

# Three in Four: Men, Suicide and Mental Health in the EU

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# About Movember

A little over 20 years ago, a bristly idea was born in Melbourne, Australia, igniting a movement that would cross borders and change the face of men's health. Movember has since united people from all walks of life, sparked billions of conversations, raised vital funds and broken the silence around men's health.

Since 2003, we have challenged the status quo, supported men's health research and changed the way health services reach, respond to and retain men. We have taken on prostate cancer, testicular cancer, mental health and suicide prevention.

Thanks to a global community of supporters, we have raised more than US$1 billion for men's health and funded more than 1,300 men's health projects worldwide. These include hundreds of advances in biomedical research and some of the world's largest prostate cancer registries, built on the experiences of hundreds of thousands of men.

Since taking on mental health and suicide prevention in 2006, Movember has focused on better social connection, earlier recognition of men's mental health problems and improving how clinicians respond to men in distress. We want more men to know what to do when mental health challenges arise, and the people around them to be better prepared to step in.

We advocate for inclusive health systems tailored to the needs of men, women and gender-diverse people from a wide range of cultural backgrounds. By improving men's health, we can have a profoundly positive impact on women, families and society. Healthier men mean a healthier world.

# About the Movember Institute of Men's Health

Building on two decades of investment in men's physical and mental health, the Movember Institute of Men's Health aims to improve the quality of life of millions of men worldwide. By bringing together global experts in men's health, it works to accelerate research and turn it into real-world outcomes.

The Institute aims to raise the profile of men's health with policymakers, so that it is prioritised in proportion to its impact on public health. Its focus areas include men's mental health, suicide prevention, prostate and testicular cancers, and health care that responds to the needs of boys and men, with the aim of addressing the preventable risk factors behind a significant share of male deaths and healthy years of life lost.

To learn more, visit movember.com/movember-institute.

# A note on standing together in gendered health

This report is about the mental health of men in the EU. Making that focus explicit is not a claim that men's health matters more than the health of women, girls, trans and non-binary people. It is the opposite: an argument that gendered health inequity, in every direction, deserves attention, evidence and investment.

Across the EU, men die younger than women, by 5.4 years on average in 2022, while women spend a larger share of their lives with activity limitations (25% of life expectancy, against 20% for men).[1] None of these gaps needs to be traded off against the others.

This report draws on data about men and women together to show where men's outcomes fall short and why. It does not attempt to address the significant and separate work still needed on women's health, or the distinct health needs of trans and non-binary people. We recognise and support the advocates who have spent decades building the evidence base on those issues.

Movember's approach follows the path first cleared by the women's health movement. We aim to stand alongside women's health and LGBTQ+ health advocates across Europe, not in competition with them, in pursuit of health systems that recognise gender, in all its forms, as a driver of health outcomes. There is no binary choice in gendered health, and there does not need to be one in gendered health policy.



# About this report

This snapshot report was written by Clíona Fitzpatrick, Policy and Evidence Director, Movember, and Dr Josh Knight, Epidemiologist, Statistically Speaking. Key contributions from Professor Simon Rice, Chief Impact Officer, Movember.

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# Introduction

*In 2023, almost 37,000 men in the EU died by suicide. That is more than 100 men every day, and three in every four suicides.*

Yet men are less likely than women to say they are struggling, and fewer men get help as a result. This report asks why. It draws on a survey of more than 26,000 people across the EU and on official records of deaths to look at which men get help, which men don't, and where things could change.

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SECTION 01

# Key findings

# Suicide in the EU

**Men account for most deaths by suicide in the EU.** In 2023, there were 48,370 deaths due to suicide in the EU, three in four (76%) of them men. Once age is taken into account, the rate of men's deaths due to suicide is 3.6 times the rate of women's (16.9 against 4.7 per 100,000).

**Suicide affects men at every age, but in different ways.** For young men, it is the leading cause of death between the ages of 20 and 44, and accounts for one in five deaths of men in their twenties.

*Men accounted for three in four deaths due to suicide, and suicide was the leading cause of death for men aged 20–44.*

Middle-aged men account for the largest number of deaths due to suicide: 57% of men's deaths due to suicide are among men aged 30–64.
Older men are at the highest risk: the rate of deaths due to suicide peaks among men aged 85+ (57 per 100,000), and men aged 65+ now account for one in three of men's deaths due to suicide.

**Men's suicide rates vary almost sevenfold across the EU.** They range from 5.0 per 100,000 in Cyprus to 34.2 in Lithuania. The five highest rates are all in Central & Eastern Europe, the region where men who report a problem are least likely to get professional help.

**Progress on men's suicide has stalled**. The rate of men's deaths due to suicide fell by 17% between 2013 and 2023, but almost all of that fall came before 2017. Some countries record many deaths as being of undetermined intent, so official figures are likely to undercount deaths due to suicide in some countries more than others.

# Emotional and psychosocial problems, help and stigma

**Fewer men recognise and report an emotional or psychosocial problem, so fewer men get help.** 39% of men reported an emotional or psychosocial problem, against 52% of women. As a share of all men, only 18% reported an emotional or psychosocial problem and received professional help, against 22% of all women. Evidence from England suggests that, at the same level of symptoms, men are less likely than women to recognise a mental health problem,[2] so many men who need help may not be counted here at all.

**Men who report an emotional or psychosocial problem are slightly more likely than women to receive professional help, but fewer men report one at all.** Among those who reported such a problem, 47% of men received professional help, against 42% of women. This does not mean men are more ready to seek help. Men who report one may be doing so later, when their symptoms are more severe, and evidence from England shows that, at the same level of symptoms, men are less likely than women to consult a GP about a mental health problem.[2]

**Around 37 million men in the EU reported an emotional or psychosocial problem in the past year and received no professional help.** That figure only includes men who recognised and reported such a problem.

**Older men depend on their GP, and many get no help at all.** Men aged 55+ who reported an emotional or psychosocial problem were more than twice as likely to have received help for it from a GP as from a psychologist (22% vs 9.5%). Only a third (32%) of men aged 65+ who reported one received professional help, the lowest of any male age group, against 46–51% of men under 55.

**Where a man lives shapes whether he gets help.** 53% of men who reported an emotional or psychosocial problem in Western Europe received professional help, against 38% in Central & Eastern Europe, where just 3% of men aged 55+ received help from a psychologist.

# 37

million men in the EU reported an emotional or psychosocial problem in the past year and received no professional help.

# 1 in 3

men aged 65+ who reported an emotional or psychosocial problem received professional help, against around half of men under 55.

**Men who go without professional help prefer different kinds of support.** They are more likely than men who received help to favour physical activity (47% vs 36%) and talking to people close to them (40% vs 26%), and less likely to choose counselling or therapy (31% vs 47%).

**Men are more likely than women to see physical activity as key to good mental health (38% vs 29%), regardless of whether they reported an emotional or psychosocial problem.** Among people who reported one, women clearly favour counselling or therapy as the most effective solution (45%, compared to 35% for physical activity), while men rate physical activity and counselling/therapy about equally (42% and 39%).

**More than four in ten men (44%) say mental health issues are perceived as not curable in their country.** This rises to half (50%) of men who reported an emotional or psychosocial problem, against 41% of men who did not report one.

**Perceptions of mental health vary by country.** Six in ten people in Italy and Spain say mental health issues are perceived as not curable, more than twice the share in Sweden (27%). Because this measures what people think others believe rather than their own view, it describes the climate in which men decide whether to seek help, and men themselves link seeking help with the risk of being seen as weak or "unmanly".[3] In Ireland, the public saw stigma around seeking help as the biggest barrier to men getting support for their mental and physical health.[4]



SECTION 02

# Data sources and approach

This briefing combines new analysis of Flash Eurobarometer 530 with Eurostat statistics and peer-reviewed research on men's mental health and help-seeking.

**Flash Eurobarometer 530.** The survey was carried out online by Ipsos for the European Commission between 14 and 21 June 2023, with 26,492 people aged 15+ in the 27 EU countries: about 1,000 per country, and 500 in Cyprus, Luxembourg and Malta.[5] Of these, 25,684 agreed to answer the questions about their own mental health, and 12,680 reported an emotional or psychosocial problem in the past 12 months. This briefing uses the respondent-level data file rather than the published tables, so results for men can be broken down by age group, by region and by whether they reported an emotional or psychosocial problem. The published tables do not include these breakdowns.[6] Figures are weighted to the EU population, and ranges in the notes are 95% intervals.

Who the findings on help describe. Questions on professional help and on what works were asked only of people who reported an emotional or psychosocial problem. These findings therefore describe men who recognised such a problem and were willing to report it, not men who did not. At the same level of symptoms, men in England were less likely than women to believe they had a common mental disorder,[2] so the men in these figures are unlikely to be all the men who need help.

Differences between EU countries. The 27 EU countries differ in their health systems and in the social and cultural norms that shape how people think about mental health, masculinity and asking for help, and these differences show up in health outcomes. A 2025 study of more than 257,000 adults in 27 European countries found that differences between men and women in their use of health services varied considerably from country to country, and that across the population as a whole, men made less use of psychological care.[7] An EU-wide average can therefore hide very different pictures in different countries, and the findings in this report should be read with that in mind.

Other evidence. Population, life expectancy and suicide figures come from Eurostat.[1,8,9,10,11,12,13] To help interpret the results, the briefing draws on peer-reviewed studies from England, the Netherlands and across Europe,[2,7,14,15,16] and on four reviews of the literature.[3,17,18,19] Movember's 2025 report on men's health in Ireland adds the view from primary care, through a survey of 80 Irish GPs about their male patients, and from nationally representative polling of the Irish public.[4] The survey shows associations, not causes, so explanations drawn from this literature are presented as possible explanations rather than conclusions.

*In June 2023, more than 26,000 people aged 15 and over across all 27 EU countries took part in a mental health survey. Nearly 12,700 said they had experienced an emotional or psychosocial problem in the previous 12 months.*



*Behind every number in this section is a man, and a family and community who lost him.*

**SECTION 03**

# Suicide in the EU

If anything in this report affects you, support is available. In some EU countries you can call 116 123, the EU number for emotional support. Wherever you are, find a helpline at movember.com/mens-health/get-support

This section is based on official death records from Eurostat. It shows how many men in the EU die by suicide, at what ages and in which countries, and how this has changed since 2013.

## GENERAL

In 2023, there were 48,370 deaths due to suicide in the EU, **three in four** (76%) of them men.

36,952 men and 11,418 women, 1.0% of all deaths. Deaths of EU residents recorded as intentional self-harm.[9,13] In 2013 there were 54,644 (77.3% men).

## GENDER

Once age is taken into account, the rate of deaths due to suicide among men is 3.6 times the rate among women: 16.9 against 4.7 per 100,000.

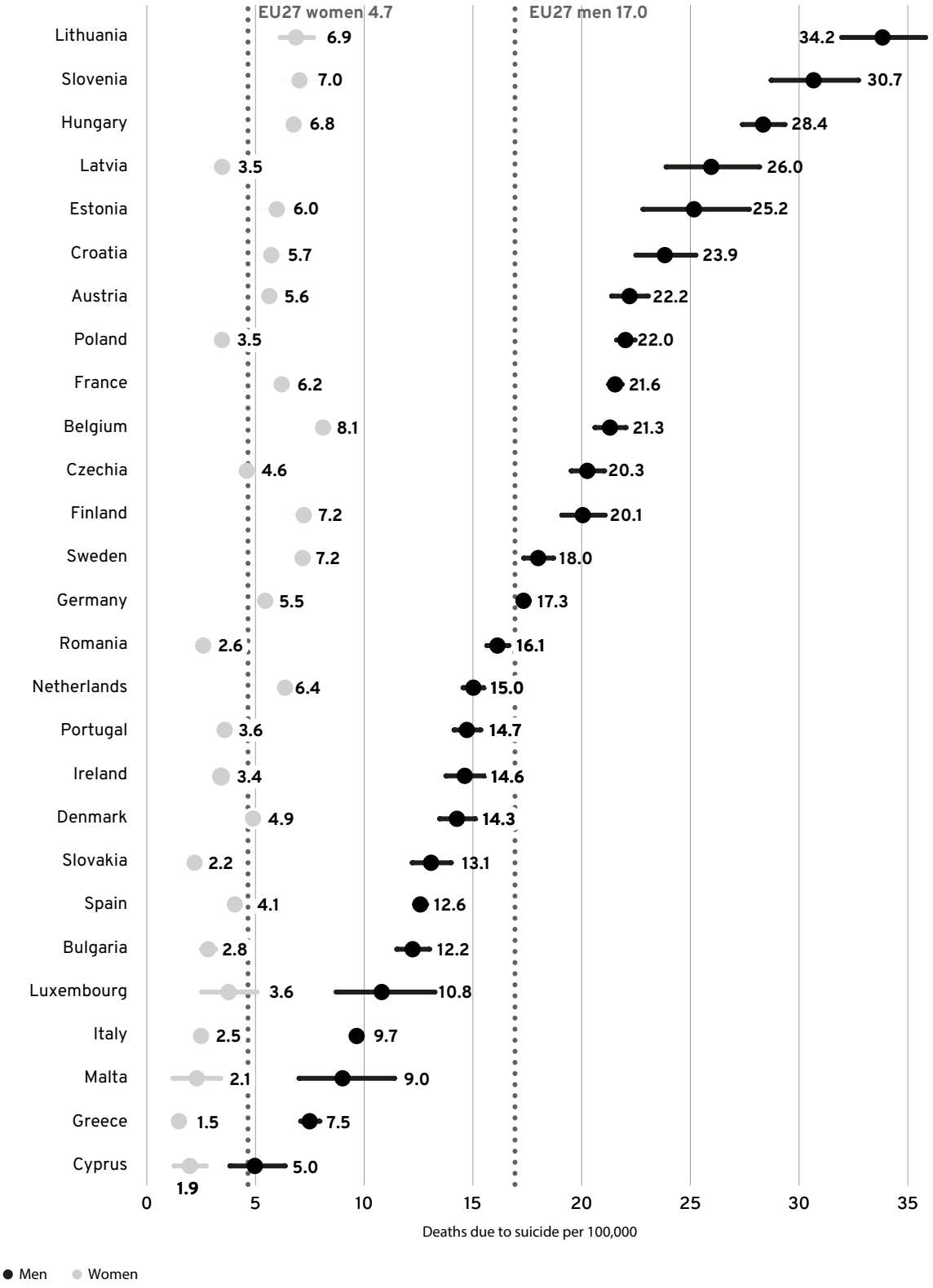
Age-standardised rates, 2023: men 16.9 (16.7–17.0), women 4.7 (4.6–4.7), all people 10.4.[9,10,20] The gap is widest in Latvia, Poland and Romania, where men's rate is more than six times women's, and narrowest in the Netherlands and Sweden (about 2.4 and 2.5 times; 2021–2023).

# 3.6

Men's age-adjusted suicide rate in the EU is 3.6 times women's: 16.9 vs 4.7 per 100,000.



**SUICIDE RATE BY COUNTRY, MEN AND WOMEN, 2021–2023**
AGE-STANDARDISED SUICIDE RATE PER 100,000; LINES SHOW 95% RANGES; COUNTRIES ORDERED BY MEN'S RATE




Eurostat hlth_cd_aro and demo_pjan; 2013 European Standard Population; 2021 to 2023 combined. Dashed lines: EU27 men and women.

Age-standardised to the 2013 European Standard Population, 2021–2023 combined so that small countries have enough deaths for a stable rate; lines show 95% ranges. Countries are ordered by men's rate. EU27: men 17.0, women 4.7. Recorded deaths due to suicide only.[9,10,20]

## AGE

Suicide is the leading cause of death for men aged 20–44 in the EU, and accounts for one in five deaths of men in their twenties.

In 2023, suicide accounted for 21% of deaths of men aged 20–29.9 It is the second most common cause of death for men aged 15–19 (after transport accidents) and 45–49 (after ischaemic heart disease).

The pattern is the same in most countries. In 2021–2023, suicide was the leading cause of death for men aged 15–29 in 15 of the 27 countries, and for men aged 30–44 in 19. Where it was not, transport accidents usually came first. This ranking counts each type of injury as a separate cause, as WHO and ONS do.21 22 If all accidents are counted together, they come first and suicide second for men aged [15–29 / 15–44] (see Methods and caveats).

The rate of men's deaths due to suicide generally rises with age and is highest among men aged 85+, but most deaths due to suicide among men (57%) are at ages 30–64.

### READING THE AGE FIGURES: YOUNG, MIDDLE-AGED AND OLDER MEN

The figures on deaths due to suicide for men of different ages can seem to contradict each other. They don't. They answer three different questions, and each answer matters for prevention.

**Young men: suicide is the leading cause of death.** Few young men die of anything, so suicide makes up a large share of the deaths that do happen. It is the leading cause of death for men aged 20–44 and accounts for one in five deaths of men in their twenties, even though young men's suicide rate is lower than older men's (8 per 100,000 at ages 15–24).

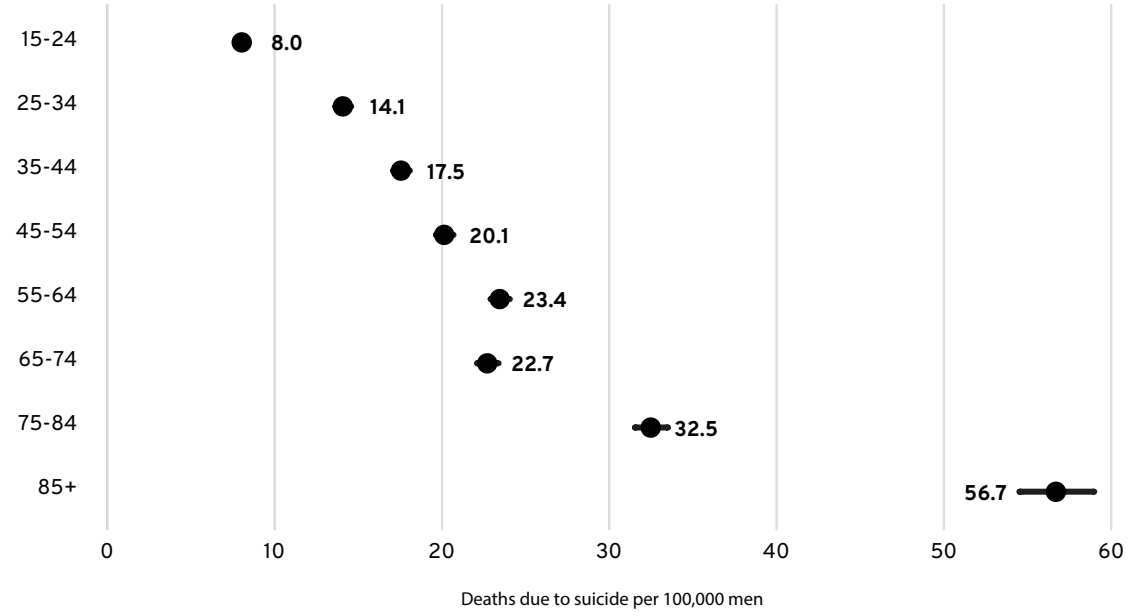
**Middle-aged men: the largest number of deaths due to suicide.** There are far more men in their thirties to early sixties than there are very old men, so this is where most suicides happen: 57% of men's suicides are at ages 30–64. It is often a stage of life when pressures pile up at once: work, money, relationships, and caring for children and ageing parents.

**Older men: the highest risk.** The chance of death due to suicide for any one man rises with age and is highest among men aged 85 and over (57 per 100,000). Because older men die of many other causes, mainly long-term illness, suicide is a small share of their deaths, which makes it easy to overlook. And as the population ages, the number of suicides among men aged 65+ is rising even though their rate has fallen.

Put simply: suicide is a leading cause of death among young men, most suicides are among middle-aged men, and older men are at the highest risk.

**SUICIDE RATE BY AGE, MEN, EU, 2023**

DEATHS DUE TO SUICIDE PER 100,000 MEN, BY AGE; LINES SHOW 95% RANGES




Crude rates (deaths per 100,000 men in each age group), EU residents, 2023, with 95% ranges.[9,10]

# 57%

of man suicide deaths occur among men aged 30–64, a life stage when pressures around work, finances, relationships and caring responsibilities can converge.

## GEOGRAPHY

Men account for 82% of deaths due to suicide in Central & Eastern Europe, 77% in Southern, 74% in Western and 72% in Northern Europe.

2021–2023, deaths of EU residents recorded as intentional self-harm.[9] Regions follow the EuroVoc grouping used throughout this report.[23]

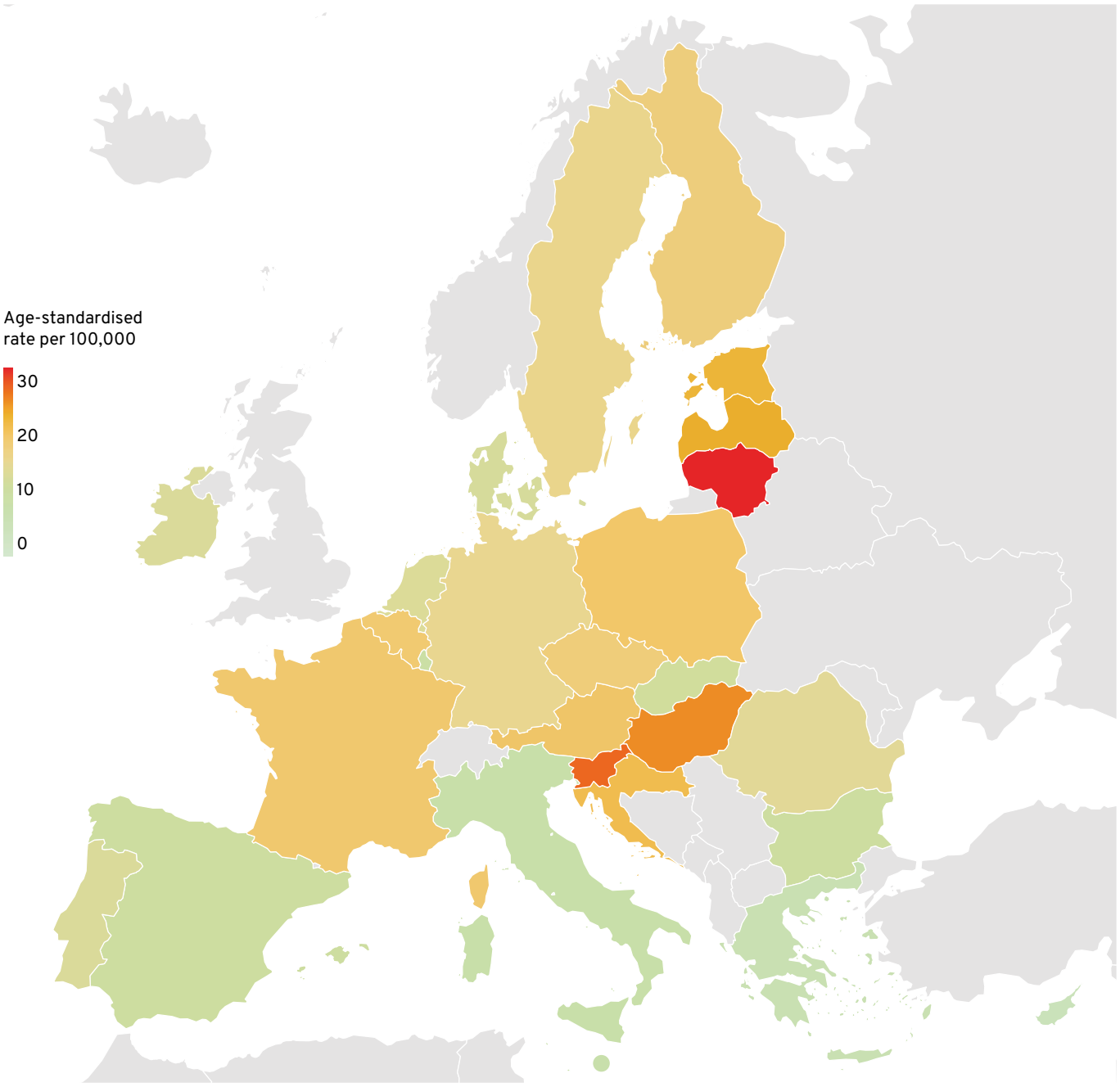
Men account for 69% of deaths due to suicide in the Netherlands, but 85% in Poland.

2021–2023. The share depends on women's rates as well as men's: Belgium, Finland and Sweden, where women's rates are among the highest in the EU (7–8 per 100,000 women), have some of the lowest shares.[9,10]

*Rates of men's deaths due to suicide vary almost sevenfold between EU countries, from 5.0 per 100,000 in Cyprus to 34.2 in Lithuania, and the five highest are all in Central & Eastern Europe. Men account for 69% of deaths due to suicide in the Netherlands, but 85% in Poland. The share depends on women's rates as well as men's: Belgium, Finland and Sweden, where women's rates are among the highest in the EU (7–8 per 100,000 women), have some of the lowest shares.*

Age-standardised, 2021–2023: Lithuania 34.2 (32.4–36.2), Slovenia 30.7, Hungary 28.4, Latvia 26.0, Estonia 25.2; lowest Cyprus 5.0 (3.8–6.4), Greece 7.5, Malta 9.0, Italy 9.7. By region: Central & Eastern 21.0, Western 19.0, Northern 17.5, Southern 10.9.[9,10,20]

**MEN'S SUICIDE RATE BY COUNTRY, 2021–2023**
AGE-STANDARDISED SUICIDE RATE PER 100,000 MEN




Age-standardised to the 2013 European Standard Population, 2021–2023 combined; the colour scale runs from 0 to the highest rate (Lithuania, 34.2). EU countries only; other countries in grey. Malta is shown with a marker.[9,10,20]
© EuroGeographics for the administrative boundaries.[24]

# TRENDS

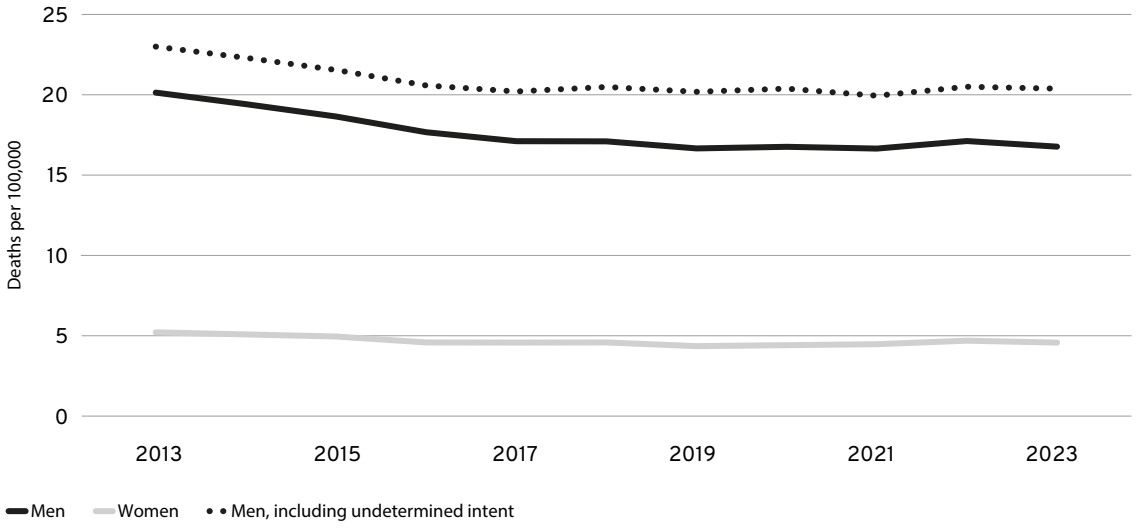
The rate of men's deaths due to suicide fell by 17% between 2013 and 2023, but almost all of that fall came before 2017.

Age-standardised: 20.2 per 100,000 men in 2013, 17.2 in 2017, 16.9 in 2023; women 5.3 to 4.7 (−12%).[9,10,20] The share of deaths due to suicide that were among men barely changed (77% to 76%). The largest falls were in Lithuania (−49%), Romania (−31%) and Poland (−26%); Sweden (no change), Malta (−2%) and Spain (−4%) changed least.[11] The recorded falls in Slovakia (−47%) and Bulgaria (−35%) potentially reflect more deaths being recorded as of undetermined intent; counting those deaths as well, men's fall across the EU is 11%.

Although the rate of deaths due to suicide among men aged 65+ fell between 2013 and 2023, the actual number of deaths due to suicide rose in this cohort due to an ageing population. Men aged 65+ now account for one in three deaths due to suicide among men.

11,313 deaths due to suicide in 2013 and 12,327 in 2023 (+9%), while the number of men aged 65+ grew by 21% and their rate fell by 10% (32.8 to 29.6 per 100,000).[9,10] Rates fell least among the oldest men: by 13% at 65–74 and 8% at 75+, against 23% at 45–64 and 19% at 15–29. Men aged 65+ made up 27% of deaths due to suicide among men in 2013 and 33% in 2023.

**SUICIDE RATE IN THE EU, 2013–2023**
AGE-STANDARDISED SUICIDE RATE PER 100,000




Deaths of EU residents, age-standardised to the 2013 European Standard Population (Eurostat hlth_d_aro, demo_pjan).
The dashed line adds deaths of undetermined intent (ICD-10 Y10-Y34, Y87.2) to men's deaths due to suicide.

Deaths of EU residents per 100,000, age-standardised to the 2013 European Standard Population.[9,10,20] The dashed line adds deaths of undetermined intent (ICD-10 Y10–Y34, Y87.[2]) to men's deaths due to suicide. The series starts in 2013, the first year with complete population data by age for all 27 countries.

Countries differ widely in how many deaths they record as of undetermined intent, so recorded rates of deaths due to suicide are likely to understate deaths due to suicide in some countries more than in others.

In 2021–2023 the EU recorded 22 deaths of undetermined intent for every 100 deaths due to suicide; Slovakia recorded 217, Bulgaria 81 and Latvia 62, while Italy, Cyprus, Spain, Ireland, Malta, the Netherlands and Slovenia recorded fewer than 5.[9] In Slovakia, men's recorded suicide rate fell by 47% between 2013 and 2023 while their rate of undetermined-intent deaths more than tripled.[11] In 2021–2023 Slovakia ranked 20th of 27 countries for men's recorded suicide rate, but 2nd once these deaths are included. Across the EU, adding these deaths raises men's rate in 2023 from 16.9 to 20.5 per 100,000 (see the dashed line in the chart above). WHO's estimates for 2023, which adjust for under-reporting and ill-defined causes, are 10–45% above recorded rates for men in 12 countries, highest in Luxembourg, Slovakia and Bulgaria, and 20% below them in Ireland.[25] Not all deaths of undetermined intent are suicides, so these figures show where recording may differ, not corrected rates.[26]

**POLICY QUESTION: WHY HAS PROGRESS STALLED, AND WHAT IS MISSING?**

Most of the fall in men's suicide rate came before 2017, and it has barely moved since. EU countries have committed to the World Health Organization target of cutting suicide rates by a third from 2015 levels by 2030.[27] On the current trend, men's rates are a long way from that goal. By 2023 men's rate had fallen 10% from its 2015 level (18.8 to 16.9 per 100,000), against the 33% the target requires.[11,27] Since 2017 the rate has fallen by 0.3% a year; at that pace it would be about 16.5 per 100,000 in 2030, against the target of 12.5. **Reaching the target would need a fall of 4.2% a year between 2024 and 2030, more than ten times the pace of the most recent trend** (see tables A1 and A2 in the appendix).

At EU level, the main framework is the European Commission's 2023 comprehensive approach to mental health, with 20 flagship initiatives and €1.23 billion in funding, including a European depression and suicide prevention initiative. It calls for gender-sensitive prevention, but the groups it singles out for targeted support are children and young people, older people, migrants and people in difficult economic or social situations. **Men, who account for three in four deaths due to suicide, are not named as a group in their own right.**[28]

The approach is also time-limited. Its flagship initiatives were tied to the current EU budget cycle, several have already ended, including the depression and suicide prevention initiative, and no successors had been announced by April 2026.[29]

This raises three questions for policymakers.

Should the next phase of EU mental health policy set an updated, quantifiable goal for reducing rates of men's deaths due to suicide up to and beyond 2030?

How can EU funding and shared learning between countries help equip primary care, and the other services men at risk come into contact with, to recognise and respond to them?

And how can countries record deaths of undetermined intent more consistently, for example through Eurostat's quality guidance on cause-of-death statistics, so that progress can be measured fairly?



SECTION 04

# Emotional and psychosocial problems, professional help and stigma

This section draws on a different source from the Suicide in the EU section. It is based on Flash Eurobarometer 530, a 2023 survey in which people described their own mental health and whether they had received help for it. It measures what people recognise and are willing to report, not diagnosed illness or deaths.

## GENERAL

How many people report an emotional or psychosocial problem, and how many of them receive professional help.

Almost two in five men aged 15+ in the EU (39%) reported an emotional or psychosocial problem in the past 12 months, and fewer than half of those (47%) received professional help.

Reported an emotional/psychosocial problem 38.6% (37–40). Of those, 46.5% (44–49) received professional help and 51.5% (49–54) did not. As a share of all men aged 15+, 18.0% (17–19) reported one and received help.

Scaled to the EU, around 37 million men reported an emotional or psychosocial problem in the past year and did not receive professional help, nearly 12 million of them aged 55+.

Weighted shares applied to the 2023 population by sex and age.[8] Women: about 57 million. The figure for men should be read as a minimum: it counts only men who reported an emotional or psychosocial problem in the survey, and evidence from England suggests that, at the same level of symptoms, men are less likely than women to recognise a mental health problem.[2]

### EU OVERVIEW

| | All aged 15+ | | |
|---|---|---|---|
| **Group** | Reported a problem (%) | n reported a problem | Reported a problem and received help (%) |
| **ALL** | 45.8 | 12,680 | 20.1 |
| **Men** | 38.6 | 5,051 | 18.0 |
| **Women** | 52.4 | 7,574 | 22.1 |

| | Those who reported an emotional/psychosocial problem | | | | |
|---|---|---|---|---|---|
| **Group** | Received professional help (%) | n received help | Saw a GP (%) | Saw a psychologist (%) | Saw any mental health specialist (%) |
| **ALL** | 43.9 | 5,024 | 18.5 | 13.6 | 28.7 |
| **Men** | 46.5 | 2,005 | 18.0 | 14.2 | 31.4 |
| **Women** | 42.2 | 2,995 | 19.1 | 13.2 | 26.9 |

Under "All aged 15+", percentages are shares of everyone who answered the sensitive questions, and n reported a problem is the number of survey respondents who reported an emotional/psychosocial problem. Under "Those who reported an emotional/psychosocial problem", percentages are shares of people who reported one: for example, 43.9% of the 45.8% who reported one received professional help, which is 20.1% of all people aged 15+; n received help is the number of survey respondents who received it. The n columns are unweighted counts and the percentages are weighted to the EU population, so dividing one count by another will not reproduce the percentages. Most of the remainder did not receive professional help (54.1% of those who reported one);

about 2% answered “don’t know” or preferred not to say. People who reported an emotional/psychosocial problem but did not receive professional help: about 37 million men and 57 million women.

Received professional help = named at least one of eight professionals (GP, psychiatrist, psychologist, psychotherapist, psychoanalyst, pharmacist, nurse or social worker). Saw any mental health specialist = named at least one of the four specialists among them (psychiatrist, psychologist, psychotherapist or psychoanalyst), so it is always the smaller figure; the gap is people whose help came only from a GP, pharmacist, nurse or social worker.

## GENDER

Men report an emotional or psychosocial problem less often than women, so fewer men overall receive professional help. Men who do report one are slightly more likely than women to receive it, and men and women differ in what they think works.

Men are a quarter less likely than women to report an emotional or psychosocial problem (39% vs 52%), yet men account for three in four suicides in the EU.

Emotional/psychosocial problems 38.6% (37–40) vs 52.4% (51–54). Suicides among EU residents: 36,952 of 48,370 in 2023.[9]

Men who report an emotional or psychosocial problem are slightly more likely than women to receive professional help (47% vs 42%), but fewer men report one at all, so overall a smaller percentage of men received professional help compared to women (18% vs 22%).

Among those who reported an emotional/psychosocial problem: 46.5% (44–49) vs 42.2% (40–44), a significant gap. As % of all men and women aged 15+: 18.0% (17–19) vs 22.1% (21–23).

Men are more likely than women to see physical activity as key to good mental health (38% vs 29%). Among people who reported an emotional or psychosocial problem in the last 12 months, women favour counselling or therapy as the most effective solution, while men rate physical activity and counselling/therapy about equally.

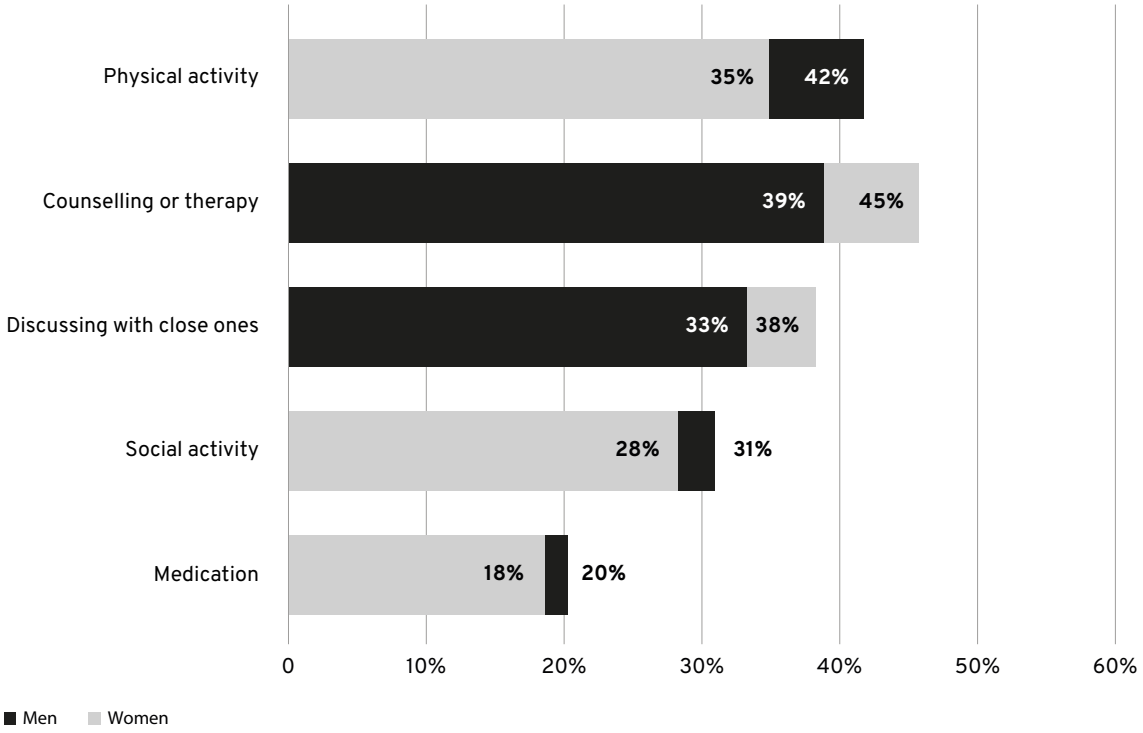
Physical activity as a main contributor to good mental health (asked of everyone): among those who reported an emotional/psychosocial problem, men 37% vs women 29%; among those who did not, 40% vs 29%. The gap is slightly smaller among people who reported one (8 vs 11 points), though not significantly. Most effective solution (asked only of people who reported one): women counselling 46% vs physical activity 35%; men 39% vs 42%. Within men the 3-point difference is not significant; within women counselling leads by 11 points (8–14).

### CONTEXT

These figures come from a single self-report question about “emotional or psychosocial problems, such as feeling depressed or feeling anxious”. It records what people recognise and are willing to report, not diagnosed illness. Based on this data and other literature, men appear less likely to recognise and/or disclose such problems. In England, for people at the same interviewer-measured level of symptoms (i.e. similar assessed level), men had about 40% lower odds than women of believing they had a common mental disorder (adjusted odds ratio 0.60), and about 46% lower odds of having been diagnosed by a professional (0.54).[2] Part of the difference between men and women is therefore likely to reflect reporting and perception rather than experience.

**WHAT WORKS, MEN VS WOMEN**

Share naming each solution as most effective, among people who reported an emotional or psychosocial problem in the past 12 months




Flash Eurobarometer 530, June 2023; up to two answers. Weighted.
Men who reported a problem n = 5,051, women n = 7,574.

Most effective solution: Q17, up to two answers. Main contributors to good mental health: Q3, up to three answers. Gender gaps for counselling, physical activity and discussing with close ones are statistically significant.

# 39%

of men reported an emotional or psychosocial problem in the past 12 months, compared with 52% of women.

## AGE

Among men who reported an emotional or psychosocial problem, what they see as most effective, and whether and where they get help, changes with age.

The preferred solution for men changes with age group. Among men who reported an emotional or psychosocial problem, those aged 15–24 are the most likely to name discussing with close ones (41%), men aged 40–54 favour physical activity (46%), and men aged 55+ are the most likely to choose counselling or therapy (45%) and medication (25%).

Men 15–24 vs 25+: discussing with close ones 10 points higher (3–16), medication 8 points lower (3–13). Men 40–54: physical activity 46% vs counselling 35%, a 10-point gap (3–17). Men 55+ vs under 55: counselling 9 points higher (4–15), medication 6 points higher (2–11).

**WHY MIGHT THIS BE?**

**Young men (15–24)** may have less routine contact with health services than older men, which would make friends and family their most familiar source of support. These are also the years when habits around asking for help, and attitudes to mental health, take shape and often stick.

**Men aged 40–54** are often at the point in life when pressures converge: peak demands at work, financial responsibilities, and caring for children and ageing parents. Physical activity is something men can do on their own terms, without seeing a professional, so it may be the more familiar way of managing stress at this age.

**Men aged 55+** are the group most likely to see a GP, and the GP is a common route to both medication and referral for counselling. Older men who have been offered these treatments may be more likely to name them as what works. This is the same pattern seen among men who received professional help. For men nearing or past retirement, leaving work can also mean losing the main source of social contact in their lives, and a regular route into care.

# 40–54

For many men, work, financial responsibilities and caring for children and ageing parents can converge at this stage of life. Physical activity may feel like a familiar way to manage stress.

Just 1 in 10 men aged 55+ who reported an emotional or psychosocial problem saw a psychologist, about half the rate of men under 40.

9.5% (7–12) vs 17–18% for men aged 15–24 and 25–39.

Older men who report an emotional or psychosocial problem are more than twice as likely to have received help from a GP as from a psychologist: 22% received help from a GP, against 9.5% from a psychologist.

GP 21.7% (18–26). For men of all ages the gap is small: GP 18%, psychologist 14%.

Only a third of men aged 65+ who reported an emotional or psychosocial problem received professional help.

32.4% (27–38), the lowest of any male age group. Women 65+: 35.8%.



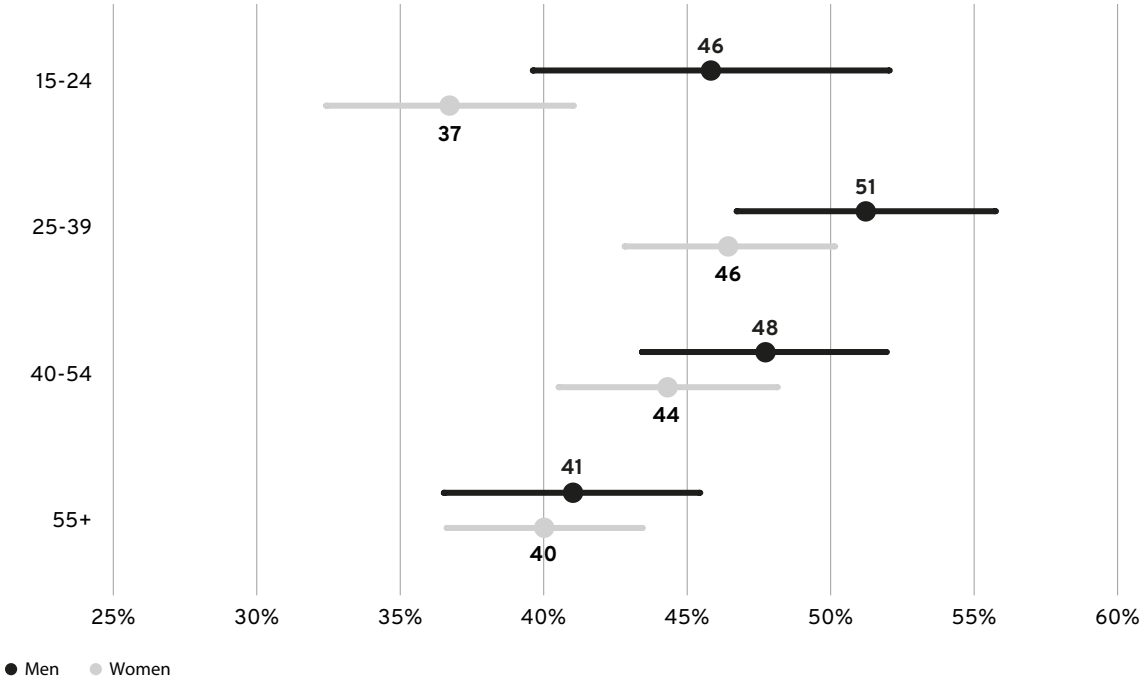
## WHY THIS MATTERS

Primary care is where men at risk are most likely to be seen. A review of 44 studies found that, on average, 80% of people who died by suicide had been in contact with primary care in the year before.[17]

GPs themselves report gaps in confidence. In a Movember survey of 80 GPs in Ireland, only 14% said they were very confident working with men showing suicidal behaviour, and 24% were not that confident. GPs named time constraints and men's reluctance to discuss mental health as major barriers, and called for more gender-specific training for staff.[4]

**RECEIVED PROFESSIONAL HELP, AMONG PEOPLE WHO REPORTED AN EMOTIONAL/ PSYCHOSOCIAL PROBLEM, BY AGE**

THESE RATES ONLY COVER PEOPLE WHO REPORTED AN EMOTIONAL OR PSYCHOSOCIAL PROBLEM. MEN REPORT SUCH PROBLEMS LESS OFTEN, SO A HIGHER RATE FOR MEN HERE DOES NOT MEAN MORE MEN OVERALL RECEIVED PROFESSIONAL HELP: 18% OF ALL MEN AGED 15+ DID, AGAINST 22% OF ALL WOMEN.




Flash Eurobarometer 530, June 2023. People who reported an emotional or psychosocial problem in the past 12 months and named at least one of eight listed professionals. Weighted; lines show 95% ranges.

% of people who reported emotional or psychosocial problems in the past 12 months and named at least one of eight listed professionals (GP, psychiatrist, psychologist, psychotherapist, psychoanalyst, pharmacist, nurse or social worker). The 1–4% who preferred not to say or did not know are kept in the base, so they lower the rate; they are not counted in the "did not receive professional help" group used elsewhere in this report.

**PROFESSIONAL HELP BY AGE**

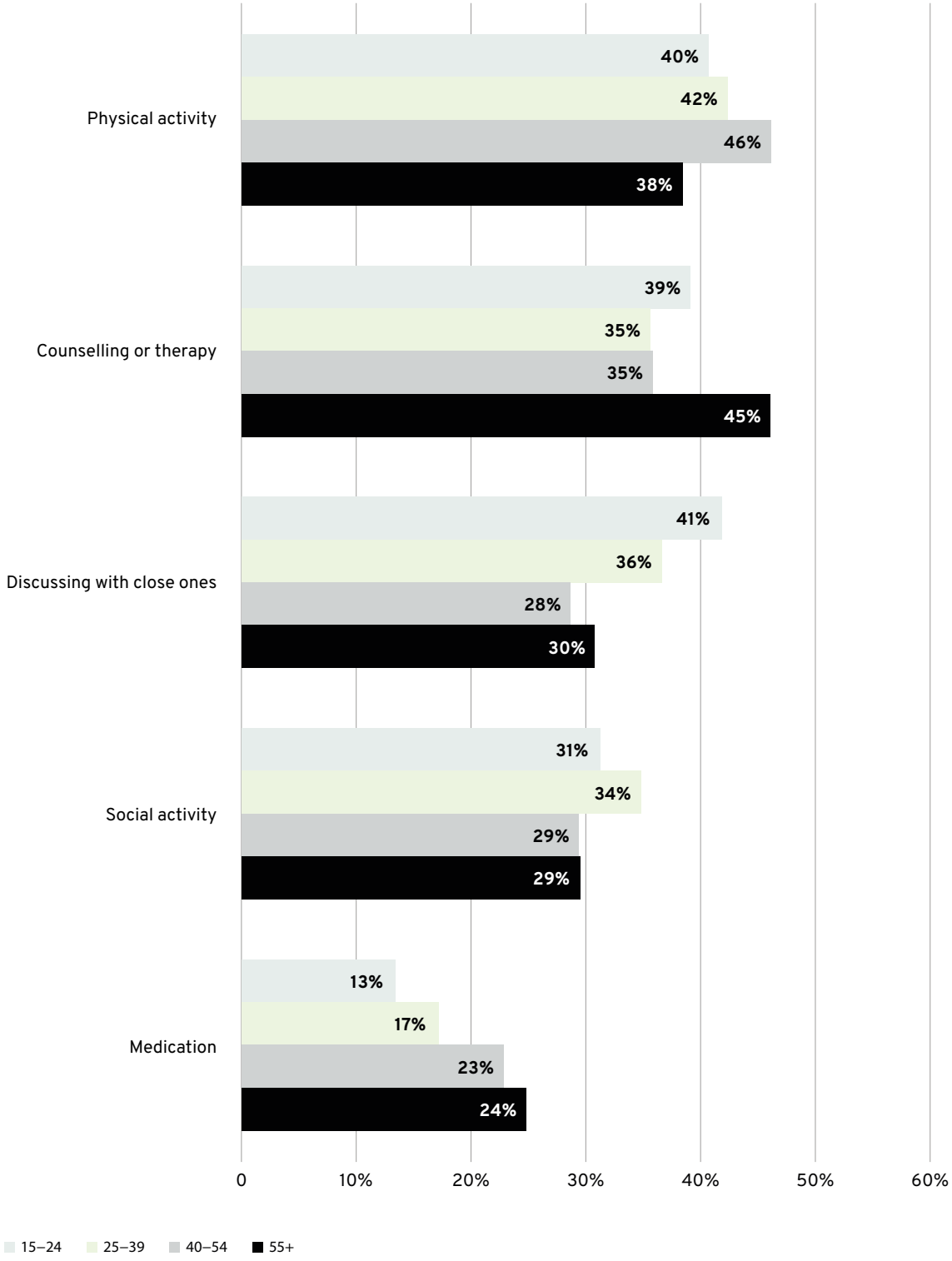
| | All aged 15+ | | Those who reported an emotional/psychosocial problem | | | | |
|---|---|---|---|---|---|---|---|
| **GROUP** | Reported a problem (%) | n reported a problem | Received professional help (%) | n received help | Saw a GP (%) | Saw a psychologist (%) | Saw any mental health specialist (%) |
| **Men 15–24** | 47.8 | 710 | 45.8 | 301 | 11.0 | 17.8 | 35.7 |
| **Women 15–24** | 69.4 | 1,245 | 36.7 | 473 | 13.3 | 20.4 | 28.2 |
| **Men 25–39** | 47.7 | 1,442 | 51.2 | 607 | 16.8 | 17.1 | 36.4 |
| **Women 25–39** | 63.4 | 2,228 | 46.4 | 890 | 17.9 | 18.6 | 34.1 |
| **Men 40–54** | 41.7 | 1,508 | 47.7 | 607 | 19.3 | 14.0 | 31.5 |
| **Women 40–54** | 55.2 | 1,904 | 44.3 | 774 | 21.6 | 12.2 | 26.5 |
| **Men 55+** | 28.3 | 1,391 | 41.0 | 490 | 21.7 | 9.5 | 24.2 |
| **Women 55+** | 41.0 | 2,197 | 40.0 | 858 | 20.6 | 6.7 | 21.2 |
| **Men 65+** | 22.3 | 665 | 32.4 | 217 | 19.0 | 6.3 | 16.3 |
| **Women 65+** | 37.8 | 1,175 | 35.8 | 428 | 20.3 | 5.6 | 16.5 |

"Reported a problem" is the share of everyone aged 15+ in each group, and n reported a problem is the number of survey respondents who reported an emotional/psychosocial problem; the other percentages are shares of those who reported one, and n received help is the number who received professional help. The n columns are unweighted counts and the percentages are weighted, so dividing one count by another will not reproduce the percentages. People could name more than one professional. The rows for men and women of all ages are in the EU overview table above.

Received professional help = named at least one of eight professionals (GP, psychiatrist, psychologist, psychotherapist, psychoanalyst, pharmacist, nurse or social worker). Saw any mental health specialist = named at least one of the four specialists among them (psychiatrist, psychologist, psychotherapist or psychoanalyst), so it is always the smaller figure; the gap is people whose help came only from a GP, pharmacist, nurse or social worker.

## WHAT WORKS, MEN BY AGE

Share of men naming each solution as most effective, among men who reported an emotional or psychosocial problem in the past 12 months




Flash Eurobarometer 530, June 2023; up to two answers. Weighted.
Men who reported a problem: n = 710 (15-24), 1442 (25-39), 1508 (40-54), 1391 (55+).

% of men who reported an emotional/psychosocial problem naming each solution as most effective for them personally (Q17, up to two answers).

# GEOGRAPHY

How often men report an emotional or psychosocial problem, and whether and from whom they receive professional help, differs across Europe.

Men in Western Europe are the least likely to report an emotional or psychosocial problem (34%), compared with 41% in Northern and Southern Europe and 44% in Central & Eastern Europe. However, Western European men who do report one are the most likely to receive professional help.

Reported an emotional/psychosocial problem: Western 33.8% (31–36), Northern 41.1% (38–44), Southern 41.4% (39–44), Central & Eastern 43.9% (42–46); Central & Eastern is 10 points higher than Western (7–13). By country, the share of men reporting one ranges from 29% in the Netherlands to 63% in Lithuania; each country figure is based on about 250–540 men, so country ranges are wide (about ±5 points).

Whether a man who reports an emotional or psychosocial problem receives professional help varies widely by geography. More than half (53%) of men who report one in Western Europe receive professional help, compared with 38% in Central & Eastern Europe.

53.3% (49–58) vs 37.9% (35–41). Northern 43%, Southern 46%.

In Central & Eastern Europe, just 3% of men aged 55+ who reported an emotional or psychosocial problem received help from a psychologist.

2.6% (1–4), based on 622 men aged 55+ who reported an emotional/psychosocial problem. Western Europe: 13.0%; Northern 7.3%; Southern 10.6%.

**REPORTING AN EMOTIONAL/PSYCHOSOCIAL PROBLEM, BY REGION**

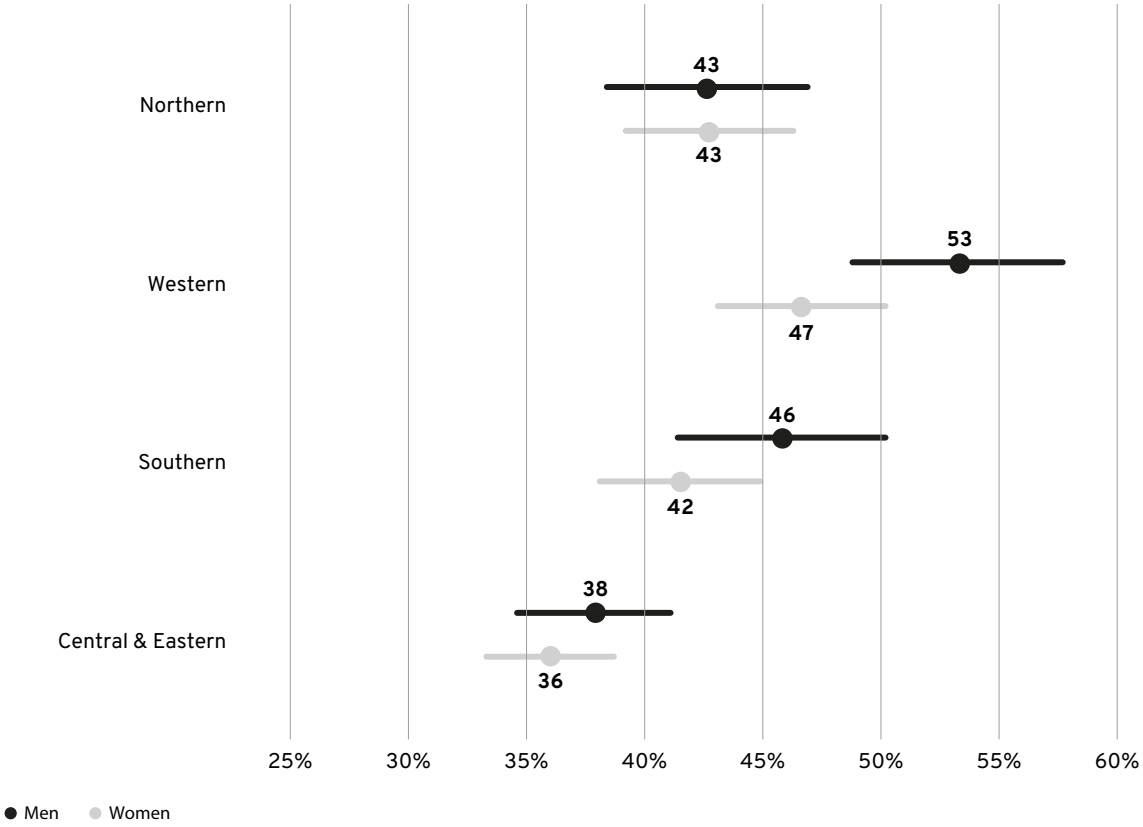
| GROUP | Reported a problem (% of all) | n reported a problem |
|---|---|---|
| **Men, Northern** | 41.1 | 573 |
| **Women, Northern** | 53.7 | 799 |
| **Men, Western** | 33.8 | 1,117 |
| **Women, Western** | 46.8 | 1,714 |
| **Men, Southern** | 41.4 | 1,090 |
| **Women, Southern** | 58.0 | 1,737 |
| **Men, Central & Eastern** | 43.9 | 2,271 |
| **Women, Central & Eastern** | 55.2 | 3,324 |

| MEN 55+ BY REGION | | |
|---|---|---|
| **Northern*** | 22.3 | 135 |
| **Western** | 25.8 | 316 |
| **Southern** | 29.2 | 318 |
| **Central & Eastern** | 33.7 | 622 |

Reported a problem: % of all men or women aged 15+ who answered the sensitive questions. n reported a problem: number of survey respondents who reported an emotional/psychosocial problem, the base for the chart and table below.

* Small sample: fewer than 150 people who reported an emotional/psychosocial problem (Northern Europe, men aged 55+: 135 people). Figures for this group are less precise; for example, 29.8% received professional help, with a 95% range of 22–38%.

## RECEIVED PROFESSIONAL HELP, AMONG PEOPLE WHO REPORTED AN EMOTIONAL/ PSYCHOSOCIAL PROBLEM, BY REGION




Flash Eurobarometer 530, June 2023. People who reported an emotional or psychosocial problem in the past 12 months and named at least one of eight listed professionals. Weighted; lines show 95% ranges.

Same measure as the age chart: % of people who reported an emotional/psychosocial problem and named at least one professional.

**PROFESSIONAL HELP BY REGION**

| GROUP | Received professional help | Saw a GP | Saw a psychologist | Saw any mental health specialist |
|---|---|---|---|---|
| **Men, Northern** | 42.6 | 18.0 | 15.7 | 29.8 |
| **Women, Northern** | 42.7 | 17.7 | 17.4 | 29.9 |
| **Men, Western** | 53.3 | 21.6 | 14.7 | 35.6 |
| **Women, Western** | 46.6 | 25.6 | 14.0 | 27.9 |
| **Men, Southern** | 45.8 | 17.3 | 17.4 | 32.1 |
| **Women, Southern** | 41.5 | 16.8 | 14.5 | 26.6 |
| **Men, Central & Eastern** | 37.9 | 13.3 | 9.1 | 24.7 |
| **Women, Central & Eastern** | 36.0 | 11.8 | 9.3 | 24.9 |

| MEN 55+ BY REGION | | | | |
|---|---|---|---|---|
| **Northern*** | 29.8 | 18.1 | 7.3 | 12.4 |
| **Western** | 50.2 | 27.7 | 13.0 | 29.3 |
| **Southern** | 37.6 | 19.7 | 10.6 | 23.4 |
| **Central & Eastern** | 31.6 | 15.0 | 2.6 | 18.4 |

All columns are % of people who reported an emotional/psychosocial problem. People could name more than one professional. Regions follow the EuroVoc grouping listed in Methods and caveats. Numbers of people in each group are in the table above.

Received professional help = named at least one of eight professionals (GP, psychiatrist, psychologist, psychotherapist, psychoanalyst, pharmacist, nurse or social worker). Saw any mental health specialist = named at least one of the four specialists among them (psychiatrist, psychologist, psychotherapist or psychoanalyst), so it is always the smaller figure; the gap is people whose help came only from a GP, pharmacist, nurse or social worker.

* Small sample (135 people); see the note under the table above.

## TREATMENT AND WHAT MEN THINK WORKS

How the views of men who received professional help differ from those who did not, and what is known about men's experiences once they reach help.

Men who reported an emotional or psychosocial problem, and did not receive professional help, are more likely to favour physical activity (47% vs 36%) and discussing with close ones (40% vs 26%) compared to men who did receive help. They are, in contrast, far less likely to choose counselling or therapy (31% vs 47%) or medication (9% vs 32%) than men who reported one and did receive professional help.

Physical activity 10 points higher (6–15); discussing with close ones 14 points higher (10–18); counselling 16 points lower (11–21); medication 23 points lower (19–27). On whether physical activity contributes to good mental health in general, the two groups barely differ (39% vs 36%, not significant). Women show a similar pattern. The differences are not explained by age: they hold within every age group and are almost unchanged after adjusting for age (see tables A6 and A7 in the appendix).

# 47%

of men who reported an emotional or psychosocial problem but received no professional help named physical activity as an effective solution.

**WHY MIGHT THIS BE?**

The reason cannot be determined from this data, but there are at least three plausible explanations, and the pattern may reflect a combination of these.

1. Counselling or therapy and medication are the treatments most commonly available through professional help, so men who prefer them are more likely to seek help and appear among those who received it.

2. Counselling or therapy and medication are the treatments most commonly available through professional help, so men who received help have been exposed to them, may have found them helpful, and therefore prefer them.

3. Views on what works may also reflect masculine norms. A systematic review found that conformity to traditional masculine norms can affect not only whether men seek help but also which services they engage with.[18]

**WHAT WORKS, BY WHETHER PROFESSIONAL HELP WAS RECEIVED**

| % | Men who reported an emotional/ psychosocial problem and received help | Men who reported an emotional/ psychosocial problem but did not receive help |
|---|---|---|
| **Counselling or therapy** | 47.2 | 31.3 |
| **Physical activity** | 36.1 | 46.5 |
| **Discussing with close ones** | 25.9 | 39.8 |
| **Social activity** | 27.2 | 34.3 |
| **Medication** | 32.2 | 9.4 |
| **Other** | 4.0 | 5.6 |
| **n reported an emotional/ psychosocial problem** | 2,005 | 2,918 |

% naming each solution as most effective for them personally (Q17, up to two answers). Tables A6 and A7 in the appendix show this by age: the differences hold within every age group and are almost unchanged after adjusting for age.

## WHAT HAPPENS ONCE MEN REACH HELP

Flash Eurobarometer 530 records whether men received professional help, but not what happened when they did. More comprehensive research is needed to understand men's experiences once they reach services, and whether that help meets their needs.

In 2025, GPs in Ireland reported limited honest communication from men presenting with suicidal behaviour, and named stigma, norms of self-reliance, a lack of support networks and fear of the impact on their career as the main reasons men hold back.[4]

They also pointed to barriers in the system itself: services not designed or delivered with men's needs in mind, limited training in engaging men, and settings that men do not find welcoming. Rejected referrals, inflexible appointment systems and long waits were reported to fall hardest on younger and more marginalised men.[4]

Masculine norms can shape which services men engage with, not only whether they seek help at all.[18] For services, the question is therefore not only whether men come forward but whether help is offered in a form they will use. Adding questions on the quality of help received to a future Eurobarometer would be one way to begin addressing this gap.

## STIGMA

Whether people say mental health issues are perceived as not curable in their country, a measure of the stigma people see around them.

Almost half of Europeans (46%) say mental health issues are perceived as not curable in their country.

46.2% agree, 44.3% disagree, 9.5% don't know. This measures what people think others believe, a form of perceived stigma, not their own view.

In Italy and Spain, six in ten say mental health issues are perceived as not curable, more than twice the share in Sweden (27%).

Italy 60.0% (57–63), Spain 58.0% (55–61), Sweden 27.1% (24–30).

People who reported an emotional or psychosocial problem are more likely to say mental health issues are perceived as not curable (51% vs 42%).

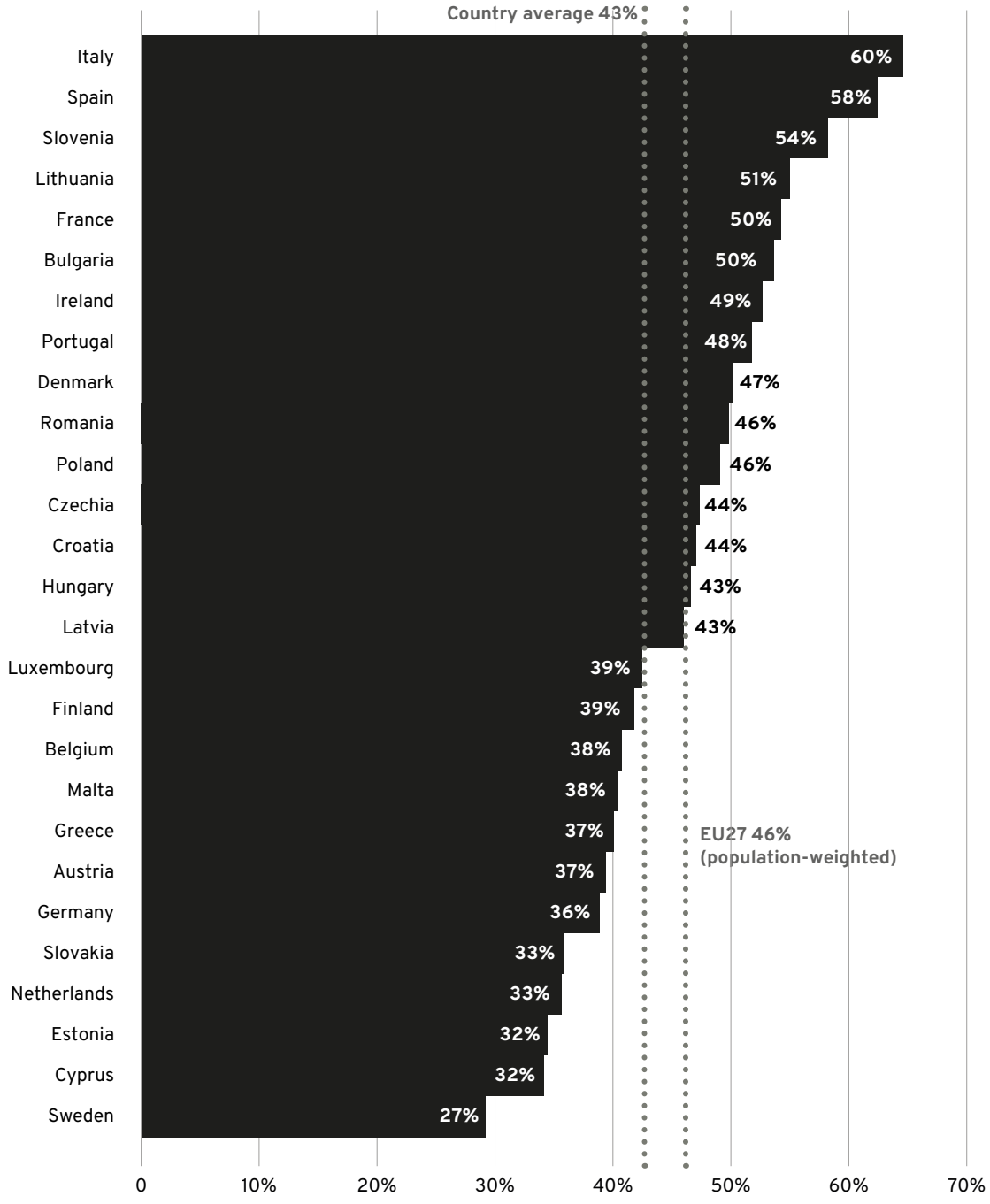
51.3% (50–53) vs 42.2% (41–44). Holds for men (50% vs 41%) and women (53% vs 43%).

**MENTAL HEALTH ISSUES PERCEIVED AS NOT CURABLE**

| % who agree | MEN | WOMEN | ALL |
|---|---|---|---|
| **BY AGE** | | | |
| 15–24 | 42.3 | 40.8 | 41.7 |
| 25–39 | 47.4 | 51.4 | 49.4 |
| 40–54 | 47.7 | 51.6 | 49.6 |
| 55+ | 40.8 | 46.1 | 43.7 |
| All ages | 44.3 | 47.9 | 46.2 |
| **BY REGION** | | | |
| Northern | 33.5 | 37.3 | 35.4 |
| Western | 39.3 | 42.9 | 41.2 |
| Southern | 54.3 | 57.9 | 56.2 |
| Central & Eastern | 43.2 | 46.7 | 45.0 |
| **BY WHETHER AN EMOTIONAL/PSYCHOSOCIAL PROBLEM WAS REPORTED** | | | |
| Reported an emotional/psychosocial problem in past 12 months | 49.6 | 52.5 | 51.3 |
| Did not report an emotional/psychosocial problem | 41.2 | 43.3 | 42.2 |

Women are slightly more likely than men to agree (about 4 points, significant). Southern Europe's high figure is driven by Italy and Spain; Greece, Malta and Cyprus are all below the EU average, and Cyprus is second lowest.

**NOT CURABLE, BY COUNTRY**
% WHO AGREE MENTAL HEALTH ISSUES ARE PERCEIVED AS NOT CURABLE IN THEIR COUNTRY




Flash Eurobarometer 530, June 2023. Totally or tend to agree, % of all respondents aged 15+; about 1,000 respondents per country (500 in Cyprus, Luxembourg and Malta).
Country average is the unweighted mean of the 27; the EU27 figure is weighted by population.

Totally or tend to agree, % of all respondents aged 15+. About 1,000 respondents per country (500 in Cyprus, Luxembourg and Malta), so small differences between countries may not be meaningful. The darker line is the EU27 figure (46%), weighted by population, so large countries count for more: Italy, Spain and France are above it, while many smaller countries are below. The lighter line is the simple average of the 27 countries (43%), where each country counts equally.



SECTION 05

# Claims to be cautious of

## *"Men are less likely than women to receive help."*

Among people who reported an emotional or psychosocial problem, men were more likely than women to receive professional help (47% vs 42%). But because fewer men report an emotional or psychosocial problem at all, a smaller share of all men received professional help (18% vs 22% of women). Although this cannot be confirmed from this data, the difference in reported emotional or psychosocial problems may point to men being less likely to recognise or report these issues. Evidence from England supports this: at the same interviewer-measured level of symptoms, men had about 40% lower odds than women of believing they had a common mental disorder (adjusted odds ratio 0.60), and about 46% lower odds of having been diagnosed by a professional (0.54).[2] If men need more severe symptoms before they report such a problem, the men who do report one are likely to carry a heavier burden, on average, than the women who do. That difference in case mix would plausibly explain why a higher share of them had received professional help, rather than men being more ready to seek help: the same study found that, at equal symptom levels, men were less likely than women to consult a GP about a mental health problem (adjusted odds ratio 0.65).



## *"Young men are the least likely to receive help."*

Young women are: 37% of women aged 15–24 who reported an emotional or psychosocial problem received professional help, against 46% of young men. Of the four age groups, this is the only one where the gender gap is significant.



SECTION 06

# Methods and caveats

**SURVEY**
Flash Eurobarometer 530, Mental Health.[5] Fieldwork 14–21 June 2023 by Ipsos, online. Residents of the EU27 aged 15+, quota sample of about 1,000 per country (500 in Cyprus, Luxembourg and Malta).

**EMOTIONAL OR PSYCHOSOCIAL PROBLEMS**
Q14: "In the last 12 months, have you had any emotional or psychosocial problems (such as feeling depressed or feeling anxious)?" Asked of the 25,684 people who agreed to answer sensitive questions. Self-reported, not a diagnosis.

**HELP**
Q16: "In the last 12 months, have you received professional help for mental health problems from any of the following?" GP, psychiatrist, psychologist, psychotherapist, psychoanalyst, pharmacist, nurse or social worker. Asked of the 12,680 people who reported an emotional or psychosocial problem. "Received professional help" means naming at least one of these. "Did not receive professional help" means answering "None of these"; the 1–4% who preferred not to say or did not know are in neither group.

**ACTIVITIES**
Q3: "In your opinion, which of the following activities and behaviours contribute the most to good mental health?" Up to three answers, asked of everyone, so it can be compared between people with and without emotional or psychosocial problems. It includes sport or physical activity but not counselling.

**SOLUTIONS**
Q17: "For you personally, what are the most effective solutions to tackle mental health issues?" Up to two answers, asked of people who reported an emotional or psychosocial problem. Within-group comparisons (for example physical activity vs counselling among men) are tested on the same respondents.

**RECEIVED HELP**
"Received professional help" as a share of all men or women aged 15+ counts people who reported an emotional or psychosocial problem and named at least one professional, out of everyone who agreed to answer the sensitive questions.

**STIGMA**
Q13_6: "To what extent do you agree or disagree with the following statements about people with mental health issues in [your country]? Mental health issues are perceived as not curable." Asked of everyone. Agree = totally or tend to agree; "don't know" is kept in the base, as in the published tables.

**ESTIMATES**
Weighted to the EU27 population. 95% ranges allow for the weights and country sampling; because the sample is quota-based, treat them as indicative. Groups with fewer than 150 people who reported an emotional or psychosocial problem are marked with an asterisk (*). The 90 people who described their gender another way are not shown separately; they are included in the stigma totals, age bands, regions and countries, and all other figures are for men or women. Analysis used R[30] with the survey[31] and eurostat[32] packages.

**INTERPRETATION**
The survey is a single snapshot, so it shows associations, not causes. For example, it cannot show whether receiving professional help shapes people's views on what works, or whether those views affect whether people seek help.

**REGIONS**
EuroVoc grouping.[23] Northern: Denmark, Finland, Sweden. Western: Austria, Belgium, France, Germany, Ireland, Luxembourg, Netherlands. Southern: Cyprus, Greece, Italy, Malta, Portugal, Spain. Central & Eastern: Bulgaria, Croatia, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia.

**MILLIONS**
Weighted shares by sex and age band applied to the EU population on 1 January 2023 (Eurostat demo_pjangroup).[8]

**SUICIDE**
Deaths of EU residents from intentional self-harm (ICD-10 X60–X84, Y87.0), from Eurostat's causes of death statistics.[9] Deaths of undetermined intent are ICD-10 Y10–Y34, Y87.2. 2023 is the latest year available for all countries. Country and regional comparisons combine 2021–2023 so that small countries have enough deaths for a stable rate. Trends start in 2013, the first year with complete population data by age for all 27 countries.

**SUICIDE RATES**
Age-standardised to the 2013 European Standard Population in 19 age bands,[20] using the average population of each year (the mean of 1 January of that year and the next),[10] with 95% ranges by Byar's method and, for age-standardised rates, the Dobson adjustment,[33] calculated with PHEindicatormethods.[34] No rate is calculated from fewer than 10 deaths. Deaths whose age is not shown (unknown age, or small numbers withheld) are spread across age groups in proportion to deaths of known age. EU and regional rates are calculated from the 27 countries. Calculated rates differ from Eurostat's published rates by a median of less than 0.01 per 100,000 across countries and years; changes in countries' rates between 2013 and 2023 use the published rates.[11] Rates for NUTS 2 regions are Eurostat's published 3-year averages for 2021–2023.[12] Rates by age are crude rates (deaths per 100,000 people in each age group).

**LEADING CAUSES**
Causes of death in Eurostat's European shortlist are ranked by number of deaths within each sex and age group.[9] Only specific causes that do not overlap are ranked: remainder groups ("other" diseases), sub-categories of ranked causes and ill-defined causes are not. As in WHO and ONS rankings,[21,22] injuries are split by type (for example transport accidents, falls, drowning and accidental poisoning), and COVID-19 is one cause. When all accidents are counted as one cause, accidents come first and suicide second for men aged 15–44 and women aged 15–29. Counting deaths of undetermined intent with suicide does not change the age groups in which suicide is the leading cause in the EU.

## POTENTIALLY HIDDEN DEATHS

Deaths of undetermined intent are shown as an indicator of how completely deaths due to suicide may be recorded, not as a correction: a high ratio of undetermined deaths to suicides is a recognised sign that suicide statistics may be incomplete.[26]
WHO's estimates are crude rates for 2023 from the Global Health Observatory, which WHO adjusts where necessary "for under-reporting of deaths, unknown age and sex, and ill-defined causes of deaths".[25] They are compared with crude rates from Eurostat's recorded deaths and population; WHO uses its own population estimates, so differences of a few per cent are not meaningful.

## MAPS

Country boundaries from Eurostat's GISCO service (Countries 2020, 1:20 million).[24] © EuroGeographics for the administrative boundaries.

## CROSS-REFERENCING

Figures that also appear in the European Commission's published tables for the survey[6] match them to one decimal place: EU totals and results by gender, age band and mental health problems (Volume B), and country results (Volume A). The published tables include 9 respondents who are not in the archived data file (Malta 4, Denmark 2, Poland, Slovakia and Sweden 1 each), so the EU share reporting an emotional or psychosocial problem (45.8% vs 45.9% published) and, in the stigma country chart, Malta (37.5% vs 37.9%) and Denmark (46.6% vs 46.7%) differ slightly. Results by gender within age band, by region, and by gender within emotional/psychosocial problem status are not published; they come from this analysis of the respondent-level data.

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APPENDIX

# What works, by help received and age (men)

This appendix checks whether the differences in what men think works, between men who did and did not receive professional help (see Treatment and what men think works), are explained by age. Men who did not receive help were slightly older (32% aged 55+, against 25% of men who received help), and views on what works change with age, so age could in principle confound the comparison.

It does not. In every age group, men who received help were more likely to name counselling or therapy and medication, and men who did not receive help were more likely to name physical activity and discussing with close ones (see table A6). Adjusting for age leaves the differences almost unchanged: counselling 16.6 points lower and physical activity 10.9 points higher among men who did not receive help, against 15.9 and 10.5 before adjustment (see table A7). Only the medication gap varies by age, being larger among men aged 40 and over. Possible explanations for these differences are discussed in the "Treatment and what men think works" section, but the data cannot determine which one applies.

**A1. MEN'S SUICIDE RATE IN THE EU AGAINST THE 2030 TARGET**

| | **Men's suicide rate, EU27, per 100,000** | **Note** |
|---|---|---|
| 2015 baseline | 18.8 | Baseline year for the target |
| 2023, latest | 16.9 | 10% below 2015 |
| 2030 target | 12.5 | One third below 2015 |
| Fall still needed, 2023 to 2030 | 4.4 | 26%, or 4.2% in each year from 2024 to 2030 |
| Pace since 2017 | 0.3% a year | 17.2 in 2017 to 16.9 in 2023 |
| 2030 at the current pace | 16.5 | 12% below 2015, against the 33% required |

**A2. MEN'S SUICIDE RATE IN THE EU, 2013 TO 2023**

| **Year** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate per 100,000 | 20.2 | 19.5 | 18.8 | 17.8 | 17.2 | 17.2 | 16.8 | 16.9 | 16.8 | 17.2 | 16.9 |

Note for A1 and A2: Deaths of EU residents recorded as intentional self-harm, age-standardised to the 2013 European Standard Population, as published by Eurostat.[11] The target is the WHO Comprehensive Mental Health Action Plan's one-third reduction in suicide rates by 2030.[27] Pace is the average annual change between 2017 and 2023; the 2030 projection applies that pace to the 2023 rate. Rates are rounded to one decimal; percentages are calculated from unrounded rates.

### A3. MOST EFFECTIVE SOLUTION FOR THEM PERSONALLY (PEOPLE WHO REPORTED AN EMOTIONAL/PSYCHOSOCIAL PROBLEM)

| % | Men | Women |
|---|---|---|
| **Most effective solution for them personally (people who reported an emotional/psychosocial problem)** | | |
| Counselling or therapy | 38.6 | 45.5 |
| Physical activity | 41.5 | 34.6 |
| Discussing with close ones | 33.1 | 38.0 |
| Social activity | 30.8 | 28.0 |
| Medication | 20.1 | 18.4 |
| Other | 4.8 | 5.0 |
| n reported an emotional/psychosocial problem | 5,051 | 7,574 |
| **Sport or physical activity as a main contributor to good mental health (everyone)** | | |
| All | 38.4 | 28.7 |
| Reported an emotional/psychosocial problem | 37.3 | 29.4 |
| Did not report an emotional/psychosocial problem | 39.6 | 28.5 |

Most effective solution: Q17, up to two answers. Main contributors to good mental health: Q3, up to three answers. Gender gaps for counselling, physical activity and discussing with close ones are statistically significant.

### A4. MOST EFFECTIVE SOLUTION FOR MEN BY AGE (MEN WHO REPORTED AN EMOTIONAL/PSYCHOSOCIAL PROBLEM)

| % | Men 15–24 | Men 25–39 | Men 40–54 | Men 55+ |
|---|---|---|---|---|
| Counselling or therapy | 38.6 | 35.1 | 35.4 | 45.4 |
| Physical activity | 40.1 | 41.8 | 45.5 | 37.9 |
| Discussing with close ones | 41.3 | 36.1 | 28.3 | 30.4 |
| Social activity | 30.8 | 34.3 | 29.0 | 29.1 |
| Medication | 13.2 | 16.9 | 22.5 | 24.5 |
| Other | 7.4 | 4.5 | 4.7 | 3.7 |
| n reported an emotional/psychosocial problem | 710 | 1,442 | 1,508 | 1,391 |

% of men who reported an emotional/psychosocial problem naming each solution as most effective for them personally (Q17, up to two answers).

### A5. AGE OF MEN WHO REPORTED AN EMOTIONAL/PSYCHOSOCIAL PROBLEM, BY WHETHER THEY RECEIVED PROFESSIONAL HELP

| Age | Received help (%) | Did not receive help (%) | n received help | n did not receive help |
|---|---|---|---|---|
| **15–24** | 15.5 | 15.2 | 301 | 383 |
| **25–39** | 30.2 | 24.5 | 607 | 785 |
| **40–54** | 29.5 | 28.6 | 607 | 868 |
| **55+** | 24.8 | 31.6 | 490 | 882 |

Column % of men who reported an emotional/psychosocial problem in each help group; n is the number of survey respondents.

### A6. WHAT WORKS, MEN WHO REPORTED AN EMOTIONAL/PSYCHOSOCIAL PROBLEM, BY WHETHER THEY RECEIVED PROFESSIONAL HELP AND AGE

| % | 15–24: received help | 15–24: did not receive help | 25–39: received help | 25–39: did not receive help | 40–54: received help | 40–54: did not receive help | 55+: received help | 55+: did not receive help |
|---|---|---|---|---|---|---|---|---|
| **Counselling or therapy** | 50.8 | 26.9 | 42.7 | 27.9 | 44.4 | 27.4 | 53.7 | 39.6 |
| **Physical activity** | 32.8 | 46.4 | 36.5 | 48.4 | 39.2 | 51.5 | 33.9 | 40.7 |
| **Discussing with close ones** | 32.3 | 50.7 | 32.9 | 40.7 | 21.6 | 34.6 | 18.6 | 38.4 |
| **Social activity** | 24.8 | 37.9 | 33.2 | 35.7 | 23.2 | 34.2 | 26.3 | 31.5 |
| **Medication** | 22.3 | 4.7 | 24.4 | 8.9 | 37.4 | 8.9 | 41.9 | 12.4 |
| **Other** | 6.1 | 9.0 | 4.1 | 4.8 | 4.5 | 5.0 | 1.9 | 5.0 |
| **n reported an emotional/ psychosocial problem** | 301 | 383 | 607 | 785 | 607 | 868 | 490 | 882 |

% naming each solution as most effective for them personally (Q17, up to two answers). Base: men who reported an emotional/ psychosocial problem in each age and help group.

**A7. DIFFERENCE BETWEEN MEN WHO DID NOT AND DID RECEIVE HELP, BEFORE AND AFTER ADJUSTING FOR AGE**

| Solution | Difference (points) | 95% range | Age-adjusted difference (points) | 95% range | Varies by age? (p) |
|---|---|---|---|---|---|
| Counselling or therapy | −15.9 | −20.6 to −11.1 | −16.6 | −21.3 to −11.9 | 0.622 |
| Physical activity | 10.5 | 5.8 to 15.1 | 10.9 | 6.2 to 15.5 | 0.766 |
| Discussing with close ones | 13.8 | 9.5 to 18.2 | 14.3 | 10.0 to 18.6 | 0.190 |
| Social activity | 7.0 | 2.6 to 11.5 | 7.4 | 2.9 to 11.8 | 0.373 |
| Medication | −22.9 | −26.7 to −19.1 | −23.5 | −27.3 to −19.7 | 0.010 |
| Other | 1.6 | −0.4 to 3.5 | 1.6 | −0.3 to 3.6 | 0.628 |

Difference = % among men who did not receive professional help minus % among men who did; negative values mean the solution was named less often by men who did not receive help. Age-adjusted differences come from a weighted regression including the four age bands. The last column tests whether the difference varies across age bands; a small p (below 0.05) means it does.





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