so that schools can offer mental health support even where access to in-person care is limited.[583]

In Poland, SOLVE was implemented in Ukrainian among refugee students across five schools serving Ukrainian pupils. Notably, this Polish implementation constituted, to the authors' knowledge, the first randomised controlled trial of any digital mental health intervention with youths exposed to war.[584] The trial used a crossover, randomised controlled design. It compared SOLVE to a typical lesson, then switched who received SOLVE to see whether improvements emerged after exposure.[585]

Regarding practical implementation, delivery took place in class on pupils' own devices via a school-shared web link. All materials were translated and back-translated by a Lviv-based agency with oversight from a Ukrainian child and adolescent psychiatrist; vignettes used familiar Ukrainian names, and the audio adopted a gentle 'motherly' voice to enhance engagement.[586] Caregivers received information and an opt-out route, and pupils provided assent in class. Teachers and school psychologists monitored sessions. No adverse events were reported, suggesting no observed safety incidents linked to the activity.[587]

Results and economic performance

In the full intention-to-treat sample, pupils allocated to receive SOLVE showed greater reductions in internalising symptoms than those in the academic practice condition at both one and four months. Standardised effects were small, indicating that, on average, SOLVE added a modest but meaningful improvement that persisted over the term.[588] Among pupils who started with elevated symptoms (more than one standard deviation above the mean), effects were larger early on and then tapered. In practice, this means the session was especially helpful for more distressed pupils shortly after delivery, with smaller but still favourable differences later.[589]

Within group patterns were consistent with these between group findings and the crossover design. The immediate SOLVE group–maintained symptom improvements relative to their own baseline, and the control group improved after they later received SOLVE, suggesting the benefits were linked to exposure to the intervention rather than to background trends alone.[590]

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583 Weisz, J. R., Steinberg, J. S., Sun, J., Mair, P., Fitzpatrick, O. M., Karapata, N., Yusyn, M., Sood, G., Danese, A., Adams, K. M. and Ougrin, D., 'Effects of a brief digital problem-solving intervention on depression and anxiety symptoms in Ukrainian children and adolescents displaced by war: A crossover, randomised controlled trial', *The Lancet Primary Care*, Vol. 1, Art. 100001, 2025.

584 Ibid.

585 Ibid.

586 Ibid.

587 Ibid.

588 Ibid.

589 Ibid.

590 Ibid.

Pupils' mean rating on the 1–5 Program Feedback Scale exceeded the pre-specified acceptability threshold, indicating that students generally found SOLVE helpful and suitable for classroom use.

Success factors and challenges

Regarding success factors, the session's brevity and self-guided format meant it fit comfortably into a regular lesson (median completion under half an hour) without needing specialist staff or equipment; teachers simply shared a link, and pupils used their own devices. Cultural and linguistic adaptation likely bolstered relevance and comprehension for Ukrainian adolescents.[591, 592, 593]

Regarding challenges, implementation faced constraints typical of work with displaced populations. Follow-up participation declined as pupils moved or circumstances changed, making it harder to track outcomes over several months. Caregiver response rates were too low for meaningful parent-report analyses, limiting multi-informant assessment. Secondary outcomes were mixed and a minority of pupils worsened over time, reinforcing the need for ongoing monitoring and referral capacity alongside brief digital supports.[594]

More generally, as seen across the international literature, effects on depression from single-session digital programmes are typically small and evidence for self-injury outcomes is still limited, highlighting the value of continued, independent trials using consistent outcome measures.[595]

Polish health education curriculum

Overview

From the beginning of the school year 2025/26, Poland introduced health education as a new, non-obligatory obligatory subject at primary and secondary schools. 1 class per week is provided to children from grade 4. At its inception, the subject was devised as an interdisciplinary course combining elements of biology, psychology, sociology, and digital education, aiming to give children and teens solid knowledge, practical skills, and mindsets to care for their own and others' health. This emphasis corresponds with the finding from one stakeholder interview, that while prevention should be the foundation of the existing three-tier care model, it remains the system's weakest area.

The review of materials prepared by the Ministry (grade by grade curriculum, a companion set of lesson scenarios, teachers' materials) suggests that the model adopted embeds the digital era mental health challenges in the wider context of health and civic education. The coverage includes e.g.: digital hygiene and family screen rules, blue-light and sleep links, cyberbullying and grooming with reporting routes (grade IV), self-esteem and social-media comparisons, 'five hours on TikTok' as a risk example (V), self-checks for internet/gaming overuse, 'filtered reality' in social media, AI/VR risks (VI), goals to assess how online content affects mood and to manage time and sleep, alongside boundaries and consent (VII–VIII) and at the upper-secondary level: credible vs clickbait health content, disinformation and deepfakes, AI's role, or hidden advertising. The following digital safety measures are applied, with clear age progression in place: building digital self-regulation (co-

591 Ibid.

592 Fitzpatrick, O. M., Schleider, J. L., Mair, P., Carson, A., Harisinghani, A. and Weisz, J. R., 'Project SOLVE: Randomized, school-based trial of a single-session digital problem-solving intervention for adolescent internalizing symptoms during the coronavirus era', *School Mental Health*, Vol. 15, 2023, pp. 955–966

593 Hatoum, A. H., Coutts-Bain, D., Hunnisett, N., Baffsky, R., O'Dea, B. and Torok, M., 'Digital single-session interventions for depression and self-injurious thoughts and behaviours in young people: A systematic review and meta-analysis', *eClinicalMedicine*, Vol. 90, Art. 103601, 2025.

594 Weisz, J. R. and Ougrin, D. et al., 'Effects of a brief digital problem-solving intervention on depression and anxiety symptoms in Ukrainian children and adolescents displaced by war...', 2025.

595 Hatoum, A. H. et al., 'Digital single-session interventions for depression and self-injurious thoughts and behaviours in young people...', 2025.

creating screen rules, active breaks, sleep routines), emotional literacy and coping (naming feelings, 'STOP'/grounding, breathing), critical digital literacy (source verification, deepfake and manipulation awareness, recognising curated 'filtered' feeds), and safeguarding with normalised help-seeking (trusted adults, school specialists, 116 111),

Results and economic performance

Given that the course was rolled out only in September 2025, neither measurable outcomes nor impacts are available so far. Nevertheless, the attendance data is available and can be used as a proxy to describe the programmes' success at roll out. Classes were attended on average by only 30 % of all the eligible students[596], with significant variation between types of educational facilities, depending on school organisation, position of the class among other classes in the daily schedule, local circumstances, or regional divergence. There is a clear territorial pattern in class attendance (2025).[597] The easternmost regions noted lower class attendance (e.g. 17.19 % in Podkarpackie), whereas the highest attendance was noted in the west (e.g. Wielkopolskie: 38.59 %).

Success factors and challenges

Among the factors that likely supported the courses' rollout, the demand on health and digital education declared by the Polish youths is a notable one-four out of five young Polish people believe that schools devote too little time to health education covering physical and mental wellbeing. Slightly fewer complain about insufficient attention to education on digital risks (74 %).[598] Another factor is that the Ministry invested in preparation of school staff to convene the course. There is also an ongoing training program for the educational staff. Workshops are run by teacher development centres. Furthermore, a set of educational materials has been uploaded online an information brochure, a sample curriculum, training materials, and textbooks for primary and secondary schools. Digital resources are available via the 'Integrated Educational Platform' to facilitate teachers' work with students. Moreover, the first unified coursebook for the staff teaching health education at schools has recently been published.[599, 600]

Regarding the challenges, in a recent interview, Mrs Nowacka, the Minister of National Education, addressed the low class attendance, attributing it to the political frictions that prevented the Ministry from making the subject obligatory at its inception: 'Once, for the reasons of a strictly political nature, the subject was made non obligatory, it was known that such would be the consequences (decreased attendance). The youth tend to not attend classes that are non-obligatory.[601] In relation to the above, the Ministry recently decided that the course would be obligatory from the school year 2026/27.[602]

While no statistical research has been identified to causally explain the territorial divergence in class attendance, the root causes for regional disparity in uptake should be noted. Notably, the socio-economic and cultural regional disparities across the country's regions are well known (E.g., the

596 Ministerstwo Edukacji Narodowej, *Edukacja zdrowotna – pierwszy rok wdrażania przedmiotu w szkole*, Portal Gov.pl, website.

597 Ibid.

598 *Stan młodych 2025: Raport ważnych spraw*, 2025.

599 Grzebieluch, J., Basiak-Rasała, A. and Grabowska, B., *Edukacja zdrowotna. Podręcznik dla nauczycieli*, Wydawnictwo UMW, 2025.

600 Uniwersytet Medyczny im. Piastów Śląskich we Wrocławiu, *Podręcznik do edukacji zdrowotnej już dostępny*, website, consulted on 22 March 2026.

601 Wyborcza.pl Katowice, 'Wciąż nie wiadomo, czy edukacja zdrowotna będzie obowiązkowa od września. Nauczyciele w zawieszeniu', website, 2026.

602 Ministerstwo Edukacji Narodowej, *Edukacja zdrowotna od 1 września będzie przedmiotem obowiązkowym*, Portal Gov.pl, website, consulted on 24 April 2026.

eastern regions on average voting more conservative, and the urbanisation rates being the lowest for the southeastern part of the country, and the highest for the westernmost regions). It appears that the key challenge to the courses' success was its entanglement in the political strife in Poland, with conservative political options and the catholic Polish Episcopal Conference voicing opposition against its contents that adhere to sexual health[603] (rather than the digital education element itself).

The overlap between regional socio-political patterns and the pattern of inter-regionally varied class attendance suggests a possible relation between the first and the latter. Given that in the context of this analysis class attendance was a necessary condition for the intervention's uptake (i.e. to increase knowledge about e.g. digital hygiene, a student had to attend a class), it follows that possibly, hailing from a community with a given sociopolitical background could predict exposure to protective factors generated by the intervention.

State Programme for Prevention of Suicidal Behaviours [PL: Krajowy Program Zapobiegania Zachowaniom Samobójczym, KPZZS]

Overview

KPZZS is Poland's first coherent, nationwide system for suicide prevention, piloted under the National Health Programme (NPZ) 2021–2025, funded by the Ministry of Health, and coordinated by the Institute of Psychiatry and Neurology (IPiN) in Warsaw through its Office for Suicide Prevention and a multidisciplinary advisory council.[604] KPZZS replaced previously fragmented initiatives with a comprehensive, multidimensional framework, and government extended NPZ to 2026 to continue the work.[605, 606] The 2021–2025 National Health Programme set a budget ceiling of 'not more than PLN 30 million' for the suicide prevention tasks, financed from the Gambling Problems Resolution Fund and the state budget.[607]

Already several years ago, Polish experts urged a national rank suicide prevention strategy with particular emphasis on children and adolescents, arguing that this group lacks sufficiently developed coping mechanisms and that preventive action should be prioritised.[608] International experience also underpins the approach: countries that introduced national suicide prevention programmes (e.g., Finland, Sweden, Estonia, Norway, Hungary) saw 30–50 % reductions in suicide rates over 10–15 years, indicating what can be achieved with sustained, evidence based action.[609]

The programme's central purpose is to prevent suicides by expanding access to help in suicidal crisis, building workforce competence, running universal/indicated/selective prevention, restricting access to lethal means, improving surveillance, and ensuring responsible public communication—while supporting research and media collaboration.[610] Digital components are embedded across this

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603 Wyborcza.pl Katowice, 'Wciąż nie wiadomo, czy edukacja zdrowotna będzie obowiązkowa od września. Nauczyciele w zawieszeniu', 2026.

604 Instytut Psychiatrii i Neurologii, *O programie*, website 2026.

605 Polska Agencja Prasowa, 'Eksperci: Krajowy Program Zapobiegania Zachowaniom Samobójczym spełnia pokładane w nim nadzieje', website.

606 MedicalPress.pl, *'Krajowy Program Zapobiegania Zachowaniom Samobójczym przynosi pierwsze mierzalne efekty'*, website.

607 Kielan, A. J. and Stradomska, M. W., 'Program Zapobiegania Zachowaniom Samobójczym w ramach Narodowego Programu Zdrowia 2021–2025. Realizacja zadań w roku 2021', *Psychiatria i Psychologia Kliniczna*, Vol. 25(2), 2025, pp. 80–89.

608 Szajna, A. P., 'Zamachy samobójcze wśród dzieci i młodzieży – potrzeba pilnego wprowadzenia strategii profilaktyki suicydalnej o randze programu narodowego', *Zeszyty Prawnicze*, Vol. 21(1), 2021, pp. 243–270.

609 Orłowska, B. A., 'Profilaktyka zachowań suicydalnych u dzieci i młodzieży szkolnej', *Acta Iuris Stetinensis*, Vol. 35(3), 2021, pp. 65–83.

610 Instytut Psychiatrii i Neurologii, *O programie*, website

agenda, particularly for digitally mediated crisis access (tele-tools and hotlines tailored by age), online counselling, and for shaping a safer information environment (media standards and monitoring).[611] Conference summarising the early results of the programme highlighted unsolicited exposure of young people to suicidal/self-harm content online, prompting experts to call for strong digital safety action within KPZZS.[612, 613]

Results and economic performance

By December 2025, the programme began to showcase early signs of effectiveness. Leaders reported large-scale workforce development and initial outcome signals.[614, 615]

More than 50 000 people were trained across sectors (teachers and specialist teachers, social workers, clergy, probation officers, journalists, and uniformed services). 41 000 teachers and specialist teachers were trained in 2025 on standards for responding to suicide risk. The standards were developed under the programme and disseminated at schools.

The Police Prevention Bureau presented the provisional mortality trend, stating that the data for the first 11 months of 2025 suggested fewer suicides than in 2024, and that in 2024 the annual total fell below 5,000 for the first time in many years. That was seen as an early, cautiously positive signal that coincides with programme maturation. The official provisionally linked improved public awareness—recognising warning signs and knowing where to seek help—to these trends.

For 2021, authors reported the launch of the first 24/7, free and anonymous national psychological crisis helpline, with options for contact with psychologists, psychiatrists, social workers or legal advisers, and an informational website to guide help-seeking.

The programme intervened in a digital space also by creating media standards and building national capacity to implement them through a consultative team of suicidology experts to advise journalists, cultural creators and public bodies on safe reporting, and a media-monitoring group to track press, broadcast, web and social media and respond to violations. Journalist trainings and webinars for frequent media voices were also delivered.

In one stakeholder interview, the programme was described as a 'wonderful initiative', and the interviewee emphasised that under its umbrella, numerous service standards have been prepared, dedicated e.g. to education stakeholders, social services, or priests.

Success factors and challenges

The key success factor identified from the literature was adoption of the approach where the system was built from fragmentation: KPZZS replaced previously dispersed actions with a comprehensive, multi-dimensional national framework. Moreover, large-scale training of teachers and school specialists on newly disseminated standards, and the explicit positioning of schools (alongside families) as primary sites for spotting warning signs, are consistent with best practice in early detection and rapid referral, especially for adolescents whose help-seeking often begins in school

611 Ibid.

612 Polska Agencja Prasowa, 'Eksperci: Krajowy Program Zapobiegania Zachowaniom Samobójczym spełnia pokładane w nim nadzieje', press release, 12 December 2025.

613 MedicalPress.pl, *'Krajowy Program…'*, website.

614 Kielan, A. J. and Stradomska, M. W., 'Program Zapobiegania Zachowaniom Samobójczym w ramach Narodowego Programu Zdrowia 2021–2025. Realizacja zadań w roku 2021', *Psychiatria i Psychologia Kliniczna*, Vol. 25(2), 2025, pp. 80–89.

615 Szajna, A. P., 'Zamachy samobójcze wśród dzieci i młodzieży – potrzeba pilnego wprowadzenia strategii profilaktyki suicydalnej o randze programu narodowego', *Zeszyty Prawnicze*, Vol. 21(1), 2021, pp. 243–270.

settings.[616] Another driver was use of tele-enabled crisis access (24/7 helpline, online counselling, infolines), therefore lowering thresholds for first contact. Additionally, media standards, monitoring and journalist training help make the digital information environment safer.[617, 618]

Regarding the challenges, targeting and equity proved a challenge in the first year, where lower preventive activity was identified in the regions with higher suicide rates, highlighting the need for stronger central targeting and local government mobilisation, with particular attention to women, children and young people.[619]

Transferability & EU policy lessons

The Polish experience offers critical lessons for the EU on how to build foundational mental health prevention and early intervention systems, particularly in a context of significant system strain and resource constraints. It demonstrates the power of combining strategic national programmes with scalable, low-cost interventions delivered through schools and digital channels to build capacity from a low base.

Prevention in schools

Poland provides two distinct and transferable models for embedding prevention within the educational system. First, UNAWEZA Foundation's 'An Hour for YOUNG HEADS' offers a blueprint for a light touch, universal prevention programme that can be scaled rapidly at low cost. Its success demonstrates that even minimal dose interventions (one lesson per month) can produce statistically significant gains in emotional and help seeking literacy. The key conditions for transferring this model are strong partnerships between civil society and schools and the provision of free, high quality, easy-to-use materials for teachers. Second, the new national health education curriculum represents a more systemic approach, showing how Member States can formally integrate mental and digital health literacy into the core educational framework. Its implementation, however, highlights a crucial governance lesson: success depends on sustained political will, investment in teacher training, and strategies to navigate the regional and cultural barriers that can affect uptake.

Early intervention services and digital tools

For early intervention, Project SOLVE stands out as a highly transferable model. As a brief, self-guided, single session digital intervention, it is exceptionally well suited for deployment in resource constrained settings where access to specialist care is limited. Its successful implementation and positive results among Ukrainian refugee adolescents in Poland provide a powerful case study for the EU on using evidence based digital tools to provide rapid psychosocial support during humanitarian crises. The conditions for its transfer are minimal, requiring basic digital infrastructure in schools (devices and internet access) and the allocation of a single class period, making it a highly efficient model for 'digital first aid.'

Digital tools and governance

The Polish State Programme for Prevention of Suicidal Behaviours (KPZZS) provides a key governance lesson relevant to the EU's approach to digital safety. A central pillar of the programme is the development and promotion of media standards for the responsible reporting of suicide, coupled with training for journalists and monitoring of online content. This demonstrates a proactive

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616 Polska Agencja Prasowa, 'Eksperci: Krajowy Program Zapobiegania Zachowaniom Samobójczym spełnia pokładane w nim nadzieje', press release, 12 December 2025.

617 Kielan, A. J. and Stradomska, M. W., *'Program Zapobiegania Zachowaniom Samobójczym w ramach Narodowego Programu Zdrowia 2021–2025*...

618 Instytut Psychiatrii i Neurologii, *O programie*, website 2026.

619 Kielan, A. J. and Stradomska, M. W., *'Program Zapobiegania Zachowaniom Samobójczym w ramach Narodowego Programu Zdrowia 2021–2025*...

'soft governance' strategy to make the digital information environment safer, which complements formal platform regulation like the Digital Services Act. For other Member States, it offers a transferable model for how to build national capacity to reduce harmful content contagion and promote public health through collaborative media engagement.

Equity and access

Finally, the Polish case serves as a cautionary tale regarding equity and access. The system's heavy reliance on NGOs to fill gaps, the significant regional disparities in service availability, and the uneven uptake of the new health curriculum all underscore the challenge of ensuring equitable access in an underfunded system. The lesson for the EU is that while innovative civil society and digital interventions are crucial, they cannot replace the need for sustained public investment in a universal and equitable public health infrastructure. However, the targeted use of Project SOLVE with refugee youth also provides a positive example of how digital tools can be effectively adapted to improve access for specific vulnerable and hard to reach populations.

Ireland

Executive summary

Table 23 – Ireland case study executive summary

Section	Details
National Context and Current Situation	Ireland's youth mental health system is guided by national strategies such as Sharing the Vision (2020–2030), which emphasises person-centred, community-based care and early intervention. Despite strong policy frameworks, services remain underfunded and overstretched, with long waiting lists, workforce shortages, and regional inequalities ('postcode lottery') in access to CAMHS. Youth mental health need is rising, with high levels of anxiety and distress and a significant 'missing middle' not served by specialist care. Digital risks, including problematic social media use and harmful content exposure, alongside COVID-19 impacts, have further increased demand and complexity.
Intervention 1: MindOut	MindOut is a universal school-based social and emotional learning (SEL) programme for adolescents, delivered by teachers through interactive weekly sessions. It builds skills such as emotional regulation, coping, and communication. Evidence from a cluster RCT in Ireland shows significant improvements in mental health, coping, and emotional skills, and the programme is low cost. Its success depends on integration into the school curriculum and trained delivery, while challenges include time pressures and variability in implementation fidelity.
Intervention 2: Zippy's Friends	Zippy's Friends is a school-based programme for younger children (5–7 years) focused on building coping skills and emotional literacy through structured sessions using stories and activities. Evidence shows improvements in self-awareness, emotional regulation, and social skills, with sustained effects over time. Strengths include its structured design and alignment with school curricula, while challenges relate to time constraints, continuity, and limited whole-school and parental engagement.
Intervention 3: Jigsaw	Jigsaw is Ireland's national early intervention service providing free, youth-friendly mental health support for 12–25-year-olds with mild to moderate needs. Delivered through community hubs, it offers brief talk therapy and promotes coping and resilience. Evidence shows strong improvements in psychological distress and high satisfaction among users. Key strengths include accessibility, early intervention focus, and tailored support, while challenges include waiting times for younger adolescents and pressures on service capacity.
Intervention 4: Big Brothers Big Sisters	This mentoring programme provides one-to-one support for disadvantaged young people through sustained relationships with trained adult volunteers. It improves emotional wellbeing, social support, and relationships. Its success is driven by strong mentor–mentee relationships and programme fidelity, while challenges include delays in matching, maintaining long-term engagement, and ensuring sufficient contact duration.
Transferability and EU Policy Lessons	Ireland demonstrates the value of embedding prevention within schools and communities through low-cost, teacher-led programmes and early intervention services. Transferable lessons include the effectiveness of SEL programmes (MindOut, Zippy's Friends) and community-based hubs (Jigsaw) in addressing the

Section	Details
	'missing middle'. Mentoring programmes highlight the importance of relational support for vulnerable youth. However, the case also underscores that strong policy frameworks alone are insufficient without sustained investment in workforce and service capacity. A balanced approach combining prevention, community support, and timely specialist care is essential, alongside efforts to build resilience to digital risks.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

Various national strategies focussed on improving mental health have been developed in Ireland. Crucially, 'Sharing the Vision' (2020–2030) is Ireland's 10-year national mental health policy which adopts a person centred, recovery oriented, and human rights-based approach. An action-oriented policy framework for mental health services in Ireland, it takes a holistic view on mental illness and emphasises a person-centred treatment approach, integrated multidisciplinary care, community accessibility, and co-produced care plans across the life course.[620] In addition, the Department for Health developed 'Pathways to Wellbeing: National Mental Health Promotion Framework' (2024-2030) which embeds mental health promotion across sectors and settings with a focus on implementation capacity and intersectoral action.[621] Other key national strategies include 'Sláintecare' (2018), 'Healthy Ireland' (2013-2025) and its 'Implementation Plan' (2023-2027), 'Stronger Together Mental Health Promotion Plan' (2022-2027) by the Health Service Executive (HSE), and 'National Framework for Recovery in Mental Health' (2024-2028).[622] Youth-specific commitments appear in the National Youth Strategy (2015-2020) which is targets 10 to 24-year-olds to improve life outcomes. It specifically focusses on supporting young people at risk of poor outcomes in life due to marginalisation, disadvantage, or socioeconomic factors, aiming to ensure they are healthy, active, safe, and economically secure. It includes priority actions, including for the HSE to develop participation mechanisms (including consultation and feedback) for service users, families, and carers in mental health services for young people at local and national levels.[623] It commits to promote quality-assured online youth mental health supports, with the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) providing national leadership.[624]

In the education space, particularly, policy in Ireland places student voice and whole-school wellbeing at the centre; various guidelines and policy framework have been developed over the last years. This includes the 'Department of Education Wellbeing Policy Statement and Framework for Practice' (2018-2023), aimed to make Irish schools the most engaged in wellbeing promotion in Europe.[625] Notably, the guidance called 'Wellbeing in Post Primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention' (2013), developed by the Department of Education, HSE, and Department of Health focussed on supporting schools in developing a whole school approach

620 European Commission, *'Ireland'*, website.

621 Barry, M., 'Enhancing Protective Factors for Youth Mental Health and Wellbeing: Broadening the Debate – Understanding the Social Context of Youth Mental Health', *UNESCO – HRB Seminar Series*, UNESCO Child and Family Research Centre, University of Galway, 2024.

622 Mental Health Ireland, *Strategy 2025–2027: Educating, Empowering and Connecting Communities*, Mental Health Ireland, 2025.

623 European Commission, *'Ireland'*, website.

624 Ibid.

625 Barry, M., 'Enhancing Protective Factors for Youth Mental Health and Wellbeing...', 2024.

to mental health promotion and suicide prevention.[626] In the context of an increasingly digital world, schools in Ireland were tasked under the Government's 'Digital Strategy for Schools to 2027' with equipping all learners with essential skills for the digital age.[627] Concerns such as rising anxiety, online bullying, and exposure to harmful content online, however, have led schools and parent groups in Ireland to ban smartphones, while others have more flexible policies, such as locked pouches or central drop-off locations.[628] In 2025, the Minister for Education provided guidance to parents regarding internet safety and smartphone access for primary students and announced intended bans in post primary schools.[629] Schools are now required to implement a policy to ban the use of and access to, personal mobile phones by pupils in all recognised schools for the duration of the school day.

Legal frameworks

A range of legal frameworks in Ireland are aimed at improving and safeguarding youth mental health. The Mental Health Act 2001 establishes criteria for admission, patient rights, mental health team responsibilities, and automatic tribunal review of involuntary detention within 21 days.[630] It states, for instance, that children in approved centres are kept separate from adults, and mandates that the best interests of the child are the primary consideration, often utilising specialist Child and Adolescent Mental Health Services (CAMHS).[631] Quality improvement of care is further driven by the 'National Quality Framework Implementation Guide' (2023) which provides practical tools for services across public, voluntary, and independent sectors (including CAMHS) to self-appraise performance against eight themes.[632] Crucially, Ireland's Online Safety Code, enforced by Ireland's media commission under the Online Safety and Media Regulation Act 2022 operates alongside the EU Digital Services Act (DSA).[633, 634] The digital age of consent in Ireland is 16 under GDPR/Data Protection Act for consent-based services.[635] The Code mandates platforms with European headquarters in Ireland – such as Facebook, Instagram, TikTok, YouTube, LinkedIn, Pinterest, Tumblr, Udemy, and X – to ban specified harmful content, deploy age checks, provide parental controls for under-16s, act on user reports, and publish annual media literacy action plans.[636] Non-compliance can attract penalties up to €20 million or 10 % of annual turnover.

Mental health funding

Although the national target in Ireland is to allocate at least 10 % of the overall health budget to mental health, current spending remains below 6 %. Within that, approximately €146.5 million was earmarked in 2024 for child and youth mental health (CYPMH) – about 10 % of the mental health

626 European Commission, *'Ireland'*, website.

627 Department of Education, '*Press release: Minister Foley publishes Digital Strategy for Schools to 2027 and announces payment of €50 million in ICT grant funding for schools*', website, 2022.

628 Reynolds, M. et al., 'Restriction or Resilience? Smartphone Bans in Schools: A Qualitative Study of the Experiences of Students', *Irish Educational Studies*, 2025.

629 Ibid.

630 European Commission, *'Ireland'*, website.

631 *Explanatory Note:* CAMHS provides assessment and specialist treatment for moderate to severe conditions including depression, anxiety, eating disorders, and self-harm for young people up to 18 years.

632 Mental Health Commission, *The National Quality Framework: Implementation Guide*, The National Quality Framework for Mental Health Services of Ireland, 2023.

633 *Explanatory Note:* The Code is part of Ireland's broader online safety framework under the Online Safety and Media Regulation Act 2022 (implementing the EU AVMSD), alongside the Digital Services Act (in force since 17 February 2024) and the Terrorist Content Online Regulation.

634 Pinsent Masons, *'Ireland's Online Safety Code enters into force'*, website.

635 Faculty of Paediatrics, Royal College of Physicians of Ireland, *Engaging in Online Activity: Prioritising and protecting the physical and mental health of children and young people*, Position Statement, March 2025.

636 Citizens Information, *'Online safety'*, website.

budget.[637] The budget for 2026 introduces new investment to expand youth services, including an additional €1.3 million per year for Jigsaw – a youth mental health charity in Ireland-offering free therapy and support to children and young people aged 12 to 25 – to develop new hubs.[638] Civil society continues to call for sustained, multi-year investment, particularly in early intervention, and for timely publication and regulation of National CAMHS Standards.[639, 640] According to HSE, however, €32 million in additional funding has been added over two years to strengthen CAMHS staffing, reduce waiting lists, expand crisis cover, and roll out Electronic Health Records, alongside a single point of access for referrals and a dedicated Child and Youth Mental Health Office established in 2023.[641] In addition, evidence generation and translation are being scaled up to inform policy and practice, with the HRB's dedicated mental health research budget having tripled since 2022.[642]

Baseline statistics

Ireland's youth mental health landscape shows rising need, tight capacity, and an increasingly digital childhood that brings both connection and risk. Against a backdrop of globally rising adolescent mental health concerns – and Irish media attention to long waiting lists and hospitalisations – the system is described by service leaders and oversight bodies as overstretched, underfunded, and unable to guarantee timely support.[643] A substantial 'missing middle' of adolescents with mild to moderate anxiety or depression and externalising difficulties remains underserved outside specialist care.[644]

Mental health status

In Ireland, mental health accounts for 45 % of the total disease burden among 10 to 24-year-olds and is the leading cause of disability in youth.[645] Community service data show steadily rising referrals to Jigsaw between 2017 and 2022, with young people presenting in greater distress; anxiety is the most common reason for referral.[646] Presenting patterns differ by gender, with young men and boys more often presenting with anger or substance use concerns, and young women and girls with anxiety, sadness or loss, self-harm thoughts, and low self-esteem.[647]

Digital habits

Digital habits are near-universal from late childhood and intensify across adolescence in Ireland. Internet use rises with age, with Irish teens aged 15 to 17 spending up to 4.2 hours per day online.[648]

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637 McDaid, D. and Park, A., *Scaling-up early intervention and services for the 'missing middle' in the children and young people's mental health system in Ireland: A mental health economics analysis*, Care Policy and Evaluation Centre, London School of Economics and Political Science, March 2025.

638 Jigsaw, *'PRESS RELEASE Jigsaw welcomes new funding for youth mental health services as vital step towards nationwide support for young people'*, press release, 2025.

639 Ibid.

640 Bowers, F., *'Young people facing long waits for mental health support, committee hears'*, *RTÉ News*, 2026.

641 Ibid.

642 Department of Health, *'Minister for Mental Health Mary Butler announces €3 million investment in mental health research'*, press release, 2026.

643 Irish Research Council, 'Getting to grips with the youth mental health crisis', *Love Irish Research Blog*, 2024.

644 McDaid, D. and Park, A., *Scaling-up early intervention and services for the 'missing middle'...*, 2025.

645 Jigsaw, *'Youth mental health needs in Ireland are on the rise'*, press release, 2025.

646 Ibid.

647 Jigsaw, *'Delivering youth mental health services'*, website, 2026.

648 Faculty of Paediatrics, Royal College of Physicians of Ireland, 2025.

15 % of Irish adolescents show problematic, addictive-like use of social media or digital gaming (above the 11 % European average), and 32 % are classified as 'intense' users.[649]

Stakeholders interviewed for the case study highlighted that the primary cost of extensive screen time is the displacement of vital offline experiences, compounded by a perpetual burden of digital 'life admin'[650] such as maintaining social media streaks. They noted that exposure to harmful content and abusive online gaming conduct remains widespread, with over a fifth of young adolescents reporting upsetting encounters on major platforms.[651] This risk is increasingly exacerbated by waning parental supervision and a rise in non-disclosure, with many children keeping their distress to themselves. [652, 653] Finally, stakeholders raised concerns over emerging digital trends, including a shift away from group-based youth activities toward isolated online engagement, and the growing use of AI tools as companions or pseudo-therapists, which risks undermining authenticity and trust in real-world relationships.

Healthcare capacity

Crucially, service capacity in Ireland is not keeping pace with need. Many young people in Ireland experience high psychological distress but face poor access to services, long waits, and a disruptive handover at age 18.[654] Children and young people waiting for mental health services rose from 2 755 in December 2020 to 4 434 in February 2023; over 3 900 children were on CAMHS waiting lists in July 2023.[655, 656] According to Families for Reform of CAMHS, some young people wait up to a year after referral.[657] In July 2023, Ireland's Mental Health Commission published an Independent Review of the provision of CAMHS, identifying 'significant shortcomings' and issuing 49 recommendations.[658] The report states services are 'completely stretched thin', significantly understaffed, and unable to assure children/families they will get the support they need within the current system.[659] Special attention is also needed for children facing barriers to access, including the Traveller community, asylum seekers, refugees and migrants, children in care, and young LGBTQIA+ people.[660]

Stakeholders confirmed severe structural pain points within the Irish mental health system, highlighting that CAMHS are chronically under-resourced, overwhelmed, and hindered by a stark regional 'postcode lottery' for waiting times. This crisis is severely compounded by a lack of primary care and school-based psychological support, alongside staffing and training bottlenecks that leave critical positions unfilled. Consequently, prolonged waiting lists force manageable cases to escalate into high-risk crises before individuals can access care, trapping the system in reactive 'firefighting'

649 Badura, P. et al., *'A focus on adolescent social contexts in Europe, central Asia and Canada', Health Behaviour in School-aged Children international report from the 2021/2022 survey*, Vol. 7, WHO Regional Office for Europe, 2024.

650 *Explanatory Note:* Life admin refers to the routine administrative tasks required to manage everyday personal affairs, including activities such as paying bills, scheduling appointments, handling documentation, and organising one's time.

651 CyberSafeKids, *Left to Their Own Devices: The virtually unprotected lives of kids in Ireland*, Trends and Usage Report 23/24, 2024.

652 Ibid.

653 Ibid.

654 Jigsaw, *'Delivering youth mental health services'*, website, 2026.

655 Eurochild, *Children's Mental Health across Europe, Children's Rights: Political will or won't? Eurochild 2023 report on children in need across Europe*, March 2024.

656 Eurochild, *Children's Mental Health, Children's Realities in Europe: Progress and Gaps. Eurochild 2024 flagship report on children in need across Europe*, February 2025.

657 Bowers, F., 'Young people facing long waits for mental health support, committee hears', 2026.

658 Eurochild, *Children's Mental Health across Europe...*, March 2024.

659 Ibid.

660 Ibid.

rather than proactive prevention. Furthermore, stakeholders noted a fractured transition at age 18, where the abrupt shift from intensive youth care to infrequent adult psychiatric reviews frequently causes vulnerable young adults to disengage from services or relapse.

Crisis Impacts

The COVID-19 pandemic had a range of negative effects on young people's mental health in Ireland. Following the reopening of schools in Ireland after prolonged COVID-19 disruptions, the data show a clear shift in Irish youths' mental health: 40 % of 10 to 17 -year-olds reported that pandemic measures negatively affected their mental health and an equal share saw a negative impact on school performance, with girls and older adolescents disproportionately affected.[661] Core wellbeing indicators declined compared with 2018.[662] Loneliness emerged as a new concern in 2022, with 20 % feeling lonely most or all the time, which was more common among girls and older adolescents.[663] Indeed, loneliness is considered a standout issue now amongst the 18 to 25 cohort, according to a stakeholder interviewed, with work-from-home norms and hollowed-out campus life having reduced opportunities to connect. Related pressures in the online environment also intensified since 2018 such as cyberbullying, with higher victimisation risk for girls and for young people from lower social class groups.[664]

Stakeholders confirmed a sharp post-COVID-19 surge in youth anxiety and school avoidance, highlighting an increasingly complex array of mental health challenges stretching across a broader socioeconomic demographic. Practitioners observed significant increases in social anxiety, depression, eating disorders, and gender identity questions, alongside an exponential growth in demand for ASD/ADHD assessments, noting that teenage boys aged 14 to 17 are particularly vulnerable to severe isolation. To prevent long-term, systemic strain on acute services, stakeholders called for a critical mindset shift away from reactive crisis management toward proactive, community-led prevention.

Deep Dive: Featured Intervention(s)

Ireland has applied various interventions to improve youth mental health, particularly in the context of an increasingly digital world. Most interventions in Ireland appear to be focussed on the school setting, with a preference for face-to-face, 'offline' activities. The further below listed interventions have been selected given their existing robust evidence of positive and longer-term impact. It includes four successful school-based interventions, one intervention focussed on increasing capacity of frontline worker, namely teachers, and two other interventions who more broadly fit under interventions in the wider healthcare space. Overall, Ireland's successful programmes tend to be low-cost, teacher-led, manualised, and supported by concise training, with family/relationship elements and, in some cases, powerful role-model storytelling. Biggest threats to success are delays in access, school capacity/timetabling and fidelity pressures, overly long duration, and COVID-19 related disruptions. Other interventions relevant to the broader Irish landscape are listed in the box below – while innovative and promising, they currently lack sufficient evidence in the Irish context to indicate positive and long-term impact.[665]

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661 Gavin, A. et al., *The Irish Health Behaviour in School-aged Children (HBSC) Study 2022*, Health Promotion Research Centre, University of Galway, April 2024.

662 Ibid.

663 Ibid.

664 Ibid.

665 Health Service Executive, 'Mental health training and resources for primary school teachers', *HSE Education Programme*, website, 2026.

Other examples of relevant interventions in the Irish ecosystem

Friends Programmes: indicating success in a range of countries, the school-based Friends Programmes are aimed at preventing anxiety and building resilience, equipping students with skills for coping, problem solving, and managing emotional distress.

SPARX-R: a multimedia, audio rich computerised CBT game delivered universally to whole classes of 15–20-year-old early school leavers in Ireland, teaching psychoeducation, core CBT (relaxation, activity scheduling, problem solving, cognitive restructuring), interpersonal/help seeking skills, and emotion regulation.

Connected – Digital Media Literacy Programme for Teens: an Irish digital media literacy programme, developed by Webwise with the National Youth Council of Ireland (NYCI), that equips youth workers to build teens' digital resilience and critical thinking through a resource pack of slides, videos, and worksheets for four workshops on online wellbeing, misinformation, the data economy, and young people's online rights.

MindOut

MindOut is a universal school based SEL programme for adolescents aged 15 to 18. It is funded and supported by HSE-Health Promotion and Improvement department. It aims to build SEL skills (self-esteem, coping, empathy, communication, and problem solving) to promote positive mental health and wellbeing.[666] By teaching core SEL competencies, students are expected to improve coping and emotion regulation in the short term, leading to better mental wellbeing and reduced stress, depression, and anxiety over time.[667] MindOut can be delivered to all students in secondary schools in Ireland, with a typical focus on the Transition Year or 5th year. The programme is delivered weekly by classroom teachers through interactive, active learning (discussion, games, group work, and scenarios), video clips, and a short task after each session. MindOut covers psychoeducation, SEL, and mindfulness elements. Teachers must participate in a one-day course led by a Health Promotion Officer (HSE Health & Wellbeing) and are provided a training manual.

Evidence of effectiveness and ROI

MindOut is rated an overall 3+ by What Works Ireland Evidence Hub (WWEICSC) (across multiple countries), with Ireland specifically receiving a 2+ rating.[668, 669] The Ireland rating is primarily based on a study from 2019 which conducted a cluster Randomised Controlled Trial (RCT) in disadvantaged post-primary schools in Ireland. They found that the intervention produced statistically significant benefits in several domains: emotion regulation, coping skills, and mental health.[670, 671] In addition, WWEICSC assigned MindOut a low-cost rating of 1 which means the estimated unit cost are under €125.[672]

666 What Works, 'MindOut', *What Works Ireland Evidence Hub*, Government of Ireland, 2026.

667 Ibid.

668 *Explanatory Note on WWEICSC:* The What Works Ireland Evidence Hub (WWEICSC) evaluates intervention programmes through evidence ratings (Level 4 to NE based on proven impact and evaluation rigor) and cost ratings (ranging from Cost rating 1 at < €125 to Cost rating 5 at > €2375).

669 Ibid.

670 Dowling, K. et al., 'A cluster randomized-controlled trial of the MindOut social and emotional learning program…', 2019.

671 What Works, 'What Works Ireland Evidence Hub', *What Works Ireland Evidence Hub*, Government of Ireland, website, consulted on 11 March 2026.

672 Ibid.

Implementation: Barriers and enablers

WWEICSC states that MindOut 'works' given the whole school embedding of SEL skills (aligned with CASEL competencies), the adequate dose, and high quality implementation.[673] According to the 2019 study, similarly, MindOut worked best where it was age/culturally aligned, embedded in routine curriculum, and supported by trained teachers with engaging, evidence based content – especially for emotional skills.[674] Its impact, however, was constrained by time pressures, limited use of whole school components, and likely variability in how fully and consistently it was implemented.

Zippy's Friends

Zippy's Friends was introduced to Ireland in February 2008 as a pilot programme to support the implementation of the Social Personal and Health Education (SPHE) curriculum for junior classes, with a specific focus on schools in disadvantaged areas.[675] It is a universal, school based programme for 5 to 7-year-olds to promote mental health and emotional wellbeing by expanding children's coping skills. Zippy's Friends in Ireland has historically been funded by health focused public bodies, including the HSE West, HSE Population Health, and the National Office for Suicide Prevention. It was also supported by the Irish Research Council for Humanities and Social Sciences. The intervention is structured around 24 weekly sessions (lasting between 45 and 60 minutes) and is grouped into modules. These modules cover the following topics: Feelings; Communication; Making and breaking relationships; Bullying and conflict; Change and loss; We cope.[676] Sessions are delivered by classroom teachers using stories about 'Zippy and friends', games, role play, and discussions. Zippy's Friends has a parent component, involving information sessions, a parent guide, and home activities after each module. Zippy's Friends requires a teacher training and external supervisor.

Evidence of effectiveness and ROI

The intervention received an evidence rating of 2+ from WWEICSC[677]. In addition, WWEICSC assigned Zippy's Friends a low cost rating of 1 which means the estimated unit cost are under €125.[678] The rating is based on a study from 2014 which conducted cluster RCTs in disadvantaged Irish primary schools with 766 children (ages 7 to 8) in total, covering 52 classes, and 44 schools.[679, 680] Results show improved emotional literacy amongst children, measured post programme and at 12 month follow up: The post test showed significant improvements in self-awareness, self-regulation, motivation, and social skills.[681] At the 12-month follow up significant indirect effects maintained for self-awareness, self-regulation, motivation, and social skills.[682] However, there has been no significant effects at post-test or follow up on emotional symptoms, hyperactivity, peer problems, or prosocial behaviour.[683]

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673 *Explanatory Note on CASEL*: The CASEL framework defines five core, interrelated SEL competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making to foster long-term success

674 Dowling, K., et al., 2019.

675 Clarke, A. and Barry, M., *An evaluation of the Zippy's Friends emotional wellbeing programme for primary schools in Ireland*, Health Promotion Research Centre, National University of Ireland Galway, March 2010.

676 What Works, 'What Works Ireland Evidence Hub', 2026.

677 Ibid.

678 Ibid.

679 Clarke, A. and Barry, M., *An evaluation of the Zippy's Friends emotional wellbeing programme for primary schools in Ireland*, Health Promotion Research Centre, National University of Ireland Galway, March 2010.

680 What Works, 'What Works Ireland Evidence Hub', 2026.

681 Ibid.

682 Ibid.

683 Ibid.

Implementation: Barriers and enablers

According to the 2010 study, Zippy's Friends appears to succeed when teachers are trained and supported to deliver a structured, activity-based, story-led programme that's integrated with SPHE, reinforced through consistent routines (e.g., circle time) and, ideally, embedded in a whole-school and home partnership.[684] Time, continuity, space, limited whole-school/parent engagement, and a few overly talk-heavy sessions are the main obstacles.

Activating Social Empathy (ASE)

ASE is a 12-week, school based SEL programme for junior cycle students (aged 15 to 18), developed by UNESCO Child and Family Research Centre (UCFRC) with Foróige – an Irish youth organisation – and Pennsylvania State University.[685] The programme aims to boost cognitive and affective empathy, improve relationships, build social responsibility, and encourage prosocial action. It runs via weekly, teacher-led interactive sessions with student workbooks, covering four strands (understand, practise, overcome barriers, put empathy into action via a class social project. Notably, during the COVID-19 pandemic, an online version was created for the programme.

Evidence of effectiveness and ROI

According to a study from 2021 which used a cluster RCT, ASE has shown to have a clear impact on empathy amongst students; students who took ASE showed higher cognitive and affective empathy than controls.[686] The study tested a 12-session school programme for junior cycle students (ages 12 to 16) in Ireland. Because of COVID-19, delivery modes varied (in-person, online, hybrid) and the actual duration stretched to 14 to 26 weeks instead of 12 weeks; one school completed 9 online sessions only. Findings showed that empathy drove wider gains: higher empathy was linked to more prosocial behaviour/helping, active defending, social responsibility and emotional efficacy, and less passive bystanding.[687] However, no clear direct effects on aggression or peer relations were detected and overall effects were small. Most students said that they would recommend ASE and teachers rated sessions valuable with good engagement.[688] Crucially, enjoyment and longer exposure to the programme related to stronger prosocial outcomes.[689]

Implementation: Barriers and enablers

ASE is most successful, according to the 2021 study, when delivered consistently with strong student engagement and interactive practice of empathy skills; its core pathway is via boosting empathy, which then lifts prosocial outcomes.[690] Time pressures, disrupted or mixed delivery, limited interactivity, and low fidelity constrain impact. Notably, the COVID-19 pandemic disrupted the delivery of the programme: while mixed online/offline delivery was feasible, combined modes were less enjoyable.

Roots of Empathy

Roots of Empathy is a universal, classroom based social–emotional learning programme for children from reception to Year 9 (primarily primary school/preadolescents).[691] It has been implemented in a

684 Clarke, A. & Barry, M., 2010.

685 Silke, C. et al., 'The Activating Social Empathy School Evaluation 2021', UNESCO Child and Family Research Centre, National University of Ireland Galway, 2021, 2026.

686 Ibid.

687 Ibid.

688 Ibid.

689 Ibid.

690 Silke, C. et al., 2021.

691 What Works, 'Roots of Empathy', What Works Ireland Evidence Hub, Government of Ireland, March 2026.

range of countries, including Ireland. The programme entails nine classroom visits in primary schools from a local parent and baby that anchor 27 instructor led sessions, led by a trained instructor. The aim is to build emotional literacy and empathy, reduce bullying/aggression, promote prosocial behaviour, mental health, responsible citizenship, and awareness of responsive parenting.[692] Roots of Empathy is trauma-informed; the programme focuses on naming/understanding feelings, perspective-taking, inclusion and bystander action. Each of the nine themes has three lessons: a pre visit (to introduce the theme), a family visit (parent and 2 to 4-month-old baby; guided observation and interaction), and a post visit (for reflection and consolidation). Learning methods include stories, art, and class activities that help children identify and discuss their own and others' emotions. Roots of Empathy is delivered by volunteers which require 4 days as well as ongoing mentor support.

Evidence of effectiveness and ROI

WWEICSC gave Roots of Empathy an evidence rating of 2+. However, this is based on country studies from Northern Ireland and Canada (rather than Ireland) which indicate improvement on child outcomes such as reduced relational aggression, reduced proactive aggression, and improved prosocial behaviour.[693] In addition, WWEICSC assigned Roots of Empathy a low cost rating of 1 which means the estimated unit cost are under €125.[694] Nevertheless, the 2022 Annual Programme Evaluation Report of Roots of Empathy,[695] also indicates successes in the Irish context: From 2021 to 2022, Roots of Empathy in Ireland showed strong, practical gains in empathy, prosocial action, inclusion, and emotional literacy, with additional benefits in understanding caregiving and classroom wellbeing. Concerning empathy and perspective-taking, 77 % of students who participated in the programme in Ireland said it helped them understand how others feel, while 86 % said it taught them that everybody has feelings. In addition, 70 % of teachers saw students become more empathic and 83 % saw better understanding of others' viewpoints. 94 % of students said they would help if they saw bullying – indicating strong inclusion/anti-exclusion attitudes. Thinking about mental health and wellbeing skills, 91 % of teachers said the programme gave students space to talk about feelings with 78 % seeing increased 'feeling' vocabulary and 70 % seeing progress in managing feelings.[696] This emphasises the importance of teaching empathy to improve mental health.

Implementation: Barriers and enablers

What helped the programme work, according to the 2022 annual report, was giving children concrete practice reading feelings and perspective taking, a clear SEL focus with measurable gains, and a flexibility to deliver either traditional in class or Recovery (virtual) programme in maintaining continuity during pandemic constraints.[697]

Jigsaw

Jigsaw is the National Centre for Youth Mental Health in Ireland; an evidence based, early-intervention, primary care service for 12 to 25-year-olds with mild to moderate difficulties.[698] Jigsaw is primarily funded through a mixed model comprising significant statutory funding from the HSE and public fundraising. It focuses on building understanding, awareness, and coping skills to

692 Roots of Empathy, '*2022 Annual Programme Evaluation Report: Republic of Ireland*', 2022, 2026.

693 Ibid.

694 Ibid.

695 Ibid.

696 Ibid.

697 Roots of Empathy, 2022.

698 Jigsaw, n.d.

prevent escalation. Jigsaw offers primary-care youth talk-therapy service and youth mental health hubs which also incorporates elements of social prescribing for young people.[699]

Evidence of effectiveness and ROI

Notably, Jigsaw's brief primary care youth talk therapy produced reliable improvements in psychological distress for most 12 to 25--year-olds: a large real-world outcomes study evaluated Jigsaw's brief, primary care youth talk therapy service across 14 Irish sites from 2017 to 2019 (covering 4,565 young people).[700] The majority achieved reliable improvement, typically around 57 to 66% across age and sex groups.[701] Attending nine or more sessions was associated with a lower likelihood of reliable improvement than attending six to eight sessions in both age groups, supporting a tailored, brief intervention model rather than the notion that more sessions are better.[702] In general, according to Jigsaw, over 90 % of young people who have accessed support from Jigsaw report improved mental health.[703] In addition, 97 % of parents or caregivers say the young person's mental health improved.[704] Most report clinically significant reductions in psychological distress and reliable progress toward personal goals.[705]

Implementation: Barriers and enablers

Jigsaw works best when it is fast, brief and tailored: short waits (especially for 12 to 16 -year-olds), a focused six to eight session model, and needs-based triage (with clear step-up/step-down) are the main enablers.[706] The main barriers are long waits for younger teens, drift into longer episodes, and early underdosage.

Big Brothers Big Sisters

Big Brothers Big Sisters is a targeted, one-to-one mentoring programme for young people aged 10 to 18 experiencing social or economic disadvantage.[707] It is primarily funded through state grants from the Irish government, including the Department of Children and Youth Affairs. The programme aims to improve social, emotional, behavioural and educational outcomes by building a strong, consistent mentor–mentee relationship.[708] The idea is that a consistent, trusting relationship with a supportive adult builds skills, confidence and access to positive opportunities. In a longer term, improved social, emotional and educational outcomes are expected as well as reductions in antisocial behaviour and substance use.[709] The programme has a community-based approach and has been implemented in Ireland as well as England, US, and Canada. Delivery includes weekly one-to-two-hour meetings for at least 12 months with an adult volunteer. Big Brothers Big Sisters staff match a mentor and a young person who will set tailored goals (e.g., school attendance/achievement, social relationships, learning new skills), update goals as progress/circumstances change, and provide ongoing monitoring and support. Activities are

699 All Ireland Social Prescribing Network, 'Social Prescribing for Children and Young People: A Growing Opportunity to Enhance Wellbeing' n.d., 2026.

700 Moore, J., et al., 'Predicting Reliable Improvements in Primary Care Youth Mental Health', *Early Intervention in Psychiatry*, 19 (2025), e13637

701 Ibid.

702 Ibid.

703 Jigsaw, n.d.

704 Ibid.

705 Ibid.

706 Ibid.

707 What Works, 'Big Brothers Big Sisters', What Works Ireland Evidence Hub, Government of Ireland, March 2026.

708 Ibid.

709 Ibid.

tailored to goals. Volunteers must participate in around ten hours of training and are supervised by a clinical supervisor.

Evidence of effectiveness and ROI

The programme received an overall 3+ by WWEICSC as evidence rating across countries.[710] The Ireland study received a study rating of 2.[711] The study from 2011 covered a total of 164 young people aged 10 to 14 years who had experienced social or economic disadvantage and were randomly assigned to receive mentoring plus regular youth activities or to regular youth activities alone.[712] Across follow-ups, the mentoring group showed statistically significant improvements in emotional wellbeing and in relationships as well as social support compared with the control group, indicating added benefits of Big Brothers Big Sisters beyond usual activities.[713]

Implementation: Barriers and enablers

According to the 2011 study, the success of Big Brothers Big Sisters rests on strong programme fidelity, integration with Foróige, skilled supervision and enough, sustained contact within a trusting relationship.[714] The main threats are insufficient match duration as well as frequency and matching delays (especially for boys).

Transferability & EU Policy Lessons

The Irish experience offers important lessons for the EU, demonstrating how a strong policy focus on whole school wellbeing, coupled with a vibrant community and voluntary sector, can build a foundational layer of prevention and early intervention. It highlights the value of embedding social and emotional support directly into the environments where children and young people spend their time, particularly when statutory clinical services are under significant strain.

Prevention in schools

Ireland provides a suite of highly transferable, evidence-based models for universal prevention in schools. Social and Emotional Learning (SEL) programmes like MindOut, Zippy's Friends, and Roots of Empathy offer a practical blueprint for how to build emotional literacy, empathy, and resilience from a young age. Because these interventions are often manualised, teacher led, and low cost, they are well suited for scaling across different educational systems. The key conditions for successful transfer include a national curriculum that creates space for health and wellbeing, sustained investment in teacher training, and a policy commitment to a whole school approach to mental health.

Early intervention services

For early intervention, the Jigsaw network serves as a standout transferable model for addressing the 'missing middle.' Its youth friendly, nonclinical primary care hubs provide accessible talk therapy and support for young people with mild to moderate needs, effectively diverting them from overburdened specialist services. For this model to be implemented elsewhere, it requires a mixed funding model combining state and philanthropic support, a trained workforce of youth mental health professionals, and strong governance to ensure clear referral pathways to and from clinical care. Additionally, mentoring programmes like Big Brothers Big Sisters offer a targeted, relational

[710] Ibid.

[711] Ibid.

[712] Dolan, P., et al., 'Big Brothers Big Sisters (BBBS) of Ireland: Evaluation Study. Report 1: Randomised Control Trial and Implementation Report', UNESCO Child and Family Research Centre, National University of Ireland Galway, 2011, accessed 11 March 2026.

[713] Ibid.

[714] Ibid.

approach to supporting disadvantaged youth, a model that is transferable to other countries seeking to improve outcomes for at risk groups.

Digital tools and governance

While Ireland has a robust regulatory framework with its Online Safety Code, the featured interventions offer a distinct insight for EU debates on digital determinants: they prioritise the development of offline skills and resilience. The strong focus on face-to-face, school based SEL and community connection can be interpreted as a deliberate strategy to equip young people with the core social and emotional competencies needed to navigate the pressures of the digital world. This provides a crucial lesson for the EU: alongside regulating platforms for safety, a comprehensive strategy must also invest in building young people's intrinsic capabilities, such as emotional regulation and critical thinking, which are protective factors in both online and offline environments.

Equity and access

Finally, the Irish case serves as a cautionary tale regarding equity and access. The long waiting lists and regional disparities ('postcode lottery') for specialist CAMHS demonstrate that without adequate funding for statutory services, significant inequities will persist. In this context, universal school-based programmes and free community hubs like Jigsaw become essential mechanisms for ensuring more equitable access to support. They lower barriers for families who cannot afford private care or navigate complex referral systems. The lesson for other Member States is that while community and school-based interventions are vital for improving equity, they are most effective as part of a fully resourced system where specialist care is also timely and universally accessible.

England

Executive summary

Table 24 – England case study executive summary

Section	Details
National Context and Current Situation	England's youth mental health system operates within a comprehensive but strained framework, with rising demand and persistent capacity challenges. Around 20 % of 8-25-year-olds report a probable mental disorder, with increasing prevalence since 2017. Despite expanded investment and policy reform, services remain overstretched, with long waiting times, workforce shortages, and regional inequalities in access. A significant proportion of need remains unmet, particularly among those below specialist thresholds ('missing middle'). Digital engagement is near-universal, with growing concerns around problematic use, cyberbullying, and exposure to harmful content, further exacerbated by COVID-19 and wider socioeconomic pressures.
Intervention 1: Barnardo's LINK	Barnardo's LINK is a social prescribing programme providing early, nonclinical support by connecting young people to community-based activities through LINK workers. It addresses social determinants such as isolation and family stress. Evidence shows 66 % of participants experience significant improvements in mental health, with strong qualitative gains in resilience and confidence. The model is cost-effective (ROI ~€2 per €1) and helps reduce pressure on clinical services. Success relies on strong relationships with LINK workers and community integration, while barriers include low awareness, engagement challenges, and logistical constraints such as transport and access.
Intervention 2: Place2Be	Place2Be delivers school-based mental health support through a whole-school approach, including counselling, group work, and parental support. It targets children with mild to moderate needs, particularly those below CAMHS thresholds. Evidence shows 78-91 % of children report improved mental health, with significant reductions in SDQ scores. The model is highly cost-effective (ROI ~€9 per €1) and improves access by embedding services in schools. Key enablers include trust, integration within school systems, and workforce development, while barriers include funding pressures, safeguarding complexity, and increasing severity of need.
Intervention 3: SCESS (Anna Freud Centre)	The Schools and Colleges Early Support Service (SCESS) is a digitally delivered early intervention programme offering brief CBT-based support for young people aged 11-25, alongside resources for staff and parents. Around 71 % of participants report reduced anxiety and depression, with strong secondary benefits for parents and school staff. Digital delivery enables scalability, flexibility, and cost efficiency, making it suitable for broad reach. Key enablers include strong institutional partnerships and practitioner training, while barriers include safeguarding challenges in remote delivery and resource constraints for supervision and scaling.
Intervention 4: CAMHS	CAMHS provides specialist clinical care for children and young people with moderate to severe mental health conditions, increasingly incorporating school-based (MHSTs), community, and digital elements. Evidence shows 70-80 % of users achieve treatment goals, with strong economic returns (ROI ~€25 per €1 for

Section	Details
	MHSTs). The system plays a critical role in managing complex cases and reducing long-term costs. However, it faces major barriers including high demand, long waiting times, workforce shortages, and high rates of rejected referrals, alongside regional variation in access and service thresholds.
Transferability and EU Policy Lessons	England demonstrates the importance of a multi-layered system integrating school-based, community, digital, and clinical interventions. Transferable lessons include the effectiveness of social prescribing (Barnardo's LINK) in addressing social determinants, school-based provision (Place2Be, MHSTs) in improving access and early intervention, and digitally enabled services (SCESS) for scalable support. The Online Safety Act also provides a model for proactive digital regulation. However, the case highlights that early intervention cannot substitute for adequately funded specialist care. Effective systems require strong workforce strategies, integrated referral pathways, and balanced investment across prevention and clinical services.

Source: Authors' summary based on case study.

National context and current situation

Policy and legal landscape

The Mental Health Act 2025

The Mental Health Act 2025 represents a major reform of the Mental Health Act 1983, aiming to modernise how people with mental illness are detained and treated in England.[715] It seeks to strengthen patient rights, increase choice and autonomy, and introduce greater safeguards and accountability in the use of compulsory powers, while addressing longstanding inequalities in the system.[716]

It is important to note that this law mostly covers patients with mental disorders that often require clinical care or involuntary treatment. This meant that those mental disorders are often severe and pose a serious risk to one's or other's life. Under the previous act, young people represented the minority of detentions with only 52.7 per 100.000 inhabitants of 16–17-year-olds in England being detained in 2022.[717]

NHS 10 Year Plan for England

This 10-year plan was first introduced in 2025 and covers all NHS services across England. In this plan the strategic actions for youth mental health in England include the expansion of mental health support teams in schools and colleges to achieve full national coverage by 2030, complemented by the establishment of Young Futures Hubs to ensure a community approach to wellbeing support.[718]

715 UK Government, *Mental Health Bill 2025: Fact Sheet*, 2024.

716 Ibid.

717 NHS Digital, Mental Health Act Statistics, Annual Figures 2022–23: Detentions – Differences between groups of people, 2024.

718 Department of Health and Social Care, *Fit for the Future: 10-Year Health Plan for England*, 2025, pp. 1-18

To address acute service pressures, the plan mandates the recruitment of 8,500 extra mental health workers and provides a €120 million investment to develop dedicated mental health emergency departments (MHEDs), designed to provide rapid specialist assessment within four hours.[719]

The plan outlines the importance of digital transformation policies that repurpose the NHS App, enabling direct self-referral to talking therapies and providing parents with a unified platform for mental health advice.[720]

Furthermore, the government aims to implement a single unique identifier for every child, utilising the NHS number to facilitate proactive, joined up care across health and education services. This is supported by a commitment to SEND reform and early intervention, with a focus on deploying specialists such as speech and language therapists directly to children rather than on administrative bureaucracy.[721]

Online Safety Act 2023

The Online Safety Act 2023, which came into effect in October 2023, establishes a comprehensive framework to improve online safety, particularly for children, by placing legal duties on social media platforms and search services to prevent harm rather than responding to it after the fact. It requires companies to remove illegal content, reduce risks from harmful material, and implement systems such as age assurance and safer platform design, with enforcement overseen by Ofcom.[722] The Act places particular emphasis on protecting young people, introducing measures to limit exposure to harmful content and ensure age-appropriate online experiences.[723]

Enforcement mechanisms are now actively being applied, including mandatory reporting of child sexual exploitation material to the National Crime Agency, the introduction of 'priority offences' such as content encouraging self-harm, and requirements for robust age assurance measures to restrict children's access to harmful content.[724] Ofcom has begun investigating and sanctioning noncompliant platforms, with penalties including substantial fines (up to 10 % of global turnover), service restrictions, and, in extreme cases, potential blocking of services in the UK.[725]

Under 16s Social Media Ban

In January 2026 the UK government announced a consultation on children's social media use, which started in March 2026, and it is due to end in late May 2026. The consultation comes as the government is exploring the potential of an under 16s ban on the use of social media. This ban follows the Australian one, and it is motivated by much of the same reasons. These reasons are closely related to those that pushed for the Online Safety Act 2023, and they related to the safeguarding of young people from potential online harms and the nature of online platforms that encourage increasing usage. Despite the implementation of the Act, the government still believes that young people run too many risks online, and so considerations on a ban should be explored.[726]

Stakeholders, including the Molly Rose Foundation and the 5Rights Foundation, have raised concerns that a blanket ban on under 16s may have unintended consequences, including

719 Ibid.

720 Ibid.

721 Ibid.

722 The United Kingdom's independent regulator for communications services, including broadcasting, telecommunications and postal services.

723 UK Government, *Online Safety Act Explainer*, 2025.

724 Ibid.

725 Ibid.

726 House of Commons Library, *Proposals to ban social media for children,* 2025, pp. 7-9.

discouraging young people from reporting harmful experiences or pushing them towards less regulated online spaces.

Baseline Statistics

Mental health status

Overall, in England mental health conditions and disorders for young people are on the rise. In 2023 around 20 % of people aged 8 to 25 had reported a probable mental disorder in England.[727] This data comes from the follow up of the 2017 survey 'Mental Health of Children and Young People in England' and it represents a rise from previous waves in 2017 and 2020.[728] In 2017 the rate of young people reporting a probable mental health disorder was 12.5 %.[729]

In 2024 young adults (ages between 16 to 24) had reported the highest rate of any depressive or anxiety disorder with just over 25 %.[730] Self-harm is much less common in England but still prevalent, with 5 % of 17-24 years olds reporting to have self-harmed in the past 4 weeks from the 2023 survey.[731] Lifetime rates of self-harm for children between 8 to 16-year-olds in 2023 was 9.4 %, as reported by parents.[732]

England faces significant shortages in its consultant psychiatrist workforce. There is approximately one consultant psychiatrist for every 12 700 people, or around one for every 2 540 people expected to experience a mental illness each year.[733] Around 14 % of consultant posts are vacant, and over a quarter are either unfilled or covered by locum staff, highlighting ongoing workforce pressures and gaps in access to care

Digital Habits

In England overall almost all children across all ages go online using differing devices.[734] The age group with the lowest amount were the 5 to 7-year-olds with 85 % going online.[735] Children from all other ages almost all go online, with 10 to 17-year-olds all going online (100 % rate).[736]

Social media use among 3 to 5-year-olds has risen notably, increasing from around 25 % in 2021 to 2022 to 29 % in 2023 and 37 % in 2025. This use is often mediated by parents, with 36 % using platforms on behalf of their child and 42 % using them together, although 19 % of children (3 to 5-year-olds) use them independently.[737] Ofcom also notes that in older age groups (13-17-year -olds) the most common use of a mobile phone is to use messaging platforms.[738] In younger age groups (3-12-year-olds), video sharing platforms seem to be the most common.[739] Stakeholders consulted for this case study have highlighted that such environments are often shaped by features such as

727 NHS Digital, *Mental Health of Children and Young People in England, 2023: Wave 4 follow-up*, 2023.

728 Ibid.

729 Ibid.

730 Department of Health and Social Care, *Independent review into mental health conditions, ADHD and autism: interim report*, 2026, p. 18.

731 *Mental Health of Children and Young People in England, 2023: Wave 4 follow-up.*

732 Ibid.

733 Royal College of Psychiatrists, *One consultant psychiatrist for every 2,500 people who will experience a mental illness each year in England, latest census shows,* 2026.

734 Ofcom, *Children and parents: media use and attitudes report 2025*, 2025, pp. 4-10.

735 Ibid.

736 Ibid.

737 Ibid.

738 Ibid.

739 Ibid.

autoplay and endless scrolling, which can encourage prolonged engagement and limit user control, particularly among younger users.

Awareness and use of digital technologies among children continue to grow, though with notable differences by age and background. Around 63 % of 8 to 17-year-olds report being aware of recommendation algorithms, up from 59 % in 2023.[740] Stakeholders have also noted that despite rising awareness, many young people report a diminished sense of agency online and increasing concerns around privacy, particularly in relation to AI driven systems.

In 2022, through a self-reported study it was noted that 23 % of young people between the ages of 11 to 15 years old expressed to have had a problematic relationship with social media in England.[741]

Additionally, over a fifth of children aged 11-15 had been cyberbullied and over an eighth had cyberbullied others. The prevalence of being cyberbullied rose from 18 % in 2018 to 21 % in 2022 with younger adolescents and girls more likely to report this.[742]

Healthcare capacity

As of 2024, mirroring a rise in probable mental health disorders, there has also been a rise in demand for children and young people's mental health support in England, with the number of those holding active referrals to Children and Young People's Mental Health Services increasing slightly from 949 200 in 2022-2023 to 958 200 in 2023-2024, meaning around 8 % of all children were in contact with services. Although investment has grown, with spending reaching €1.3 billion, this still represents a relatively small share of overall health spending (1.04 %), and significant regional inequalities persist, with spending per child ranging from €633 to €2 902 depending on location.[743]

There are substantial unmet needs in England's mental health space, as only 24 % of children with a mental health need received support based on a two-contact measure. Although, some improvements have been made as 36 % of children began treatment, a 4-point percentage increase from the 2022-2023. At the same time, 33 % (around 320 000 children) were still waiting for treatment at the end of the year (2023), an increase from 28 %, and waiting times remained considerable, with a median wait of 35 days for initial contact rising to 45 days for direct treatment, and much longer delays for some. Among those still waiting, average waits reached 179 days, with 32 % waiting over a year and 14 % over two years, particularly for services related to autism and neurodevelopmental conditions, where up to 78 % of children remained on waiting lists.[744]

The estimated costs of inaction are substantial. Analysis reports that childhood mental health difficulties could lead to €1.2 trillion in lost earnings across the current generation, and that the cost of persistent school absence is equal to €1.3 billion a year.[745]

Crisis Impacts

COVID-19 Aftermath

During the COVID-19 pandemic, children and young people in the UK reported a wide range of impacts on their mental health, with many experiencing heightened feelings of loneliness, boredom,

740 Ibid.

741 HBSC England, *Health Behaviour in School-aged Children: 2022 Full Report*, 2022, p. 93.

742 *Health Behaviour in School-aged Children: 2022 Full Report*, 2022, p. 126.

743 Children's Commissioner, *Children's Mental Health Annual Briefing May 2025*, 2025, pp. 8-24.

744 Ibid.

745 Mind, *The Big Mental Health Report*, 2025, p. 25.

and frustration due to isolation from friends, disrupted routines, and limited activities.[746] These conditions often led to increased anxiety, low mood, and a sense of 'empty' or unproductive time, particularly where structure was lacking.[747]

Many of the mental health stakeholders consulted for this case study reported that the rise of mental health disorders can be timed back to the pandemic. They attribute that lockdown measurers and halt of in person schooling have contributed to a worsening mental health for most young people across the country.

Geopolitical and social context

The current geopolitical and social context for young people in England is shaped by economic pressures, inequalities and changing civic engagement. Many young people face constrained opportunities linked to the cost of living, with around 40 % reporting concerns about their financial future. Economic uncertainty is reflected in worries about stable employment and access to affordable housing, both of which influence long term life choices.[748]

Inequalities remain a defining feature of young people's experiences. Those from disadvantaged backgrounds report poorer wellbeing and fewer opportunities, with participation in enrichment activities significantly lower among lower income groups. Geographic disparities are also evident, with young people in deprived areas less likely to access youth services and community infrastructure.[749]

Deep Dive: Featured Interventions

This section focuses on four interventions selected to represent the England's contribution to the study: Barnardo's LINK social prescribing service, Place2Be, the Anna Freud Centre's Schools and Colleges Early Support Service (SCESS), and NHS Child and Adolescent Mental Health Services (CAMHS). Together, these interventions reflect the breadth of the English response to youth mental health, spanning community-based prevention, school embedded provision, digitally enabled early intervention, and specialist clinical care. Importantly, they collectively cover the full spectrum of need, from mild and emerging difficulties through to severe and complex mental health conditions. The analysis is further informed by stakeholder consultations conducted across all four interventions, providing practice-based insight into their design and implementation.

These interventions were selected because they combine policy relevance, scale, maturity, and strength of evidence. Barnardo's LINK service offers a holistic, nonclinical social prescribing model addressing the social determinants of mental health through community based support and early intervention; Place2Be provides a well-established school based model delivering targeted and universal services for children with mild to moderate needs; the Anna Freud Centre's SCESS introduces a digitally enabled, scalable early intervention approach aligned with whole school systems; and CAMHS represents the statutory clinical backbone, delivering multidisciplinary care for moderate to severe and complex conditions. Taken together, they illustrate a continuum of care that bridges gaps between prevention, early support, and specialist treatment, while also highlighting current policy debates around integration, access, and system capacity.

746 UK Covid-19 Inquiry, *Children and Young People's Voices*, 2025, pp. 131–162.

747 Ibid.

748 UNICEF UK, *UK joint second to last for teenage life satisfaction*, n.d.

749 Ibid.

Social prescribing: Barnardo's LINK service

Description

Barnardo's' Social prescribing programme aims to provide a holistic and preventative approach, addressing the wider social determinants of mental health. This includes factors such as loneliness, family stress, poverty, and disengagement from education.[750]

It does so by using a combination of one-to-one support and facilitated access to community-based activities through LINK workers who are the key workforce for delivery. These practitioners work collaboratively with young people to understand their needs, strengths, and preferences, before connecting them to appropriate nonclinical support within their local communities.[751] This support might include participation in creative arts, sports, youth groups, mentoring schemes, or practical support services. The programme functions as both an early intervention and a means of preventing escalation to more intensive statutory services such as CAMHS.[752]

The social prescribing services are designed for young people aged 5 to 19, although in practice most participants are typically between 11 and 15-years-old.[753]

Referral pathways are varied, with schools acting as the primary route, alongside GPs, family members, and self-referrals. Referrals are generally triggered when young people display signs of mental health distress or become socially isolated, particularly from education or community settings.[754]

Barnardo's services are funded by partly NHS funding and Barnardo's own funding.

Evidence of Effectiveness & ROI

One of the most successful case studies for Barnardo's has been their services in Cumbria. Most of the evidence below comes from the Cumbria services.

Evaluations of the Barnardo's LINK Cumbria service demonstrate significant quantified impacts, with 66 % of service users showing a statistically significant improvement in mental health based on the Outcomes Rating Scale (ORS).[755] Qualitative data further indicates that children feel more resilient, less isolated, and more confident in seeking help after participating.[756] For many, the service helps them address the root causes of their distress rather than just treating clinical symptoms. Young people frequently report that the service has helped them develop the confidence to seek help when they need it, leading to more positive experiences if they eventually interact with statutory services.[757]

Social prescribing is effective at providing support for children and young people who have needs too complex to self-manage but who do not meet the high clinical thresholds for specialist services (CAMHS). By acting as a nonclinical 'safety net,' social prescribing prevents these individuals from being referred across the system and reaching a point of crisis where they would require intensive

750 Barnardo's, *The Missing Link: Social prescribing for children and young people*, 2023, pp.17-20.

751 Ibid.

752 Ibid.

753 Ibid.

754 Ibid.

755 Barnardo's, *The Missing Link: Social prescribing for children and young people*, 2023, pp.21-40.

756 Ibid.

757 Ibid.

and expensive inpatient care.[758] Furthermore, the model recognises that approximately one in five GP appointments are for nonclinical issues such as social isolation, bullying, or family stress that medical interventions and antidepressants are not designed to solve. If applied across England, social prescribing could reduce the annual need for GP appointments by 2.5–3 %, saving millions of appointments.[759]

Regarding economic performance, a cost benefit analysis of the service revealed a ROI of €2 for every €1 invested.[760] The quantified cost per user is estimated at €8 652, while the generated benefit to the state and wider economy is valued at €15 309 per user, largely due to reduced pressure on GP appointments and specialist mental health services.[761] According to the Barnardo's stakeholder consulted, the peruser cost is kept low, but the programme still needs to address the logistical costs involved in areas like transportation and the training of LINK workers.

Implementation: Barriers and enablers

The successful implementation of Barnardo's social prescribing model is supported by a combination of relational, community based, and multiagency factors.

The relationship with the LINK Worker is often cited in the evaluation as the most critical factor in these positive outcomes. Unlike clinical settings, service users describe their LINK Worker as a friend rather than a therapist, providing a safe, nonjudgmental space where they feel truly listened to and supported.[762] Parents also emphasise the value of having an independent advocate who support them and can help them navigate complex systems like school or LGBTQIA+ support groups.[763]

Community links are also essential. As explained by the stakeholder interviewed schools act not only as key referral pathways but also as active partners, engaging in a feedback loop with Barnardo's to monitor progress and support young people within the educational environment. This ensures that interventions are well integrated with existing school-based support, contributing to improved overall wellbeing.

Other enablers of success reported by the evaluation of Barnardo's services are clear referral criteria and well managed expectations enhance service coherence, while positioning social prescribing within a wider network of clinical and community support strengthens its effectiveness as an early intervention.[764]

The evaluation identified that barriers to success in social prescribing emerge at multiple stages, from access through to sustained engagement. A persistent issue is the lack of awareness and understanding of what social prescribing involves, alongside difficulties with the language used and confusion about the role of the voluntary sector in delivering what may be perceived as healthcare interventions.[765] Engagement is further constrained where parents and carers are unconvinced of the appropriateness of interventions or are unable or unwilling to support participation. Structural barriers also play a significant role, including costs associated with activities, transport

[758] Ibid.

[759] Ibid.

[760] *The Missing Link: Social prescribing for children and young people*, 2023, pp.1–17.

[761] Ibid.

[762] *The Missing Link: Social prescribing for children and young people*, 2023, pp.21–40.

[763] Ibid.

[764] Ibid.

[765] Ibid.

requirements, inconvenient timing, and challenges linked to communication, particularly where language or digital access is limited. [766]

With increase complexity in young people's mental health needs, services risk being overwhelmed or misused when referral pathways are unclear or when social prescribing is expected to substitute clinical provision, rather than covering its gaps.

School based: Place2Be

Place2Be is a longstanding charity that focuses on children's mental health within school communities across England (and the United Kingdom). Over the past 35 years, they have developed a comprehensive 'whole school approach' to mental health, working in both primary and secondary school settings.[767] Their services include one-to-one and group targeted interventions, universal support for the entire school population, and specialist parenting training such as Personalised Individual Parenting Training (PIPT).[768, 769] These services are target to young people suffering from mild to moderate mental health symptoms.[770] Most of the children that they have within the system are pre CAMHS.[771]

Moreover, all of their services are embedded directly within over 650 primary and secondary schools to reach children who may be underserved by statutory health services.[772] Place2Be operates on a mixed funding model; for the 2023/24 financial year, income included school fees (€12 million), voluntary donations (€11.6 million), and government/NHS commissioning (€3 million).[773]

Evidence of Effectiveness & ROI

Evaluation data shows that 78 % of primary aged children and 91 % of secondary aged young people reported improved mental health after receiving one-to-one counselling.[774] On average, children receiving this service experienced a 3.5-point reduction in their Strengths and Difficulties Questionnaire (SDQ) score, with 2.1 points specifically attributable to the Place2Be intervention.[775] Furthermore, 75 % of children moved successfully towards their personal goals according to Goal Based Outcome measurements.[776]

A school based approach is effective because it reaches children and young people who are traditionally underserved by statutory healthcare services, such as young people coming from diverse ethnic backgrounds.[777] Pleace2Be has reported the 53 % of those who self-referred to their Place2Talk service in 2023-2024 were from global majority ethnic communities.[778] Schools are uniquely positioned to promote help seeking behaviour and reduce the stigma associated with mental health, allowing for the early identification of needs before they escalate.[779] This is essential

766 Ibid.

767 Place2Be, *NHS Quality Accounts 2025*, 2025, p. 3.

768 Ibid.

769 Place2Be, *Impact Report 2024*, 2024, p. 6.

770 Place2Be, *NHS Quality Accounts 2025*, 2025, pp. 4-14.

771 Ibid.

772 Place2Be, *Impact Report 2024*, 2024, p. 4.

773 Ibid.

774 *Impact Report 2024*, 2024, p. 4.

775 Pro Bono Economics, *The economic case for school-based counselling: Place2Be*, pp. 4-9.

776 Place2Be, *NHS Quality Accounts 2025*, 2025, pp. 4-14.

777 Ibid.

778 Ibid.

779 Grant et al., *Impact of counselling provision in primary schools on child and adolescent mental health service referral rates: a longitudinal observational cohort study, Child and Adolescent Mental Health 28,* No. 2, 2023, pp. 212–220.

given that approximately two thirds of children with a diagnosable mental health condition are currently unable to access NHS care, often because they do not meet the high clinical thresholds required for specialist support.[780]

Furthermore, implementing services in schools alleviates significant pressure on the healthcare system by managing mild to moderate mental health challenges internally rather than overwhelming CAMHS with a flood of referrals.[781] Being embedded in the school community also allows for a more holistic approach that involves parents, teachers, and school staff in the child's wellbeing.[782] This proximity builds deep trust and enables clinicians to support the child's learning and social development in real time, which leads to more sustained mental health improvements than isolated healthcare interventions.[783] Ultimately, this model ensures that expert support is accessible at the point of need, bridging the significant provision gap that exists in state funded healthcare.[784]

The interviewed stakeholder also explained that, particularly in primary school settings, traditional mental health support is often less effective. For younger children, the method of delivering mental health support is quite different, relying more heavily on play based intervention and the child's home environment.

This intervention appears to be beneficial as well on the economic front. For every €1 spent on the primary school counselling service, the program generates €9 in benefits to society.[785] The average cost per user for the one-to-one service is approximately €1 270 per child.[786] The long-term economic benefit is estimated at €8 700 per child over their lifetime, driven by improved employment prospects, higher wages, and reduced risks of depression or criminal justice involvement.[787] If this model were scaled to all schools in England currently without an NHS Mental Health Support Team (MHST), it is estimated it could generate €751 million in economic benefits annually.[788]

Implementation: Barriers and enablers

The primary enabler of success is the embedded school approach, which fosters trust and allows clinicians to manage high complexity needs internally without overwhelming the healthcare system.[789] As described above, this system allows for comprehensive coverage of a young person's life as a whole. To this end, it is essential that Place2Be has succeeded in establishing robust, trusting relationships with the entire system surrounding the child.[790] This approach has been partly supported by Parent Partnership sessions, which provided over 20 000 support sessions in a single year to empower families alongside their children.[791]

Another key driver of success for Place2be, as reported by internal evaluation and the stakeholder interview, is Place2Be's investment in the mental health workforce. Through training programmes,

780 Ibid.

781 Ibid.

782 *NHS Quality Accounts 2025*, 2025, pp. 4–14.

783 Ibid.

784 Pro Bono Economics, *The economic case for school-based counselling: Place2Be*, pp. 4–9.

785 Ibid.

786 Ibid.

787 Ibid.

788 Ibid.

789 *NHS Quality Accounts 2025*, 2025, pp. 4–14.

790 Place2Be, *Salford Research Programme Report: 2-year Interim Full Reportv*, 2024, p. 1.

791 *NHS Quality Accounts 2025*, 2025, pp. 4–14.

bursaries, and professional development pathways, Place2Be strengthens capacity within schools and sustains its own workforce pipeline, including Counsellors on Placement.[792]

Through their annual report Place2Be has also identified key risks and barriers to their delivery, with safeguarding representing a high risk given its complexity.[793] Complex safeguarding can place pressure on staffing, slow service expansion, and require continuous organisational investment. Additionally, as case complexity increases, maintaining sufficient safeguarding capacity across multiple regions becomes an ongoing challenge.[794]

Another barrier is funding available at schools, given that most of the funding comes through them.[795] Schools are facing shrinking budgets and rising costs, particularly due to wage inflation and limited government funding, their ability to pay for mental health services is reduced. This creates a tension between maintaining service quality and affordability.[796]

Finally, as also mentioned by the stakeholder, there is an increasing severity of mental health needs coming from pupils that are part of the service. This means that the workforce needs more target training and hat coverage for those cases is too complex.

School and digital based: Anna Freud's Schools and Colleges Early Support Service

Detailed Description

The Schools and Colleges Early Support Service (SCESS), developed by the Anna Freud Centre, is a digitally delivered early intervention programme designed to support young people aged 11–25 experiencing mild to moderate mental health difficulties, including anxiety, low mood and emotional dysregulation.[797]

The programme adopts a whole school approach, integrating support for students, school staff and parents/carers. For young people, the service provides brief, structured interventions (typically 6 to 8 one-to-one sessions), alongside single session consultations and asynchronous psychoeducational materials. Staff and parents are supported through consultations, webinars and on demand resources aimed at strengthening the wider support system around the young person.[798]

As explained by Anna's Freud stakeholder, the programme is funded through a mixed model: participating schools incur a subsidised fee, while philanthropic funding alleviates additional costs.

For younger participants aged 11 to 15, referrals are mandatorily mediated by a school professional, ensuring that young participants are guided and supported in accessing the service. For those aged 16 and above, there is a self-referral option provided that their educational institution has commissioned the service.[799]

The delivery of the programme is conducted by a varied workforce with background in counselling, youth work, and education. The practitioners undergo specialised training that equips them with the

[792] Place2Be, *Trustees' Report and Accounts 2025*, 2025, pp. 20–22.

[793] Ibid.

[794] Ibid.

[795] Ibid.

[796] Ibid.

[797] Anna Freud, *Schools and Colleges Early Support Service*, n.d.

[798] Ibid.

[799] Ibid.

necessary skills to deliver low intensity CBT interventions suitable for a mild to moderate clinical threshold.

Evidence of Effectiveness & ROI

Programme level evaluation data indicates clear and measurable improvements in mental health outcomes. Approximately 71 % of participating young people report reductions in symptoms of anxiety and depression, alongside broader gains in goal-based outcomes and overall wellbeing. The impact extends beyond young people themselves: around 90 % of parents and carers report increased confidence in supporting their child, while approximately 89 % of staff indicate an enhanced ability to respond to students' mental health needs.[800]

Assessments have been conducted on similar early interventions, and they have concluded that effective early intervention are designed to prevent problems from occurring or to tackle them head on when they first emerge, preventing them from worsening while fostering personal strengths and skills for adult life.[801] Intervening early brings several advantages, including addressing issues before patterns become ingrained, reducing the burden on families, and lowering the long term costs associated with treating adult mental disorders. Schools are considered a critical setting for this work because they provide an opportunity to reach large numbers of young people simultaneously, and staff are well placed to notice early changes in mental health or behaviour.[802]

Its online environment has also proven to be a positive feature as other similar online/school based early interventions have reported clinically significant reductions in depression levels among students.[803] Also, virtual and digital interventions can achieve comparable effect sizes to face-to-face provision, even if they rarely outperform them, but with significantly reduced costs. Digital and virtual delivery is considered a highly cost-efficient strategy because it can achieve a very large reach at a low unit cost.[804] Digital interventions are noted for requiring fewer resources, such as reduced face-to-face contact time, less intensive training, and fewer curriculum timetabling requirements. Furthermore, digital tools are capable of supporting a vast number of students simultaneously and were particularly useful when physical schools were closed for extended periods, such as during the COVID-19 pandemic.[805]

Implementation: Barriers and enablers

In terms of implementation, a number of enabling factors underpin the programme's success, as reported by the Anna Freud stakeholder. Its national reach, facilitated through digital channels, allows it to engage a broad and geographically dispersed population, supporting both rapid scaling and timely access. The flexibility and adaptability of the model, particularly its alignment with young people's preferences for online interaction, further contributes to strong engagement. This is reinforced by comprehensive training and ongoing supervision for practitioners, ensuring they are well equipped to deliver effective digital mental health support. Strong institutional partnerships, especially with educational settings, also play a crucial role by embedding the programme within school systems and enabling smoother delivery.

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800 ibid.

801 Early Intervention Foundation, *Adolescent mental health: A systematic review on the effectiveness of school-based interventions*, 2021, pp. 23-26.

802 Ibid.

803 Early Intervention Foundation, *Adolescent mental health: A systematic review on the effectiveness of school-based interventions*, 2021, pp. 38-41.

804 Ibid.

805 Ibid.

However, several barriers to implementation remain. Resource constraints present a significant challenge, particularly in the context of increasing case complexity. The availability of sufficiently experienced practitioners to provide oversight and support can limit both scalability and the maintenance of service quality. In addition, complex safeguarding needs can be more difficult to manage in a remote context, requiring robust coordination with local safeguarding leads to ensure timely and appropriate responses.

Healthcare based: CAMHS

Detailed Description

CAMHS refers to the NHS services that assess and treat children and young people struggling with poor mental health. It is part of a broader umbrella of Children and Young People's Mental Health Services (CYPMHS), which provides support across the spectrum of need, from prevention and early intervention to urgent and crisis care.[806]

Although delivery has been mostly clinical, there has been an increase over the past years to diversify this service provided by the NHS, as also confirmed by an NHS stakeholder. It has been increasingly multidisciplinary and multisectoral and includes different modes.[807] A significant portion of the service typology is now school based, delivered through MHSTs that provide evidence based early interventions within primary and secondary education settings. Another emerging sector is community based early support, often delivered through open access hubs such as the 'Young Futures' programme, which offers nonclinical, localised assistance.[808] The service also maintains a robust digital presence, utilising online platforms to provide advice and therapeutic support, which has become a core component of the 'transformation' agenda in recent years.[809]

Given its varied nature, support is provided through in person appointments, phone or video calls, and in some cases, support at home. Specialist and acute care can also be delivered in inpatient hospital settings.[810]

Referrals to CAMHS are typically made via a GP, school staff, or social worker, though some local services allow self-referrals from young people or parents. Referrals require detailed information about the child's needs and consent from those with parental responsibility.[811]

CAMHS is funded primarily through Integrated Care Boards (ICBs), which are mandated by NHS England to meet a Mental Health Investment Standard. However, children's services currently receive only 8% of overall mental health spending.[812]

Evidence of Effectiveness & ROI

Evaluations of MHSTs show that 70–80 % of children and young people achieve their specific treatment goals, with two thirds reaching reliable symptomatic recovery.[813] These teams deliver evidence based early interventions within primary, secondary, and further education settings for those aged 5 to 18. The economic case for MHSTs is exceptionally strong, as these teams pay for themselves within just two years of operation. Every €1 invested in MHSTs is estimated to generate

806 YoungMinds, *Your Guide to CAMHS*, *n.d.*

807 Children and Young People's Mental Health Coalition, *Future Minds Report 2025*, 2025.

808 Ibid.

809 Ibid.

810 YoungMinds, *Your Guide to CAMHS*, *n.d.*

811 Ibid.

812 Children and Young People's Mental Health Coalition, *Future Minds Report 2025*, 2025.

813 Ibid.

€25 in wellbeing benefits.[814] Furthermore, the average benefits per individual intervention are calculated at €6 466, which includes healthcare savings, increased lifetime earnings, reduced crime costs, and educational improvements. Currently, these teams cover approximately 44 % of pupils in England, and their continued rollout is a key recommendation for closing the 'treatment gap'.[815]

NHS Talking Therapies deliver multidimensional benefits that extend beyond immediate mental health improvement, approximately doubling recovery rates for service users. These clinical services are essential for system efficiency, as they reduce both hospital outpatient and inpatient admissions, helping to reverse the 65 % rise in acute bed use observed for young people over the last decade.[816] The impact of these therapies also encompasses physical health benefits, such as reducing further cardiovascular risk. From a macroeconomic perspective, Talking Therapies are a driver of prosperity because they move people back into employment and reduce the number of young people who are not in education, employment, or training (NEET), thereby helping to grow the economy. Moreover, these clinical services are also vital for navigating the complex diagnostic landscape of neurodevelopmental conditions like ADHD and autism, ensuring that those with the highest levels of impairment receive appropriate clinical adjustments.[817]

Investing in these clinical models is a strategic necessity, as treating a young person in the community is 100 times cheaper than an inpatient hospital admission. Failure to provide these services results in an estimated €295 million annual cost due to the deterioration of mental health while young people wait for support.[818] By shifting care from hospitals to the community through proven clinical interventions, the government can realise significant savings while unlocking the lifetime earnings potential of the current generation, which is otherwise threatened by over €1 trillion in lost earnings due to childhood mental health problem.[819]

Implementation: Barriers an enablers

A primary enabler of improved access is the adoption of self-referral mechanisms, which bypass professional 'gatekeepers' and empower children and families to seek help directly.[820] Self-referrals are also associated with some of the shortest waits for services. In the 2023-2024 period, the median wait for self-referrals was 28 days, significantly lower than the 52-day median for primary healthcare referrals.[821]

Relational continuity (seeing the same professional consistently) was also mentioned as important enabler, as it allows young people to develop therapeutic trust and so continue being engaged with the service for longer.[822]

Another enabler mentioned both by the NHS stakeholder and studies on CAMHS has been technological use. Nationally standardised digital referral platforms are identified as being essential to reduce variability and improve data quality. Digital tools also allow for early and ongoing communication, providing families with updates on their progress through the system, which

814 Ibid.

815 Ibid.

816 Ibid.

817 ibid.

818 ibid.

819 Ibid.

820 Kirk et al., *Perceptions of the key components of effective, acceptable and accessible services for children and young people experiencing common mental health problems: a qualitative study*, Volume 23, article number 391, 2023.

821 Children's Commissioner, *Children's Mental Health Annual Briefing May 2025*, 2025, pp. 8-24.

822 Kirk et al., *Perceptions of the key components of effective, acceptable and accessible services for children and young people experiencing common mental health problems: a qualitative study*, Volume 23, article number 391, 2023.

reduces the anxiety of waiting and allows for a smoother referral process. [823] The stakeholder also mentioned in the interview that other digital tools, such as online therapy platforms can be significant enablers to reduce costs and increase the reach of NHS services.

As the stakeholder mentioned, CAMHS is slowly improving its services in schools and communities. Studies find that these switches can prove to be very beneficial to overall CAMHS. MHSTs in schools and communities can deliver needs led early intervention directly where children spend their time.[824] This helps by addressing mental health needs before they escalate to a crisis point, which reduces the long term demand on specialist healthcare and welfare systems.[825] This approach is essential for moving away from a medical, diagnosis led model toward a social model that is needs led, allowing children to access help without the requirement of a formal 'label' or diagnosis.[826]

The most pervasive barrier to effective implementation is the chronic mismatch between surging demand and existing capacity, with approximately one in five children now experiencing a diagnosable mental health condition while the NHS is only able to support around 40 % of those in need.[827] This significant capacity gap results in prolonged waiting times for support, where children in England wait an average of 21 weeks for a first appointment, and approximately 40 % of Trusts report young people who have remained on lists for over two years.[828]

A significant administrative barrier is the high rate of unsuccessful referrals, with between one quarter and one third of all referrals being rejected or closed before treatment begins.[829] This frequently stems from a lack of transparency and confusion regarding clinical thresholds and service specifications, which vary by region and lead parents and referrers to push for a referral.[830]

Operational barriers are further exacerbated by severe workforce shortages, with NHS staff vacancy rates rising to 17 % in 2022 and staff retention declining.[831] This instability leads to a heavy reliance on agency staff, which undermines the relational continuity and trust essential for building effective therapeutic relationships.

Transferability & EU Policy Lessons

The English experience offers significant lessons for the EU on designing and scaling a multilayered mental health system that integrates statutory services with school based, community, and digital interventions. It demonstrates a dual track approach: innovating in service delivery to address the 'missing middle' while simultaneously implementing a robust regulatory framework to shape a safer digital environment.

Prevention in schools and early intervention services

England provides several transferable models for embedding early intervention directly into the systems surrounding young people. The NHS Mental Health Support Teams (MHSTs) offer a powerful governance blueprint for how a national health service can systematically fund and roll out

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823 Abel et al., *Enhancing referrals to Child and Adolescent Mental Health Services: the EN-CAMHS mixed-methods study, Health and Social Care Delivery Research, No. 13.21,* 2025.

824 Children and Young People's Mental Health Coalition, *Future Minds Report 2025*, 2025.

825 Ibid.

826 Children's Commissioner, *Children's Mental Health Annual Briefing May 2025*, 2025, pp. 8-24.

827 Children and Young People's Mental Health Coalition, *Future Minds Report 2025*, 2025.

828 Ibid.

829 Kirk et al., *Perceptions of the key components of effective, acceptable and accessible services for children and young people experiencing common mental health problems: a qualitative study*, Volume 23, article number 391, 2023.

830 Ibid.

831 Children and Young People's Mental Health Coalition, *Future Minds Report 2025*, 2025.

evidence-based, early intervention teams in schools. For deeper, more intensive support, Place2Be provides a well evidenced model for embedding therapeutic services within the school fabric. In the community, Barnardo's LINK service is a transferable social prescribing model that addresses the nonclinical, social determinants of mental health. The successful transfer of these models depends on three key conditions: a long-term strategy for building a skilled workforce (including roles like Education Mental Health Practitioners and Link Workers), sustainable mixed funding models, and strong cross sectoral governance to ensure seamless referral pathways between schools, community services, and clinical care.

Digital tools and governance

The English case provides two distinct and highly relevant insights for EU level debates on digital policy. First, the Anna Freud Centre's SCESS offers a transferable model for a digitally enabled early support service, demonstrating how to scale up brief, evidence-based interventions for mild to moderate needs while integrating support for staff and parents. It serves as a blueprint for moving beyond simple apps to create a comprehensive, digitally delivered service. Second, the Online Safety Act 2023 provides a world leading example of proactive digital governance. Its focus on mandating safety by design and holding platforms accountable for systemic risks offers a concrete roadmap for the EU and its Member States on how to operationalise and enforce the principles of the Digital Services Act (DSA), particularly regarding the protection of minors.

Equity and access

Finally, the English experience serves as a crucial cautionary tale regarding equity and access. While innovative models like school-based support and social prescribing demonstrably improve access for underserved groups, the system as a whole remains overwhelmed. The persistence of long waiting lists for specialist CAMHS, significant regional inequalities, and a high number of rejected referrals highlights a critical lesson: early intervention and prevention models are a vital part of the solution, but they cannot substitute for adequately funded and accessible specialist clinical care. The most effective system is an integrated one where sub-clinical supports work in tandem with a properly resourced statutory service. The adoption of self-referral mechanisms within CAMHS, however, offers a simple yet powerful transferable strategy for lowering administrative barriers and improving direct access for families.

Youth mental ill-health in the EU-27 is high, rising and increasingly associated with digital environments.

This study shows how persuasive platform design, harmful content and emerging AI-mediated interactions amplify offline vulnerabilities in the context of under-resourced, fragmented services and a large 'missing middle' between schools and specialist care.

Using seven country case studies and an EU-27 cost model, it estimates that youth mental ill-health will cost about €1.68 trillion over 2024-2033 if current policies continue.

It proposes a coherent package of EU-level options, school-based promotion, youth-friendly early-intervention services, social prescribing, safer digital tools, child-centred enforcement of the digital acquis and stronger data and governance, that could reduce this burden while respecting EU competences and fundamental rights.

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