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WHO Collaborating Center
for Maternal and Child Health
Trieste, Italy



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Protecting and Improving the Mental Health of Children and Adolescents in Europe: Evidence and Good Practices

A review of practices across 27 EU Member States, as well as Iceland, Norway and the UK, found that:



More than 338 documented practices
are already in place, covering different population
targets, sectors and levels of intervention.



42 practices show evidence
of effectiveness, accessibility and potential for transfer,
having been implemented across multiple countries.

This factsheet is designed to inform policymakers and forms part of the evidence base
for the "Prevention Toolkit for Children's Health and Wellbeing".

Overall, mental health conditions affect one in six children and adolescents

**around 1 in
4 adolescents**

aged 10 to 19 living
with a mental health condition

**around 1
in 14 children**

aged 0 to 9 living
with a mental health condition

+37%

increase in prevalence
rate of mental health
conditions, 2013 to 2023

18 million+

children and adolescents
suffer from at least
one mental health condition



According to the latest estimates from the Global Burden of Disease (GBD) study¹, approximately 18 million children and adolescents aged 0 to 19 in the 30 countries reviewed are estimated to be living with at least one mental health condition, equivalent to approximately 16% of this age group. Anxiety disorders are the most common of these (10.4 million), accounting for more than half of all diagnoses,

followed by depressive disorders, attention deficit hyperactivity disorder (ADHD), and conduct disorders. Estimated prevalence of mental health conditions varies considerably across countries, from 10.1% to 22.8%, though these differences should be interpreted with caution, as they reflect development, reduces risk of non-communicable disease and contributes to a and families' access to high-quality, timely support promotes healthier child. Both genuine variation in rates of mental health conditions and differences in diagnostic practices and data quality across national contexts.

Trends

Between 2013 and 2023, the prevalence rate of mental health conditions increased by 36.8%. The increase has been steeper among girls (+38.5%) than boys (+35.0%)¹.

Age patterns

The prevalence of mental health conditions increases markedly with age, rising from 2.1% among children under 5 years to 24.7% among adolescents aged 15 to 19. The type of condition also varies with age: neurodevelopmental conditions, including intellectual development disorders, autism spectrum conditions, and ADHD, account for a larger proportion of conditions in younger children, while internalising disorders such as anxiety and depression become increasingly prevalent during adolescence¹.

Sex differences

The prevalence of mental health conditions is higher among girls (17.4%) than boys (14.1%), and this gap widens significantly in adolescence: at ages 15 to 19, prevalence reaches 28.9% among girls compared to 20.7% among boys¹. Patterns also differ by type of condition: anxiety, depressive disorders and eating disorders are more common among girls, while autism spectrum disorders, ADHD, and conduct disorders are more frequently diagnosed among boys¹.

Vulnerable groups

Certain groups face substantially elevated risk. Children from lower socio-economic backgrounds, those who have experienced adverse childhood events, migrants and refugees as well as LGBTQIA+ young people face disproportionately high rates of mental health conditions. Among LGBTQIA+ adolescents, rates of depression and anxiety are significantly higher than in the general adolescent population^{2,3}.

Good Practices:

- **Jigsaw (Ireland):** provides free, accessible mental health support for young people aged 12 to 25 with no out-of-pocket spending, including online access options, making help available to those who might not otherwise seek support.
- **headspace (Denmark):** offers low-threshold support at the first signs of distress, adapted from the Australian model and explicitly referenced in Denmark's national 10-year plan for psychiatry.
- **@ease (Netherlands):** a low-threshold community mental health service supported by the Dutch Ministry of Health, Welfare and Sport, reaching young people who would not otherwise seek help.
- **Prompt Mental Health Care – PMHC (Norway):** a dedicated model offering free, low-threshold access to care for mild-to-moderate anxiety, depression, sleep problems, and early substance use difficulties.

Suicide is the leading cause of death for adolescents

Suicide is the leading cause of death among young people aged 15 to 19 across the 30 countries reviewed, accounting for almost 1 in 5 deaths in this age group, the equivalent of around 26 deaths per week. Rates vary from 1.1 to 9.1 per 100,000 across countries⁴.

17.3%

of adolescent deaths
caused by suicide

**4.9 per
100,000**

suicide rate among
15- to 19-year-olds

2.6x

higher rate of death
by suicide among
boys vs girls

**1.1–9.1
per 100,000**

range of suicide rates
across countries

Trends and age patterns

Suicide rates rise from 0.7 per 100,000 among children aged 10 to 14, to 4.9 per 100,000 among those aged 15 to 19 (2023)¹. Despite the scale of the problem, suicide mortality has declined significantly over recent decades: between 2000 and 2023, rates fell by 42% among males (from 12.2 to 7.0 per 100,000) and 24% among females (from 3.7 to 2.8 per 100,000)¹.

Sex differences

Boys are approximately 2.6 times more likely to die by suicide than girls (7.0 vs 2.8 per 100,000)¹. However, girls report higher rates of non-fatal lifetime self-harm (42.1 per 100,000 girls compared to 37.4 per 100,000 boys)¹.

Risk factors and vulnerable groups

Risk factors for suicide and self-harm are complex and multifaceted, including mental health conditions, adverse childhood experiences, family conflict, social isolation, and access to means of suicide^{5,6}. Migrants and asylum seekers show higher rates of self-harm and suicidal ideation than the general population^{5,6}. LGBTQIA+ young people face disproportionately high risk of suicidal ideation and attempts, and non-binary young people are particularly likely to have contacted crisis helplines and support services^{7,8}.

Good Practices:

- **Youth Aware of Mental Health (YAM):** a school-based programme evaluated in a cross-national trial across Europe found to reduce suicide attempts and depression rates and increase peer support among adolescents.
- **Mental Health First Aid (MHFA):** trains adults and young people to recognise and support peers experiencing mental health difficulties or suicidal distress; widely implemented across schools and communities.



Substance use

Substance use is a significant and interconnected risk factor for poor mental health among young people. Data from the European School Survey Project on Alcohol and Other Drugs (ESPAD)⁹ and Health Behaviour in School-aged Children (HBSC) study¹⁰ indicate that 74.4% of 15- and 16-year-olds in the region have consumed alcohol, 44.5% have used e-cigarettes, and 14.5% have used illicit drugs. An estimated 1.2 million adolescents in the region meet criteria for a substance use disorder.

74.4%

lifetime alcohol use
among 15- and 16-year-olds

44.5%

lifetime e-cigarette use
among 15- and 16-year-olds

14.5%

lifetime illicit
drug use among
15- and 16-year-olds

1.2 million

adolescents with a
substance use disorder

Trends and age patterns

Between 2003 and 2024, the use of traditional substances (cigarettes, alcohol, and cannabis) declined. However, e-cigarette use among 15- and 16-year-olds rose, from 41.2% in 2019 to 44.5% in 2024⁹.

Substance use increases with age and early initiation is common: alcohol use by age 13 is the most commonly reported early substance use behaviour, followed by e-cigarette use and cigarette smoking. Among adolescents who report lifetime cannabis use, around 1 in 5 first used cannabis by age 13 or younger⁹.

Sex differences

Girls report higher rates of alcohol use, smoking, and e-cigarette use, while boys report higher rates of illicit drug use⁹. Substance use disorders are more common among boys¹¹.



Good Practices:

- **Unplugged (Austria, Belgium, Germany, Greece, Italy, Spain, Sweden):** combines knowledge about substance use risks with social influence approaches and life skills training; demonstrated effectiveness in reducing tobacco, alcohol, and cannabis use among adolescents.
- **Strengthening Families Program (France, Ireland, Austria, Italy, Portugal, Denmark, Sweden, Slovenia):** a group-based family skills programme developed to reduce substance use risk, building family bonds and communication through joint parent-child sessions; documented effectiveness in delaying substance use initiation among young people across multiple European countries.
- **IPSY - Information + Psychosocial Competence = Protection (Germany, Italy):** school-based programme for the prevention of adolescent misuse of licit substances. It combines the promotion of intra- and interpersonal life skills (e.g. communication skills, problem solving, coping with anxiety and stress) with training in skills related to substance use (e.g. refusal skills). Results show short-term effects on alcohol consumption and long-term effects on tobacco use.

Well-being and peer violence among school-aged children

Beyond diagnosed conditions, data from the HBSC study¹⁰, covering more than 220,000 adolescents aged 11 to 15 across 44 countries, show that many young people experience subclinical mental health problems that affect their daily lives. The average well-being score for the region is 59.1 out of 100, with life satisfaction averaging 7.38 out of 10. More than one in six adolescents (16.3%) report feeling lonely, and a third report irritability (34.8%), nervousness (34.9%), and concerns about body image (31%).

38%

of 11- to 15-year-olds
report feeling irritable
(up from 22% in 2014)

35%

of 11- to 15-year-olds
report feeling nervous
(up from 22% in 2014)

31%

of 11- to 15-year-olds
have sleep difficulties
(up from 21% in 2014)

**35.7%
vs 16.7%**

girls vs boys aged 11 to 15
report feeling lonely

Trends

Data point to a clear deterioration in adolescent well-being from 2014 to 2022. Among adolescents aged 11–15, reported irritability rose from 22.3% to 37.8%, nervousness from 21.7% to 34.9%, and sleep problems from 20.7% to 30.6%. Life satisfaction declined from 7.6 to 7.4 out of 10 over the same period¹⁰.

Age patterns

Well-being declines progressively across adolescence for both boys and girls. Average well-being scores (out of 100) fall from 65.8 at age 11 to 53.9 at age 15. The share of adolescents reporting loneliness rises from 11% at age 11 to 21% at age 15, while those reporting irritability rise from 26.7% to 40.8% and nervousness from 26.4% to 41.4% over the same age range¹⁰.

Sex differences

Girls are significantly more affected than boys across nearly all indicators. Girls are more likely to report feeling low (35.7% of girls vs 16.7% of boys), nervous (45.4% vs 24.4%), irritable (44.5% vs 25.1%), and lonely (22.1% vs 10.4%). Concerns about body image are also higher among girls: 36.7% report being unhappy with their weight, compared to 25.3% of boys¹⁰.

Risk factors and vulnerable groups

Adolescents from lower socioeconomic backgrounds consistently report poorer well-being, lower life satisfaction, and higher levels of emotional and psychosomatic complaints. Girls, particularly at age 15, emerge as a key vulnerable group, reporting the lowest well-being and life satisfaction scores alongside elevated loneliness, nervousness, irritability, and

body image concerns. Adolescents exposed to bullying, cyberbullying, or peer victimisation are also at heightened risk. Other groups likely to face elevated vulnerability include those

with disabilities, migrants and refugees, and LGBTQIA+ young people, though comparable data for these groups remain limited¹².

Good Practices:

- **Mental Health and High School Curriculum Guide (Finland, Germany, Portugal, Romania, UK):** a free classroom resource helping young people understand mental health, reduce stigma, and seek help. Materials are freely available in multiple languages.
- **KiVa (Finland, national legislative mandate):** a whole-school anti-bullying programme with a strong evidence base; shown to reduce bullying prevalence and improve school climate across diverse national settings.
- **Incredible Years (Ireland, Portugal, Slovenia, UK):** group-based parenting and teacher programmes that build skills and competencies through structured sessions, with demonstrated effectiveness across diverse national contexts. Results show stronger parent-child relationship and improved social-emotional competence.



Emerging challenges of the digital revolution

4.5 hours

average daily screen time among 13- to 18-year-olds on school days

16%

of adolescents aged 11 to 15 have been cyberbullied (past 2 months)

12%

of adolescents aged 11 to 15 have perpetrated cyberbullying

11%

of adolescents aged 11 to 15 show problematic social media use

12%

of adolescents aged 11 to 15 show problematic gaming

According to a 2026 Flash Eurobarometer¹³, adolescents aged 13 to 18 across the EU spend an average of 4.5 hours on digital devices on a typical school day, rising to 6.1 hours at weekends. Social media is the most common activity, averaging 2.6 hours per day. Many of the adolescents surveyed report clear benefits: 70% say social media helps them feel connected to others, 65% say they learn a lot through it, 63% report it puts them in a better mood, and 62% say it helps them express themselves. However, more than 30% of the adolescents surveyed report feeling stressed, anxious or sad in relation to social media use. The Eurobarometer informed President von der Leyen's Special Panel on child safety online¹⁹ as well as the proposal for an EU KIDS Act, which seeks to protect minors from risky digital services and AI systems, uphold the digital single market and maintain a coherent regulatory framework and enforcement structure for the protection of minors online²⁰.

In addition, data from the HBSC 2022 study¹⁰ indicate that 36% of adolescents aged 11 to 15 report continuous online contact, reflecting how embedded digital communication has become in adolescents' daily lives. 16% report cyber-bullying victimisation, and around 11% show problematic social media use. Data from the Programme for International Student Assessment (PISA)¹⁴ suggest that 18% of 15-year-olds experience digital anxiety, feeling nervous when their device is not nearby.

Trends

Between 2018 and 2022, among adolescents aged 11 to 15, the share reporting cyberbullying perpetration rose from 9.2% to 11.6% (a 26% increase) and victimisation from 12.7% to 15.8%. The share showing problematic social media use grew from 7.8% to 10.8%.

Age patterns

By age 10, 71.7% of children across Europe already own a smartphone¹⁵. Digital Screen exposure and associated risks increase with age. Continuous online contact grows progressively through adolescence, while cyberbullying perpetration and victimisation, and problematic social media use, appear most prevalent around age 13^{10,16}.

Sex differences

Girls aged 11 to 15 are disproportionately affected by problematic social media use (14.3% vs 8.6% of boys) and cyberbullying victimisation (16.5% vs 14.8% of boys)¹⁰. Boys are more likely to perpetrate cyberbullying (14.4% vs 8.8% of girls) and report higher levels of online gambling (21.0% vs. 8.7% girls), and gaming-related problems (28.9% vs. 13.4% of girls)⁹.

Risk factors and vulnerable groups

Girls face elevated risk through greater exposure to appearance-related content and social comparison on social media platforms^{10,16}. LGBTQIA+ young people experience higher rates of online harassment and victimisation¹⁷. Young people with pre-existing vulnerabilities, including mental health conditions, learning difficulties, or a history of adverse childhood experiences, are at greater risk of harm from digital exposures.¹⁸

Digital and online services represent an emerging and rapidly growing component of child and adolescent mental health support. By overcoming traditional barriers to access, including cost, geography, stigma, and waiting times, digital tools have the potential to reach young people who might not engage with conventional services, offering support at scale. The evidence base for digital mental health interventions is still developing, but these tools represent an important and expanding component of the support landscape across the countries reviewed.



Good Practices:

- **I Fight Depression (Germany):** a web-based, CBT-based self-help tool for mild-to-moderate depression, integrated into routine care in Germany and available free of charge across multiple countries.
- **Nepanikar App (Czech Republic, available in 18 languages):** provides immediate, accessible support across anxiety, eating disorders, and crisis situations; also delivers courses and training on mental health prevention and contains a directory of contacts to mental health professionals.

Data gaps

The 30 countries reviewed have monitoring systems in place that provide a valuable and growing evidence base on child and adolescent mental health. However, important gaps remain across the five areas outlined below that limit what can currently be monitored and compared.



1. Limited data for younger children.

Most multi-country surveys focus on adolescents from age 11 upwards. Comparable data on the mental health and well-being of children under 10 remain scarce, limiting the ability to identify early risk factors and design preventive approaches across the life course.



2. Limited data on vulnerable groups.

Existing datasets rarely provide comparable data for groups such as refugees, Roma children, LGBTQIA+ young people, or children not in school. Many of these groups face the greatest mental health risks, yet their needs remain less visible in monitoring systems and policy planning.



3. Limited comparability across data sources.

Key indicators, including cyberbullying, screen exposure, and substance use, are defined and measured differently across countries and datasets. This limits cross-country comparison and the ability to track trends over time.



4. Gaps in trend data for emerging risks.

Repeated data over time are available for suicide, substance use, and mental health conditions, but are much more limited for digital screen exposure, online gambling, and newer forms of anxiety.



5. Limited data on severity and co-occurrence.

Most indicators capture whether a condition or a symptom is present, but provide less information on severity, duration, or co-occurrence with other conditions. Anxiety, substance use, self-harm, sleep difficulties, and loneliness may co-occur, yet many datasets examine these domains separately, limiting visibility of children with multiple and overlapping needs.

Factors associated with effective child and adolescent mental health systems

Overall, the 42 good practices reviewed, some of which are highlighted in this factsheet, point to a consistent set of system-level factors associated with effective implementation and sustainability, summarised below.

Policy frameworks and institutional ownership

- Practices embedded within national policy frameworks and supported by stable institutional ownership demonstrate greater reach and sustainability, as illustrated by Ireland's Jigsaw and Denmark's headspace programmes, each anchored in national mental health strategies.
- Where legislative mandates are in place, they provide both an accountability mechanism: Finland's KiVa programme is supported by a legal requirement for schools to implement evidence-based bullying prevention plans, paired with concrete tools to enable compliance.

Intersectoral coordination and workforce capacity

- Coordination across health, education, and social care is a consistent feature of effective approaches: integrated, low-threshold entry points address fragmentation and support continuity of care.
- Extending delivery to teachers, community workers, and trained peers, known as task sharing, broadens reach across all levels of support. Training-of-trainers models embed expertise within institutions, supporting sustainability beyond the initial implementation phase.

- Stigma and practical barriers, including cost, geography, and waiting times limit help-seeking, particularly among those already facing disadvantage. Peer-based approaches such as @ease and Mental Health First Aid extend support into social networks where formal services cannot easily reach; digital tools such as Nepanikar address access barriers for those unable or unwilling to attend in person.

Evidence generation and transferability

- Practices with structured implementation materials, including manuals, training programmes, and fidelity monitoring tools, are better placed for transfer across national and cultural contexts, as demonstrated by programmes such as Incredible Years and Strengthening Families, which provide global technical assistance to support adaptation.
- Building evaluation into programme design from the outset is a feature of well-documented effective practices. Cross-national evaluations such as those for Youth Aware of Mental Health (YAM) across ten countries and Unplugged across a European multi-centre trial demonstrate how academic and institutional partnerships strengthen the evidence base for replication.



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