Mental Health Europe

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Rethink To Rebuild:

Towards Rights-Based and Gender-Just Mental Health Systems in Europe

2025

“For the master’s tools will never dismantle the master’s house. They may allow us to temporarily beat him at his own game, but they will never enable us to bring about genuine change. Racism and homophobia are real conditions of all our lives in this place and time.

I urge each one of us here to reach down into that deep place of knowledge inside herself and touch that terror and loathing of any difference that lives here. See whose face it wears. Then the personal as the political can begin to illuminate all our choices.”

— Audre Lorde

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Executive Summary

This EU-level scoping study examines the intersection of gender and mental health, by looking at the experiences of persons who identify as women, offering evidence- and human rights-based policy recommendations for EU and national policymakers. It highlights mental health realities of women, including lesbian, bisexual, trans, and intersex (LBTI+) women, and women with psychosocial disabilities, providing evidence to inform inclusive, gender-responsive, and recovery-oriented policy. It shows that despite EU commitments to gender equality, mental health, and disability rights, these agendas and related data and monitoring tools remain fragmented.

Systemic gender inequalities directly shape women's mental health outcomes. Socioeconomic disparities, including gender pay and pension gaps, precarious work, and disproportionate care responsibilities, amplify mental health stressors. One of the most significant determinants of mental health for women is exposure to gender-based violence (GBV), which increases the risk of poor mental health, while those who experience mental health conditions are at a much greater risk of experiencing GBV. Marginalised groups, including migrants, refugees, racialised women and LBTI+ women, face further significant barriers to safe, trauma- and violence-informed, and recovery-oriented mental health care. LBTI+ women often experience compounded mental health risks due to stigma, minority stress, and systemic exclusion, which includes trans women facing heightened violence, while intersex women are disproportionately subjected to non-consensual medical interventions.

Gender bias often results in women's experiences being minimised, dismissed, or over-medicalised, compounding cycles of disempowerment, including within services and institutions. Women with psychosocial disabilities are disproportionately exposed to sexual violence, coercive practices, forced medication, seclusion, and, in some cases, forced sterilisation or denial of reproductive rights. Such violations cause immediate and long-term harm to mental health and trust in healthcare and support systems. These practices erode bodily autonomy, exacerbate trauma, and violate the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

This report underlines an urgent message: mental health policies that overlook gender, and gender equality policies that neglect their intersection with mental health, risk reinforcing inequalities, further excluding marginalised populations. Understanding gender and mental health requires an intersectional lens, acknowledging how social position, identity, and structural inequalities shape mental health. This aligns with the psychosocial model of mental health, which situates mental health within broader life contexts. Social and environmental determinants, such as poverty, inequality, violence, and trauma, significantly influence mental health outcomes.

Peer-led and community-based support is crucial, yet underfunded. Strengthening these supports alongside professional care is urgently needed. Personal recovery should be supported through complex support systems including peer support, accessible community-based services, and inclusive policies which, in design and practice, recognise people with lived and living experience as experts in their own recovery, thus emphasising autonomy, choice, and meaningful participation.

Re-imagining mental health systems – both in policy and practice – through a gender justice lens requires structural change. Embedding a gender-responsive, gender-just, psychosocial model-based, and recovery-oriented approach into health, equality, disability and human rights strategies is essential. Policies must address GBV, unequal care burdens, restrictive norms, and institutional discrimination, while promoting trauma- and violence-informed, participatory, survivor-led, psychosocial, human rights-based, and recovery-oriented approaches. Embedding gender justice in mental health is a human rights obligation and a public interest imperative, aligned with the UNCRPD, Istanbul Convention, and EU equality and human rights commitments.

Mental health policies that overlook gender, and gender equality policies that neglect their intersection with mental health, risk reinforcing inequalities, further excluding marginalised populations.

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1.

Introduction

Why Gender Matters in Mental Health: Scope and Aims of the Report

Gender fundamentally shapes how individuals experience, express, and respond to mental health challenges, yet it is often invisible and remains marginal in dominant mental health policy frameworks. From the social conditions and traumas that contribute to distress to the ways people are diagnosed, treated, supported or excluded from care, gender is a decisive factor in shaping mental health outcomes.[1]

Distinct patterns emerge across different groups. Women are disproportionately affected by anxiety, depression, and stress-related conditions, often linked to the unequal distribution of unpaid care responsibilities, exposure to gender-based violence (GBV), and enduring structural inequalities.[2] By contrast, men are more likely to encounter pressures linked to dominant norms of masculinity, such as expectations of toughness, self-reliance, and emotional suppression. These "norms" can act as barriers to seeking help and are associated with elevated rates of substance use and suicide.[3] [4] Moreover, the prevalence of poor mental health appears to be rising among specific groups, notably older men and young women.[5] Such differences demonstrate the importance of developing mental health policies and practices that are not only responsive to gender but actively challenge restrictive, harmful and binary stereotypes and address the systemic drivers behind them.[6]

This report aims to bring gender from the margins to the centre of mental health policy discourse at EU level. By exploring how mental health systems reproduce or resist gendered inequalities, it identifies key areas for transformation. It maps emerging trends and highlights under-addressed challenges, situating these in a critical examination of current EU policy landscapes. Specific, multi-level recommendations for building inclusive, gender-just mental health systems follow this analysis. The goal is not only to inform but also to lay the groundwork for sustained advocacy, ensuring that future mental health and gender equality strategies are rooted in equity, justice, and lived experience.

1 Baños RM, Miragall M. (2024) Gender Matters: A Critical Piece in Mental Health. The Spanish Journal of Psychology. 27:e28. DOI:10.1017/SJP.2024.29

2 Ibid.

3 Seedat S, Scott KM, Angermeyer MC, et al. (2010) Cross-National Associations Between Gender and Mental Disorders in the World Health Organization World Mental Health Surveys. Arch Gen Psychiatry. 66(7):785–795. DOI:10.1001/archgenpsychiatry.2009.36

4 WHO (2025) World Mental Health Today: Latest Data. https://iris.who.int/server/api/core/bitstreams/31714489-1345-4439-8b37-6cbdc52e15ca/content

5 Eurofound (2025) Mental Health: Risk Groups, Trends, Services and Policies: https://www.eurofound.europa.eu/en/publications/all/mental-health-risk-groups-trends-services-and-policies

6 IPPF European Network: https://en.europe.ippf.org/address-the-root-causes-of-gender-inequality

Intersectional and Rights-Based Lens

This report adopts an intersectional and rights-based approach to understanding gender and mental health in Europe. Grounded in the principles of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), it recognises mental health as a public health, human rights, social, and gender justice issue. An intersectional lens is applied to account for how overlapping structures of oppression, such as misogyny, sexism, ableism, transphobia, and homophobia, may interact to shape mental health outcomes, access to care, and lived experiences of mental health and psychosocial disability. Rather than treating gender as a binary or isolated category, this approach highlights how gender intersects with other axes of identity and power, producing layered inequalities.

The report centres on social and structural determinants of mental health (e.g., GBV, discrimination, and institutionalisation) over individualised, pathologised or biomedicalised explanations of distress. The primary method is desk-based, drawing on research including testimonies and advocacy by people with lived experience. Emphasis is given to groups often excluded from mainstream policy discourse to ensure recommendations are informed by those most affected. This approach is aligned with Mental Health Europe's (MHE) commitment to human rights, equality, and meaningful participation in mental health reform.

For more details on the primarily desk-based methodology, reflexivity, and ethical reflections, see Annex 1.

A glossary of key terms used in the report is included in Annex 2.

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2.

Current Realities in Europe and Their Impact on Mental Health

Gendered Inequalities, Gender-Based Violence, and the Mental Health of Women and Girls

Women and girls across the EU continue to experience systemic gender inequalities that directly shape their mental health outcomes. Socio-economic disparities, such as the persistent gender pay and pension gaps[8], higher rates of part-time and precarious work, and disproportionate care responsibilities, increase women's exposure to stress, financial insecurity, and social exclusion. These structural inequalities increase the risk of mental health conditions and limit access to resources and support, with accessibility itself often already being an issue.[9] At the same time, healthcare systems across Europe, particularly mental healthcare, frequently lack a gender-sensitive perspective, often failing to account for how women's mental health is shaped by broader social determinants.[10] This underscores the need for a psychosocial approach in both understanding mental health and designing services and policies. Evidence shows that women are disproportionately represented among users of primary mental healthcare services.[11] [12] [13] Also, over the past decade, suicide rates have risen among women under 20, highlighting emerging vulnerabilities that require gender-informed prevention strategies.[14]

"I feel like a very, very big part of my experience is due to the fact that I'm a woman. (...) And now I feel very insecure, at work, and on the street. It's just constant paranoia that someone is going to attack because harassment is so common. Well, that's just the way it is. I almost always have it in my mind that I'm a woman, it's very hard to forget that." – A woman with a psychosocial disability.[7]

GBV is a critical factor undermining women's mental health in Europe, with profoundly adverse effects. GBV constitutes a significant global public mental health problem, given its widespread prevalence and its far-reaching consequences for the mental health and well-being of individuals, as well as for communities, at both local and global levels. At least one in three women[15] has experienced psychological, economic, physical or sexual violence, including domestic and intimate partner violence, with profound and long-lasting impacts on mental and physical health, and such long-term mental health consequences as post-traumatic stress, depression, anxiety, substance use, and suicidality. Similarly high rates of abuse, particularly intimate partner violence, also affect teenage girls: nearly one in four adolescent girls who have been in a relationship report experiencing such violence worldwide[16]

One in three women has experienced psychological, economic, physical or sexual violence.

Nearly one in four adolescent girls who have been in a relationship report experiencing such violence worldwide

7 Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2025) Experiences of Women with Disabilities in Lithuania when their Gender, Disability, Domestic Violence, and Mental Health Services Intertwine. Disability and Health Journal: https://doi.org/10.1016/j.dhjo.2025.101837

8 European Parliament, Committee on Employment and Social Affairs and Committee on Women's Rights and Gender Equality (2025) Report on the gender pay and pension gap in the EU: state of play, challenges and the way forward, and developing guidelines for the better evaluation and fairer remuneration of work in female-dominated sectors (2025/2038(INI)).

9 European Data Journalism Network (2021) Pay up or put it off: how Europe treats depression and anxiety. https://www.europeandatajournalism.eu/cp_data_news/pay-up-or-put-it-off-how-europe-treats-depression-and-anxiety/

10 Justyna Kucharska (2018) Cumulative trauma, gender discrimination and mental health in women: mediating role of self-esteem, Journal of Mental Health, 27:5, 416-423, DOI: 10.1080/09638237.2017.1417548.

11 Thompson, A.E., Anisimowicz, Y., Miedema, B. et al. (2016) The influence of gender and other patient characteristics on health care-seeking behaviour: a QUALICOPC study. BMC Primary Care. https://doi.org/10.1186/s12875-016-0440-0

12 Gao, Y., Burns, R., Leach, L. et al. (2024) Examining the mental health services among people with mental disorders: a literature review. BMC Psychiatry. https://doi.org/10.1186/s12888-024-05965-z

13 Bernal Arenas M, Arroyo-Sánchez A, Torres Parejo Ú, Muñoz-Negro JE. (2025) A systematic review and meta-analysis on gender differences in the treatment of anxiety and depression. International Journal of Social Psychiatry. DOI:10.1177/00207640251331898

14 Eurofound (2025) Mental Health: Risk Groups, Trends, Services and Policies. https://www.eurofound.europa.eu/en/publications/all/mental-health-risk-groups-trends-services-and-policies

15 WHO (2021) Violence Against Women: Prevalence Estimates. https://www.who.int/publications/i/item/9789240022256

16 LynnMarie Sardinha, Ilknur Yüksel-Kaptanoğlu, Mathieu Maheu-Giroux, Claudia García-Moreno (2024) Intimate partner violence against adolescent girls: regional and national prevalence estimates and associated country-level factors. The Lancet Child & Adolescent Health, 8:9, 636 – 646. https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(24)00145-7/fulltext

Women who have experienced GBV are **at least three times** more likely to develop mental health conditions compared to women without such experiences. Conversely, women with mental health conditions face an increased risk of being subjected to GBV. The risk is even greater for women with psychosocial disabilities, who experience rates of violence **two to five times higher** than women without disabilities.[17] These harms are often intensified by stigma, victim-blaming, and social exclusion, which together may restrict recovery and limit access to appropriate care. Survivors of GBV frequently face re-traumatisation in their interactions with institutions, including physical and mental healthcare, law enforcement, and judicial systems. For example, if survivors of sexual violence access mental health support in Ireland, counselling notes made by their therapist can be accessed by legal teams defending alleged perpetrators.[18]

Migrant, refugee, and minority women, as well as women with psychosocial disabilities, encounter additional barriers to safe, trauma- and violence-informed care and protection.

Despite EU-level commitments, service provision remains underfunded and uneven across Member States. Migrant, refugee, and minority women, as well as women with psychosocial disabilities, encounter additional barriers to safe, trauma- and violence-informed care and protection.[19] Tackling the mental health impacts of GBV requires survivor-centred and lived experience-led approaches that combine accessible and appropriate mental health care and complex support with legal, health, and social interventions, while simultaneously addressing the broader structural inequalities, cultural and societal "norms" that sustain violence.

"I would take it that the person who abused me knew that I was a vulnerable person because the anti-depressants were found, and he knew very well that they were drugs for the treatment of mental health conditions. It was stigmatised. I was called a 'psycho' and stuff like that." – A woman with a psychosocial disability.[20]

"There is no system, they don't know how to react when there is a case of violence against a person with a disability. They have no idea, not a single institution knows how to proceed in such situations. That's a fact." – A woman with a psychosocial disability who lives in an institution and has experienced domestic violence.[21]

The current political climate in Europe exacerbates these challenges. The rise of anti-gender movements, rollback of women's rights, and the backlash against gender equality organisations undermine progress on gender equality and weaken the infrastructure of support available to women and girls. In healthcare, women continue to face forms of medical misogyny, including dismissal of their symptoms, overmedication, or pathologisation of their distress rather than recognition of its social and gendered roots. This not only deepens mistrust in services but also perpetuates cycles of harm and exclusion. These dynamics are further intensified when gender intersects with other axes of marginalisation. For example, women who experience racism often face additional barriers, such as the systematic under-recognition of their pain or minimisation of their symptoms, highlighting the urgent need for an intersectional approach in both healthcare provision and policy design.[22]

These recent political and societal trends and healthcare austerity are significantly undermining women's mental health and access to mental health care.[23] These trends create a hostile environment for women, threatening reproductive rights, recognition of gender identity, and participation in advocacy.[24] Human rights defenders, particularly women, face increased stigma, intimidation, and psychological stress.[25] Marginalised groups, such as migrant women, women with disabilities, and LBTI+ women, are especially vulnerable. The concept of minority stress is important to help frame these outcomes as the product of intersecting social and structural oppressions, not just individual factors.[26]

17 Grigaitė, U. (2025) Responses to the Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal. DOI: 10.13140/RG.2.2.11760.98563

18 The Irish Association of Humanistic and Integrative Psychotherapy (2025) IAHIP Statement on the Use of Therapy Notes in Sexual Assault Court Trials: https://iahip.org/IAHIP-Statement-Therapy-Notes

19 UNHCR (2024) Integration Handbook: Mental Health. https://www.unhcr.org/handbooks/ih/mental-health/mental-health

20 Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2025) Experiences of Women with Disabilities in Lithuania when their Gender, Disability, Domestic Violence, and Mental Health Services Intertwine. Disability and Health Journal: https://doi.org/10.1016/j.dhjo.2025.101837

21 Elena Krasteva, Aneta Genova (2024) DIS-CONNECTED: Disability-Based Connected Facilities and Programmes for Prevention of Violence against Women and Children in Bulgaria. Kera Foundation: https://validity.ngo/wp-content/uploads/2025/02/DIS-CONNECTED_NatRep_BG_EN_approved-1-1.pdf

22 MHE (2024) The mental health impacts of racial discrimination: https://www.mentalhealtheurope.org/wp-content/uploads/2024/12/Report-The-mental-health-impacts-of-racial-discrimination.pdf

23 UN Women (2025) Women's rights in review 30 years after Beijing: https://www.unwomen.org/en/digital-library/publications/2025/03/womens-rights-in-review-30-years-after-beijing:

24 Frank C. Worrell (2023) Denying Abortions Endangers Women's Mental and Physical Health. American Journal of Public Health. 113, 382-383: https://doi.org/10.2105/AJPH.2023.307241

25 Testimonies of SRHR Defenders under attack in Poland: https://defendthedefenders.eu.

26 Matthew Rivas-Koehl, Dane Rivas-Koehl, Shardé McNeil Smith (2023) The temporal intersectional minority stress model: Reimagining minority stress theory. Journal of Family Theory and Review. https://doi.org/10.1111/jftr.12529

At the same time, there are some encouraging EU-level initiatives, as referenced in the Overview of Key EU Frameworks section of this report, which at least partially recognise the importance of tackling intersecting inequalities. On the ground, civil society organisations and women's rights groups continue to provide innovative, community-based mental health and support services, often filling critical gaps left by formal systems.

Taken together, gender inequalities, GBV, and systemic discrimination highlight the urgent need for EU institutions and Member States to more comprehensively address women's mental health as a matter of rights and equality. This requires sustained investment in gender-sensitive, gender-just, trauma- and violence-informed, and recovery-oriented mental health services, stronger enforcement of EU commitments to protect women and girls from violence, and meaningful inclusion of women with lived experience in policy design and monitoring.

"I knew there was something wrong with me, because of the eating disorder, because I had missed my periods (...). It was then that I started going to psychologists and even to a psychiatrist, and I took anti-depressants. It was really difficult for me. But at that time, maybe they might have asked me about the violence, but even if they did, they didn't talk about it any further. We didn't touch on this topic of violence."
– A woman with a psychosocial disability.[27]

"The only solution I have [for the traumas] is to go to the psychiatrist, to fill myself up with medication. I take 15 pills a day. I take medication. In terms of support, no one has ever recommended anything to me. It's just medication, medication, medication after medication." – A woman with a psychosocial disability.[28]

"Especially when I was a teenager, when I started going [to a psychologist], it [domestic violence] should have been brought up and received more attention. Because I was growing up in extreme tension all the time. In all kinds of shame, guilt, and tension. And that was never of any interest to anyone." – A woman with a psychosocial disability.[29]

27 Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2025) Experiences of Women with Disabilities in Lithuania when their Gender, Disability, Domestic Violence, and Mental Health Services Intertwine. Disability and Health Journal: https://doi.org/10.1016/j.dhjo.2025.101837

28 Patrícia Neca (2023) DIS-CONNECTED: Disability-Based Connected Facilities and Programmes for Prevention of Violence against Women and Children in Portugal. Fenacerci: https://validity.ngo/wp-content/uploads/2025/02/DIS-CONNECTED_NatRep_PT_EN.pdf

29 Grigaitė, U., Aginskaitė, S., Pedrosa, B., Aluh, D.O., Santos-Dias, M., Silva, M., Cardoso, G., Caldas-de-Almeida, J.M. (2025) Experiences of Women with Disabilities in Lithuania when their Gender, Disability, Domestic Violence, and Mental Health Services Intertwine. Disability and Health Journal: https://doi.org/10.1016/j.dhjo.2025.101837

Lesbian, Bisexual, Trans, and Intersex Women: Marginalisation and Mental Health Impacts

Lesbian, bisexual, trans, and intersex (LBTI+) women often face a distinct set of mental health difficulties that are shaped by intersecting experiences of minority stress, stigma, discrimination, and violence. Research and community evidence consistently demonstrate that LBTI+ women are at heightened risk of mental health conditions and symptoms, such as depression, anxiety, and suicidal ideation, compared to the general population.[30] These outcomes are driven by systemic exclusion, family rejection, hostile societal narratives, and the persistent threat and experiences of violence.

Across Europe, LBTI+ women frequently encounter barriers in accessing safe and affirming mental health services. Discrimination in healthcare settings remains common, and even where outright hostility is absent, many providers lack adequate training on LGBTQI-specific issues. This creates situations where individuals either conceal core aspects of their identity, which may impede the effectiveness of therapy, or are subjected to subtle but harmful forms of invalidation.[31] [32] Moreover, the lack of LGBTQI-informed providers of mental healthcare and psychosocial support services is particularly acute for migrant and refugee women who cannot easily access therapy in their native language, leading to long waiting lists and further exclusion.[33]

Individuals either conceal core aspects of their identity or are subjected to subtle but harmful forms of invalidation.

Because many LBTI+ women also experience socioeconomic precarity, private mental healthcare is often financially out of reach, reinforcing structural inequities.[34] [35] **Specific experiences compound these challenges across various subgroups**. For example, lesbian and bisexual women face both hypersexualisation and desexualisation, with many exposed to sexual violence.[36] Bisexual women often experience erasure, particularly in heterosexual relationships, which undermines identity affirmation.[37] Moreover, trans women face relentless attacks from anti-gender movements and hostile media narratives that portray them as threats rather than victims or survivors, leading to social isolation, heightened anxiety[38], and reduced mobility in public spaces. They also experience disproportionate levels of violence, including homicide, with trans women of colour, migrants, and sex workers at the greatest risk.[39]

Intersex children are disproportionately steered toward female gender assignment regardless of their identity.

30 FRA Data Explorer: https://fra.europa.eu/en/publications-and-resources/data-and-maps/2024/eu-lgbtiq-survey-iii.

31 Council of Europe (2024) Right to the Highest Attainable Standard of Health and Access to Healthcare for LGBTI People in Europe: https://rm.coe.int/prems-124824-gbr-2575-right-to-the-highest-attainable-standard-of-heal/1680b1ba4d:

32 Bettergarcia, J., Matsuno, E., Conover K.J. (2021) Training mental health providers in queer-affirming care: A systematic review. Psychology of Sexual Orientation and Gender Diversity, Vol 8(3), 365-377. https://psycnet.apa.org/buy/2021-92937-006

33 Nyikavaranda, P., Pantelic, M., Jones, C.J. et al. (2023) Barriers and facilitators to seeking and accessing mental health support in primary care and the community among female migrants in Europe: a "feminisms" systematic review. International Journal for Equity in Health. https://doi.org/10.1186/s12939-023-01990-8

34 Bianca D.M., Wilson, Allegra R. Gordon, Christy Mallory, Soon Kyu Choi, M.V. Lee Badgett (2021) Health and Socioeconomic Well-Being of LBQ Women in the US. https://glma.org/docs/LBQ-Women-Mar-2021.pdf

35 Kinitz, D.J., Shahidi, F.V., Kia, H. et al. (2024) Precarious Employment: A Neglected Issue Among Lesbian, Gay, Bisexual, and Transgender Workers. Sexuality Research and Social Policy. https://doi.org/10.1007/s13178-024-00950-3

36 Hequembourg, A. L., Livingston, J. A., Parks, K. A. (2014). Sexual Victimization and Associated Risks Among Lesbian and Bisexual Women. Violence Against Women, 19(5), 634-657. https://doi.org/10.1177/1077801213490557

37 Emma M. Leonard (2021) The Erasure of Monosexism: An Exploration of Identity Development in Bisexual Women. Missouri State University. https://bearworks.missouristate.edu/theses/3702

38 Cirley Novais Valente Junior, Adriane Mesquita de Medeiros (2022) Voice and Gender Incongruence: Relationship between Vocal Self-Perception and Mental Health of Trans Women. https://doi.org/10.1016/j.jvoice.2020.10.002

39 Trans Murder Monitoring Update (2024) https://tgeu.org/files/uploads/2024/11/TGEU-TMM-TDoR2024-Table-2.pdf. Press release (2024): https://tgeu.org/will-the-cycle-of-violence-ever-end-tgeus-trans-murder-monitoring-project-crosses-5000-cases/

In addition to the above, many intersex women are often subjected to non-consensual, medically unnecessary interventions in childhood, leading to long-term trauma and mistrust of healthcare providers. Hence, intersex women face particularly severe mental health risks rooted in medical, familial, and societal trauma. The non-consensual and medically unnecessary procedures that are aimed at supposedly "normalising" their bodies based on societal "norms" are often carried out under strong pressure from doctors and families, leaving individuals with long-term mental health harm, disrupted bodily integrity, and mistrust toward healthcare providers.[40] Because feminising surgeries are more common than masculinising ones, intersex children are disproportionately steered toward female gender assignment regardless of their identity, resulting in an overrepresentation of intersex women and significant numbers of trans and non-binary intersex people.[41] Growing up under these conditions often entails family stress, societal stigma, and a lack of supportive models of identity development. As adults, many intersex women may delay or avoid seeking healthcare, including mental health support, because service providers themselves may have been perpetrators of their earlier trauma. **This reinforces cycles of exclusion, isolation, and untreated distress**, underlining the urgent need for trauma- and violence-informed, rights-based healthcare and peer-led support for intersex communities.[42] [43]

All these experiences collectively illustrate the deep psychological toll of pathologisation, coercion, marginalisation, and trauma for LBTI+ women. Community-based peer support plays a crucial role in mitigating these harms. Peer-led or peer-informed groups often provide the only safe and affirming spaces available to LBTI+ women across the EU. However, these initiatives remain severely underfunded, typically volunteer-driven, and vulnerable to collapse when key individuals burn out.[44] Strengthening and resourcing community centres that can sustain peer support alongside professional psychosocial care represents a promising and urgently needed intervention. This situation is further worsened by restricted funding across the EU, highlighting the critical need to prioritise mental health in both policy and funding decisions going forward.

Finally, structural gaps in policy and service design exacerbate all these inequalities for LBTI+ women. EU-level mental health programmes are often inaccessible to organisations working with intersectionally marginalised populations, particularly in countries where LGBTQI+ persons and communities are already excluded from state funding.[45] Without targeted resourcing and systemic reform, LBTI+ women's specific mental health needs will continue to be overlooked. Addressing this requires not only funding and training for service providers, but also the promotion of survivor-led, community-rooted approaches and recognition of the unique drivers of distress among LBTI+ women: family exclusion, societal stigma, anti-gender politics, pathologisation, medicalised and institutional violence.

40 Valentine Hallard (2024) Intersex Bodies, Surgery, and the Pursuit of "Normality". Human Rights Research Centre: https://www.humanrightsresearch.org/post/intersex-bodies-surgery-and-the-pursuit-of-normality

41 Human Rights Watch (2017) "I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US. https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us

42 OII Europe (2020) A report on the situation of intersex people in Europe and Central Asia: https://www.oiieurope.org/covid-19-survey-report/

43 OII Europe (2022) Follow-Up COVID-19 Intersex Survey: https://www.oiieurope.org/oii-europe-follow-up-covid-19-intersex-survey-2022/

44 Erin Howe and Somjen Frazer (2021) Funding to Meet Changing Realities: LGBTI Organisations on the State of Funding in Europe and Central Asia. Strength in Numbers Consulting Group for ILGA-Europe. https://www.ilga-europe.org/files/uploads/2022/04/Funding-Meet-Changing-Realities-LGBTI-Organisations-State-Funding-Europe-Central-Asia.pdf

45 Ibid.

Psychosocial Disability and the Gendered Realities of Coercion and Institutionalisation

Women and girls with psychosocial disabilities in the EU face profound and persistent violations of their rights, often rooted in a legacy and remaining aspects of institutionalisation, coercion, and systemic discrimination. Despite some progress in deinstitutionalisation agendas, many women remain confined in psychiatric hospitals, segregated residential care facilities, or other segregated settings where they are exposed to heightened risks of neglect, coercion, and GBV.[46] [47] [48] Institutional environments frequently exacerbate rather than alleviate distress, stripping women of autonomy, silencing their experiences, and reinforcing stigma around both disability and mental health.

The gendered dimension of institutionalisation is often overlooked. Women with psychosocial disabilities are disproportionately exposed to sexual and GBV in institutional contexts, including forced medication, seclusion, and in some cases, forced sterilisation or denial of reproductive rights.[49] [50] Such violations not only cause immediate harm but also have long-term consequences for mental health, bodily autonomy, and trust in healthcare and support systems. These practices run counter to the commitments under the UNCRPD, ratified by the EU, which mandates the protection of legal capacity, freedom from abuse and coercion, and the right to live independently and be included in the community. A gender-sensitive approach to deinstitutionalisation requires ensuring that women have access to safe, community-based services that specifically address risks of violence and provide holistic support. This includes adequate funding, gender-informed training for staff, and mechanisms that empower women to exercise choice and control over their lives during and after the transition from institutional care.

Mandates the protection of legal capacity, freedom from abuse and coercion, and the right to live independently and be included in the community

According to the European Disability Forum (EDF)[51], women and girls with disabilities, including those with psychosocial disabilities, continue to face a wide range of harmful stereotypes. These reinforce discrimination and heighten exposure to violence, exclusion, and rights violations, which in turn may also result in deeply adverse mental health outcomes. Common assumptions include the belief that women and girls with disabilities cannot care for children or relatives, should not have children, or are incapable of making decisions about their own bodies and sexuality. These misconceptions fuel practices such as forced sterilisation, contraception, and abortion without free and informed consent, which are explicitly prohibited under the UNCRPD and the Istanbul Convention. Exclusion from sexuality education and sexual and reproductive health services is common, resulting in increased risk of sexual violence, exploitation, unwanted pregnancies, and sexually transmitted infections.

Additional stereotypes depict women and girls with disabilities as **less deserving of education, unsuitable for certain jobs, or incapable of leadership roles**. Such biases affect their mental health and well-being, limit their participation in schools, workplaces, and political life, perpetuating cycles of marginalisation, disempowerment, and economic dependence. Women and girls with psychosocial disabilities are further stigmatised by damaging stereotypes and myths that portray them as supposedly violent, unpredictable, or unreliable. These prejudices not only undermine their employment prospects and parental rights but also restrict their access to justice and protection services, with survivors of violence often denied the needed and appropriate support, including mental health care.

46 MHE and University of Kent (2017) Mapping and Understanding Exclusion in Europe: https://mhe-sme.org/wp-content/uploads/2018/01/Mapping-and-Understanding-Exclusion-in-Europe.pdf

47 WHO Europe (2018) Mental health, human rights and standards of care: assessment of the quality of institutional care for adults with psychosocial and intellectual disabilities in the WHO European Region: https://iris.who.int/bitstream/handle/10665/342203/9789289053204-eng.pdf?sequence=1

48 Grigaitė, U., Levickaitė, K., Juodkaitė, D., Goštautaitė-Midttun, N. (2025) Promoting Human Rights-Based Deinstitutionalisation in Lithuania by Applying the World Health Organization's QualityRights Assessments. International Journal for Quality in Healthcare, Oxford University Press. https://doi.org/10.1093/intqhc/mzae118

49 EDF and CERMI Women's Foundation (2017) Ending forced sterilisation of women and girls with disabilities: https://www.edf-feph.org/content/uploads/2021/06/EDF-and-CERMI-Womens-Foundation-report-on-ending-forced-sterilisation-of-women-and-girls-with-disabilities.pdf

50 EDF (2022) Forced sterilisation of persons with disabilities in the European Union: https://www.edf-feph.org/content/uploads/2022/09/EDF_FS_0909-accessible.pdf

51 EDF (2025) EDF Position Paper on Gender Stereotypes against Women with Disabilities: https://www.edf-feph.org/publications/gender-stereotypes-against-women-with-disabilities/

Women with disabilities who live in residential care institutions face heightened risks of abuse due to isolation, power imbalances, and a lack of accountability within institutional settings, making violence and its consequences for mental health more frequent and harder to report. They are also less likely to be recognised as credible witnesses in cases of abuse, further entrenching impunity.[52] These intersecting stereotypes, rooted in ableism and gender bias, deny women and girls with psychosocial disabilities their rights to autonomy, dignity, and equality, and demand urgent action through inclusive policies, awareness-raising, accessible services, and targeted measures to dismantle structural discrimination.

Women with disabilities who live in residential care institutions face heightened risks of abuse

These realities reinforce structural exclusion, leaving women with psychosocial disabilities at the margins of both mental health care and gender equality agendas. Yet, across Europe, some promising practices offer potential pathways forward. The European Strategy for the Rights of Persons with Disabilities 2021–2030 includes a renewed emphasis on deinstitutionalisation and strengthening community-based support, recognising the need to replace coercive models with rights-based, person-centred approaches. In implementing these measures, Member States are encouraged to ensure that investments in accessible and affordable community-based services explicitly address the barriers faced by women in accessing social and mental health care services, integrating a gender perspective into deinstitutionalisation policies. EU-funded projects should also consider the compounded challenges faced by persons with disabilities who experience intersectional discrimination, including those from racial and ethnic minorities, LBTI+ women, and women with psychosocial disabilities, to promote equitable access to supportive, inclusive, and safe community-based services.[54]

"Well, when you have a disability, it's immediately that one [reaction]. The first thing that comes up, you know, it's just like a stamp or a label – that they "make things up". You know, that as if it's not true what they are saying. Because as if only "non-sick people" can tell the truth. (...) In that sense, everyone is very, very quick to say that if you are disabled, you are written off. (...)." – A Legal Guardian of a girl with a psychosocial disability, victim of GBV.[53]

"It must be stressed, however, that there is still little accessible data on disability-specific violence, on violence in closed environments (institutions, asylum centres or psychiatric hospitals), on the relationship between the victim and the perpetrator(s), and on the barriers to reporting violence that keep women and girls with disabilities silent and invisible as underlined by the European Disability Forum.[57][58]

Some Member States have introduced peer-led crisis alternatives, crisis respite houses, and survivor-driven advocacy initiatives that demonstrate the potential of non-coercive, community-based responses (e.g., the Bochum Crisis Rooms in Germany[55], the Open Dialogue Approach in Finland and the Trieste Model in Italy[56]). Civil society organisations, including women's disability rights networks, continue to highlight and challenge abuses while piloting trauma- and violence-informed support models that affirm women's agency and lived experience.

Realising the rights of women with psychosocial disabilities requires the EU and its Member States to move beyond rhetoric and ensure effective enforcement of the UNCRPD obligations in practice. This means investing in gender-sensitive and gender-just deinstitutionalisation, prohibiting coercion in mental health services, ensuring access to justice and redress for survivors of violence and abuse, and embedding lived and living experience leadership in service design and monitoring. **Protecting the mental health and dignity of women with psychosocial disabilities is not only a question of healthcare reform but a matter of gender justice and human rights at the heart of the EU's commitments.**

52 Leanne Dowse, Simone Rowe, Eileen Baldry and Michael Baker (2021) Police responses to people with disability: Research report. https://apo.org.au/node/314892

53 Grigaitė, U., Baltrušytė, G.M., Sipko, K. (2025) Access to Justice for Children with Disabilities who are Victims of Crime in Lithuania: A Qualitative Study. The International Journal for Children's Rights. https://doi.org/10.1163/15718182-33010005

54 European Commission (2024) Guidance on independent living and inclusion in the community of persons with disabilities in the context of EU funding: https://employment-social-affairs.ec.europa.eu/news/commission-adopts-guidance-independent-living-persons-disabilities-2024-11-20_en

55 Council of Europe (2021) Compendium Report: Good Practices to Promote Voluntary Measures in Mental Health Services. https://rm.coe.int/inf-2021-9-compendium-final-e/1680b11f60

56 WHO (2021) Guidance on community mental health services: Promoting person-centred and rights-based approaches. https://iris.who.int/server/api/core/bitstreams/184ff4ef-9c4c-4aad-b1c5-437b08bc0184/content

57 EDF (2021) EDF Position Paper on Violence against Women and Girls with Disabilities in the European Union: https://www.edf-feph.org/publications/edf-position-paper-on-violence-against-women-andgirls-with-disabilities-in-the-european-union

58 Yousra Sandabad (2024) RESPONSE: Responsive services to address gender-based violence against women with disabilities – State of the Art Report. https://easpd.eu/fileadmin/user_upload/Projects/0_RESPONSE_State_of_the_Art_Report.pdf

Medical Misogyny and Devaluation of Lived Experience in Mental Health and Healthcare Systems

Across Europe, women continue to encounter deeply gendered forms of bias and discrimination within healthcare systems, including mental health services. Medical misogyny in mental healthcare may manifest in over-medicalisation of women's distress, misdiagnosis, and disregard for the social and structural factors that shape mental health and well-being. Depression, anxiety, or trauma-related conditions are frequently treated as individual "pathology" rather than recognised as responses to violence, discrimination, or societal inequalities. This reinforces a cycle in which women are regularly silenced, their suffering medicalised, and their autonomy undermined.

A related dimension is epistemic (intellectual) injustice[59]: women are too often positioned as unreliable narrators of their own suffering, with clinicians privileging biomedical or psychiatric frameworks over first-hand accounts of distress.[60] This is particularly harmful for survivors of GBV, whose disclosures are often doubted, minimised, or reframed as supposed symptoms of a psychiatric condition; for example, in cases of the manifestations of epistemic privilege in psychiatry.[61] For women with psychosocial disabilities, this dynamic is compounded by structural ableism, leading to persistent exclusion from decisions about their own care and support.

"Yes, when I was in Sofia, I started mentioning the sexual [violence], I don't think they really believed me. That is something that happens too, when you tell them. They think that everything is caused by the psychosis." – A woman with a psychosocial disability who experienced multiple forms of gender-based violence.[62]

The consequences of medical misogyny and the devaluation of lived experience are profound. They contribute to delayed or inadequate diagnoses, inappropriate or coercive treatments, and erosion of trust in healthcare systems. Moreover, these dynamics perpetuate stigma and create barriers to help-seeking, leaving many women without effective, rights-based support. They also reproduce structural inequalities: for example, **migrant and refugee women face a double burden of racial bias and gender bias, while trans and intersex women encounter additional layers of pathologisation and delegitimisation of their identities**.

59 Fricker, M. (2007) Epistemic injustice: Power and the ethics of knowing. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198237907.001.0001

60 Liz Jonas, Sondra Bacharach, Sarah Nightingale, Sara Filoche (2025) Under the umbrella of epistemic injustice communication and epistemic injustice in clinical encounters: a critical scoping review. Ethics, Medicine and Public Health. https://doi.org/10.1016/j.jemep.2024.101039

61 Kidd, I. J., Spencer, L., Carel, H. (2022) Epistemic injustice in psychiatric research and practice. Philosophical Psychology, 38(2), 503–531. https://doi.org/10.1080/09515089.2022.2156333

62 Elena Krasteva, Aneta Genova (2024) DIS-CONNECTED: Disability-Based Connected Facilities and Programmes for Prevention of Violence against Women and Children in Bulgaria. Kera Foundation: https://validity.ngo/wp-content/uploads/2025/02/DIS-CONNECTED_NatRep_BG_EN_approved-1-1.pdf

Moreover, women across Europe continue to face systemic barriers to sexual and reproductive health and rights (SRHR). Restrictive abortion laws, unequal access to assisted reproductive technologies, and the lack of universal, stigma-free care create legal, financial, and practical obstacles. These barriers often force women to delay or forgo essential healthcare, disproportionately affecting those in marginalised groups.[63] Additionally, general reductions in global aid, combined with the mounting backlash against gender equality, further endanger women's health.[64]

According to the International Planned Parenthood Federation (IPPF) – European Network, inconsistent national policies reveal a clear breach of reproductive rights and deepen existing inequalities across the region. Obstetric and gynaecological violence remains a widespread and under-addressed form of GBV, encompassing mistreatment, coercion, neglect, and non-consensual procedures in healthcare settings.[65] Such violations undermine bodily autonomy, perpetuate distrust in health systems, and highlight the absence of effective safeguards, accountability, and professional training. Women facing intersecting discrimination, including women with disabilities, migrants, LBTI+ women, and survivors of GBV, are most **at risk of exclusion, mistreatment, and systemic neglect**, while trans and intersex women encounter uniquely **severe violations of their health and human rights**.

Closing these gaps requires comprehensive, intersectional policies that recognise how gender, sexuality, migration status, disability, ethnicity, and socio-economic position shape access to care. Expanding comprehensive sex education, ensuring equal access to SRHR, and addressing obstetric and gynaecological violence must be prioritised as urgent mental health and human rights imperatives. The EU has an essential role to play: harmonising access to SRHR across Member States, supporting cross-border solidarity mechanisms for abortion care, combating medical and institutional violence, and strengthening funding for women's rights and SRHR organisations to ensure equitable, rights-based, and recovery-oriented healthcare for all.

Ultimately, dismantling medical misogyny and epistemic injustice in healthcare requires more than incremental reforms. It demands structural shifts toward gender justice, rights-based practice, and accountability mechanisms that ensure women's lived experiences are not just heard but acted upon. Without such transformation, mental health systems risk reproducing the very inequalities they are meant to address.

63 IPPF European Network: https://en.europe.ippf.org/address-the-root-causes-of-gender-inequality.

64 UN Women (2025) Progress on the Sustainable Development Goals: the Gender Snapshot 2025. https://www.unwomen.org/sites/default/files/2025-09/progress-on-the-sustainable-development-goals-the-gender-snapshot-2025-en.pdf

65 IPPF European Network (2022) Obstetric and Gynaecological Violence: https://europe.ippf.org/resource/gynaecological-and-obstetric-violence-form-gender-based-violence

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3.

Gender and Intersectionality in Mental Health

Practical Relevance of the Psychosocial Model of Mental Health

Understanding gender and mental health requires an intersectional lens that acknowledges how social position, identity, and structural inequalities shape lived experiences of distress and mental health. Intersectionality in practice means recognising that gender often interacts with other factors: people may also face discrimination linked to such parts of their identities as disability, age, ethnicity, class, migration status, or sexuality, and these combined forces can compound the risk of mental health difficulties and mental health conditions.

Such an approach resonates strongly with the psychosocial model of mental health[66] [67], which challenges narrow biomedical interpretations by situating mental health within broader life contexts. Recovery is not defined simply by biomedical treatment results but is given individual meaning and connected to factors such as complex support systems that include peer support, accessible, community-based, individualised, person-centred services, and inclusive policies. Central to this approach is the idea that people with lived experience are experts in their own recovery, and that choice, autonomy, and meaningful participation are essential for mental health.

Applying this perspective to gender makes clear how gendered inequalities, including GBV, unequal care responsibilities, and systemic misogyny, directly affect mental health. As has been shown, women often face intersecting barriers that exacerbate exclusion and distress. For example, migrant women, racialised women, women with psychosocial disabilities, or LBTI+ women may encounter multiple layers of discrimination in health, employment, or housing, which cannot be separated from their mental health outcomes. The psychosocial approach, by recognising these intersecting inequalities, provides a framework for designing responses that address both individual needs and structural injustices.

People with lived experience are experts in their own recovery, and that choice, autonomy, and meaningful participation are essential for mental health

For EU policymakers, this framing underlines an urgent advocacy message: mental health policies that disregard gender (or vice versa: gender equality policies that overlook mental health and disability rights) and intersectionality risk deepening inequality and leaving the most marginalised persons behind. A gender-transformative, gender-just, psychosocial approach should therefore be embedded into the EU's strategies on health, equality, and human rights. This requires not only investment in accessible and inclusive mental health services, but also coordinated EU-level action to dismantle structural barriers, such as GBV, discrimination, and precarious socio-economic conditions, that undermine women's mental health. By embracing intersectionality in policy and practice, the EU can position itself as a global leader in reimagining mental health systems through equality, justice, and human rights. This vision is firmly aligned with the EU's obligations under the UNCRPD and the Istanbul Convention, both of which affirm the **right to full inclusion, equality, and freedom from violence and discrimination**.

66 MHE (2023) Promoting understanding of the psychosocial model of mental health: https://www.mhe-sme.org/wp-content/uploads/2023/04/MHE-Psychosocial-model-Toolkit.pdf

67 Karilė Levickaitė and Ugnė Grigaitė (2020) Mental Health, Psychosocial Disability and the Right to live in the Community: Deinstitutionalisation and Advocacy for Change. https://perspektyvos.org/wp-content/uploads/2021/06/psp_module_final_2020.pdf

Challenges of Data Gaps and Gender-Blind Mental Health Systems

A persistent barrier to effective gender-sensitive and gender-just mental health policy and practice in the EU is the lack of comprehensive, disaggregated data. Current mental health research and service data often fail to capture differences in experiences and outcomes based on gender, intersecting identities, or social determinants. This invisibility undermines the ability of policymakers to design targeted interventions, allocate resources equitably, and monitor the effectiveness of services. Moreover, many existing mental health systems operate under gender-neutral assumptions, overlooking how structural inequalities, GBV, caregiving responsibilities, and social expectations and "norms" shape mental health outcomes.[68]

Addressing these gaps requires a systematic, rights-based approach to data collection, monitoring, and evaluation. This includes the routine disaggregation of mental health indicators by gender, age, migration status, type of disability, socioeconomic status, and other intersecting factors, while ensuring robust safeguards. Complementing quantitative data with qualitative insights, including lived experience narratives, can illuminate barriers, discriminatory practices, and unmet needs that traditional metrics often miss. Investment in quality research informed by a full intersectional understanding must be prioritised while ensuring transparency, ethical safeguards, and community participation.

Importantly, improving gender-responsive and intersectoral data systems is not merely a technical necessity but a matter of human rights, accountability, and social justice, enabling evidence-based interventions that uphold the UNCRPD, the Istanbul Convention, and advance meaningful inclusion for all people across Europe.

68 Mischa Barr, Renata Anderson, Sandra Morris, Kate Johnston-Ataata (2024) Towards a gendered understanding of women's experiences of mental health and the mental health system. Women's Health Victoria, Issues Paper 17.2. https://www.whv.org.au/wp-content/uploads/2023/01/Issues-Paper-17-2_Nov-2024_Towards-a-gendered-understanding-of-womens-experiences-of-mental-health-and-the-mental-health-system.pdf

Participatory and Inclusive Research, Policy, and Practice

Ensuring that research, policy-making, and mental health practice are participatory and inclusive is essential for addressing gendered inequalities and promoting gender justice in mental health. Traditional approaches often marginalise the voices of those with lived experience, particularly women, as well as those from intersecting marginalised groups such as migrants, LGBTQI+ persons, and persons with disabilities. This exclusion limits the relevance, effectiveness, and equity of mental health policies and services, reinforcing epistemic injustice and systemic barriers.

Participatory approaches involve co-creating and co-designing research, policies, and services with those most affected, recognising lived and living experience as expertise. By fostering meaningful engagement at every stage, such approaches increase accountability, relevance, and the potential for systemic change. Advocacy for participatory and inclusive approaches calls on EU institutions and Member States to establish frameworks that mandate lived-experience leadership, embed co-creation and co-production in policy and service design, and fund research that prioritises inclusion. Such efforts are aligned with rights-based obligations under the UNCRPD and broader EU equality and anti-discrimination frameworks, ensuring that mental health systems are equitable, responsive, and capable of addressing structural and gendered determinants of mental health. Other relevant policy areas, such as housing, social policies, and digitalisation, must also incorporate both gender and mental health perspectives.

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4.

Holistic Approaches to Mental Health

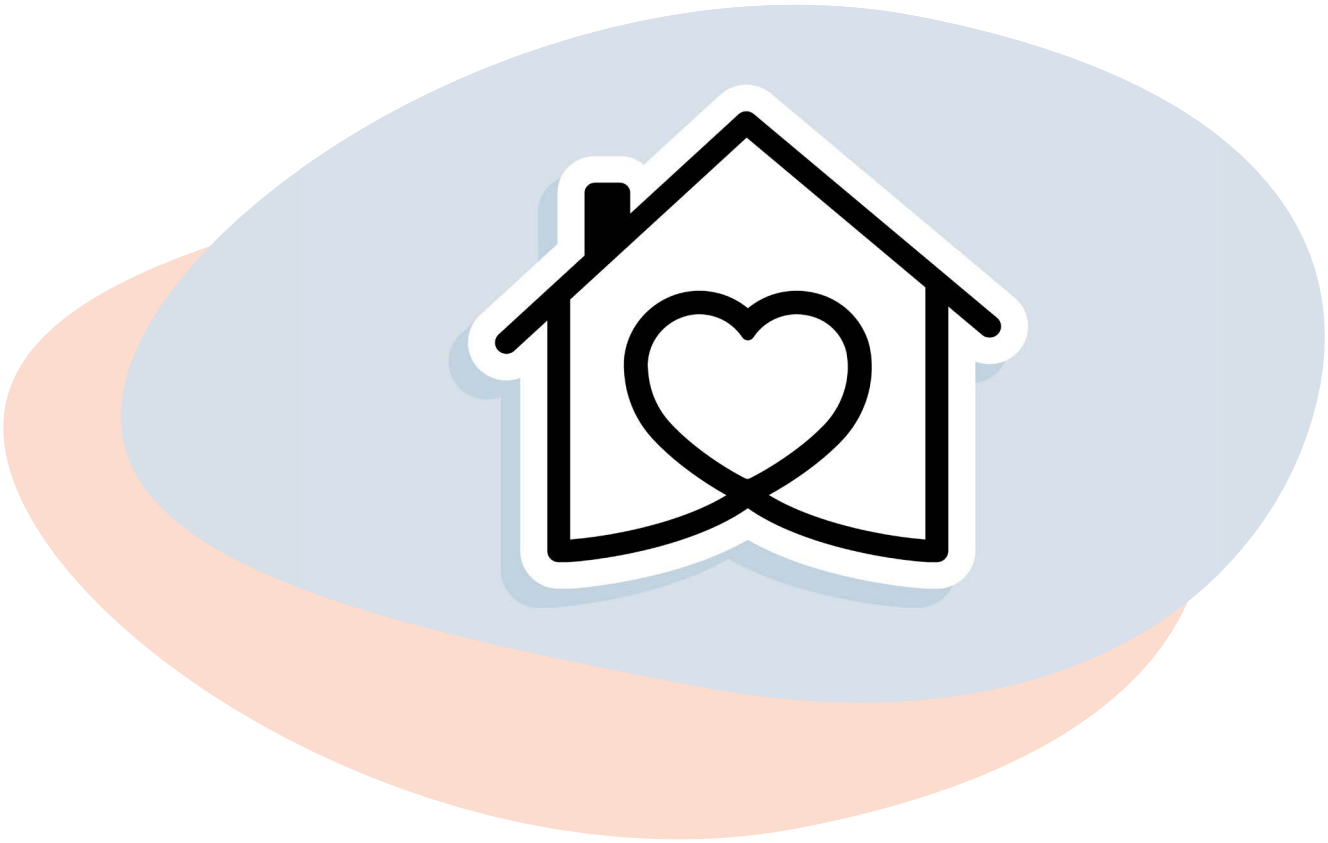
Social Determinants and Recovery Approach

The intersectional and psychosocial approach naturally bridges into the concept of social determinants of mental health. It acknowledges that mental health is deeply influenced by socioeconomic and environmental conditions, and highlights the necessity of addressing inequality, discrimination and violence, which are particularly relevant when discussing women's mental health. Such a holistic approach to mental health requires moving decisively to embracing integrated, community-based, gender-just, and rights-based perspectives. Addressing mental health, therefore, demands action also through social, economic, and equality policies that enable prevention, inclusion, and dignity.

Within this framework, the recovery approach[69] is essential. In the context of gender and mental health, the recovery approach requires services that are responsive to individual realities, including exposure to GBV and unequal access to resources. Promising practices can already be found in community-based peer support networks, survivor-led services, and gender-sensitive crisis alternatives that prioritise safety, choice, agency, autonomy, and dignity over coercion and institutionalisation.[70]

At the EU level, the European Strategy on the Rights of Persons with Disabilities reflects the UNCRPD's principles, which are in line with the recovery approach, but also acknowledges ongoing legal and systemic barriers, particularly for women with psychosocial disabilities. Policy discussions are underway, but lived experience testimonies indicate that institutional, coercive and paternalistic practices remain symbolically and practically entrenched. To make recovery-oriented, rights-based mental health systems a reality, EU policies and professional practices must be equipped with clear guidance, tools, and accountability mechanisms that translate the recovery approach and principles into everyday care.

Lived experience testimonies indicate that institutional, coercive and paternalistic practices remain symbolically and practically entrenched



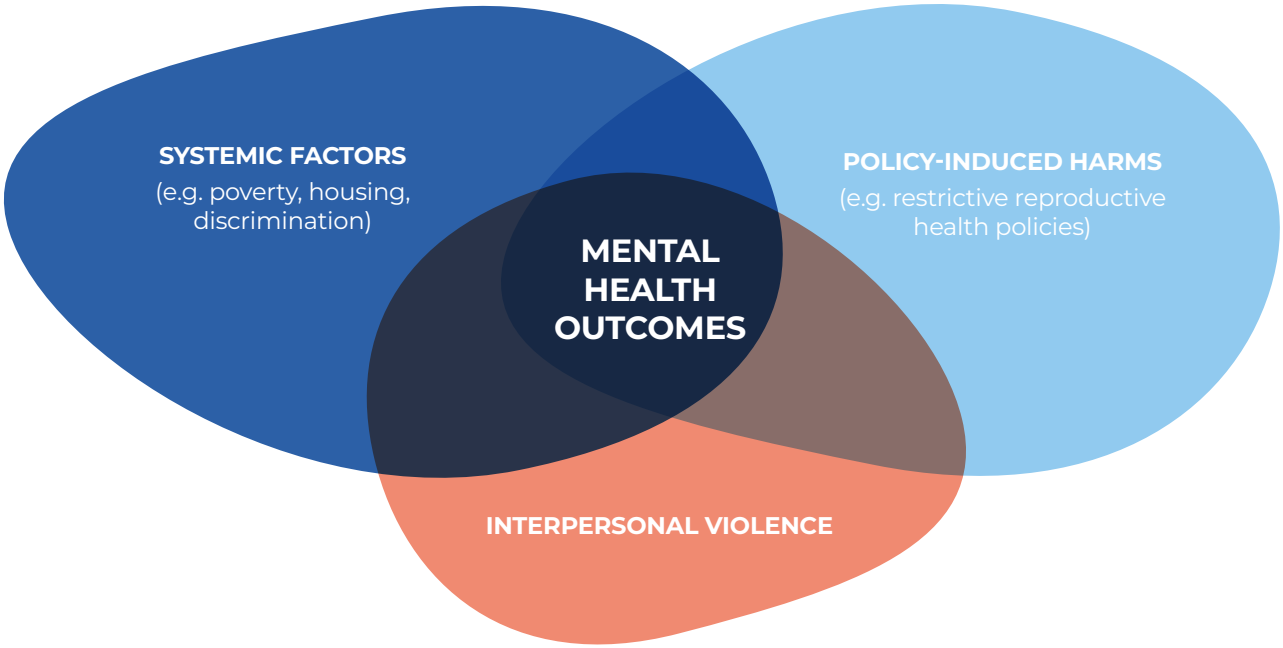
69 Diana González-Mañas, Francisco José Eiroa-Orosa, Camille Roux (2024) Recovery in Mental Health Services: https://www.mentalhealtheurope.org/wp-content/uploads/2024/12/Policy-Report-Recovery-Based-Human-Rights-Indicators-in-Mental-Health-Services.pdf

70 WHO (2021) Guidance on community mental health services: Promoting person-centred and rights-based approaches. https://iris.who.int/server/api/core/bitstreams/184ff4ef-9c4c-4aad-b1c5-437b08bc0184/content

Trauma- and Violence-Informed Care

For many women, including survivors of GBV, mental health distress is deeply rooted in trauma. Services that fail to recognise this risk re-traumatising survivors through coercion, disbelief, or lack of sensitivity.[71] A truly recovery-oriented mental health system must integrate trauma and violence-informed care.[72] [73] This would mean prioritising safety, trust, and empowerment, recognising the pervasive impact of violence on women's lives and tailoring the mental health support responses accordingly.

Trauma- and violence-informed care[74] represents an evolution from traditional trauma-informed approaches, expanding the focus from individual interventions to a broader understanding of interpersonal and structural violence, especially GBV. It situates experiences of various forms of violence within wider social and structural inequities, recognising that **systemic factors**, such as poverty, housing insecurity, discrimination, and **policy-induced harms** (e.g. restrictive reproductive health policies, healthcare exclusion, institutionalisation policies), intersect with **interpersonal violence to shape mental health outcomes**. It is guided by four core principles: understanding and acknowledging the impact of trauma and structural violence; prioritising the physical, emotional, and cultural safety of service users and providers; promoting person-centred collaboration, choice, and connection; and building on existing strengths while supporting skill and capacity development.



Trauma is not only a psychological experience but also shaped by social and structural conditions

This approach emphasises that trauma is not only a psychological experience but also shaped by social and structural conditions. It highlights the responsibility of organisations and providers to adapt systems and services to meet individual needs, rather than requiring people to navigate inflexible structures to access support. In practice, this approach integrates these principles into programmes and services, ensuring that interventions are responsive, sustained, and embedded within broader systems of care.[75] Importantly, it also underscores the responsibility of policymakers to recognise the intersectional nature of mental health and to ensure that these considerations are integrated across all policy domains, as decisions in areas such as health, housing, education, and social protection profoundly shape both the need for and the accessibility of support.

71 Grigaitė, U. (2025) Responses to the Mental Health Care Needs of Survivors of Intimate Partner Violence by Mental Health Services in Lithuania and Portugal. DOI: 10.13140/RG.2.2.11760.98563

72 Wathen, C. N. and Mantler, T. (2022) Trauma- and Violence-Informed Care: Orienting Intimate Partner Violence Interventions to Equity. Current Epidemiology Reports, 9, 233–244. https://doi.org/10.1007/s40471-022-00307-7

73 Wathen, C. N. and Varcoe C. (2023) Implementing trauma-and violence-informed care: A handbook. University of Toronto Press. ISBN: 978-1-4875-2927-7.

74 Wathen, C. N. and Mantler, T. (2022) Trauma- and Violence-Informed Care: Orienting Intimate Partner Violence Interventions to Equity. Current Epidemiology Reports, 9, 233–244. https://doi.org/10.1007/s40471-022-00307-7

75 Ibid.

Embedding and fostering such approaches as a standard across mental health systems (in both policy and practice) would represent a fundamental step toward gender justice in mental health care: by embedding trauma- and violence-informed principles in mental health and other services, care becomes not only trauma-sensitive but also rights- and recovery-based, intersectional, and responsive to the gendered realities of women's experiences. By redistributing knowledge power, mental health care can become not only more inclusive but also more effective, rooted in the realities of those it seeks to support. Beyond services, however, these principles must also inform prevention efforts, ensuring that systems address the root causes of trauma and structural violence before they manifest in adverse mental health outcomes.

Holistic, gender-responsive, recovery-oriented, trauma- and violence-informed, and peer-led approaches are not optional add-ons: they are requirements for building mental health systems that are both effective and just. At the EU level, this calls for policies that explicitly integrate gender, intersectionality, and human rights into mental health strategies, ensuring alignment with the UNCRPD and the Istanbul Convention. By promoting holistic and gender-just approaches, the EU has the opportunity to lead in reimagining mental health systems that truly heal rather than harm. This also presents an opportunity to recognise that mental health must be considered across all policy areas, as decisions in education, housing, employment, migration, justice, social protection, and beyond, all profoundly shape mental health and well-being.

Holistic, gender-responsive, recovery-oriented, trauma- and violence-informed, and peer-led approaches are not optional add-ons: they are requirements for building mental health systems that are both effective and just.

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5.

EU Policies on Gender Equality and Mental Health

Overview of Key EU Frameworks

Gender Equality: The EU Gender Equality Strategy

The EU Gender Equality Strategy 2020–2025[76] represents the Commission's flagship initiative to advance equality between women and men across Europe. It outlines a comprehensive set of objectives to eliminate GBV, dismantle stereotypes, reduce gaps in pay, pensions, care responsibilities, and political and economic participation, while promoting gender balance in decision-making. A dual approach, mainstreaming gender into all policies alongside targeted measures, is at the heart of the Strategy, with intersectionality serving as a guiding principle. Recent relevant legislative milestones under this framework include the Pay Transparency Directive (2023), the Directive on Gender Balance in Corporate Boards (2022), the Work-Life Balance Directive (2022), and the European Care Strategy (2022), all of which seek to address structural inequalities that affect women's lives and, by extension, their mental health and well-being.

The Strategy has also prioritised action against GBV, with the Directive on Violence against Women and Domestic Violence (2024) marking the first EU-wide legal framework to criminalise certain forms of violence and provide victims with stronger access to justice and support services such as shelters and helplines. Complementary steps include the EU's accession to the Council of Europe Convention on preventing and combating violence against women and domestic violence – Istanbul Convention (2023), the launch of the EU Network on the Prevention of Gender-Based and Domestic Violence (2023), and the #EndGenderStereotypes Campaign (2023).

These initiatives demonstrate a growing EU-level commitment to dismantling barriers that reinforce gender inequality. However, persistent gender stereotypes, reflected in the 2024 Eurobarometer on Gender Stereotypes[77], indicate that **progress remains insufficient and uneven across Member States**, underscoring the need for sustained efforts to ensure that equality commitments are fully translated into practice.

Several gaps are evident in EU policies on mental health, psychosocial disability, and GBV, including the EU Gender Equality Strategy. The European Economic and Social Committee (EESC)[78] has criticised the Directive on Violence Against Women and Domestic Violence[79] for failing to address serious and emerging forms of violence, such as institutional violence affecting women with psychosocial disabilities, reproductive exploitation, and forced sterilisation. The EESC also highlights that sexual and reproductive rights, such as access to abortion, emergency contraception, and protection from harassment at clinics, are not recognised as forms of violence, despite growing restrictions in some Member States, including Poland and Hungary, which can have profound adverse mental health impacts.[80] [81] Additionally, the Committee notes the lack of robust, victim-centred support and coordination between general health services, mental health care, and specialised victim support services, observing that neglecting survivors' mental health needs constitutes a human rights violation.

This critique aligns with the EDF's position[82] [83], which emphasises that the EU Directive still leaves gaps affecting women and girls with psychosocial and other disabilities. Laws must define rape based on lack of consent ("only yes means yes") rather than on resistance or a "no means no" standard. The latter disproportionately excludes women with disabilities, particularly those in segregated psychiatric or social care settings. Sexual harassment, posing heightened risks for women with mental health conditions, also requires stronger legal protection. Finally, the **absence of a clear obligation to collect disability-disaggregated data remains a major shortcoming**, limiting understanding of prevalence and the design of effective, targeted measures.

76 EU Gender Equality Strategy (2020-2025): https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/gender-equality/gender-equality-strategy_en#gender-equality-strategy-2020-2025

77 Eurobarometer on Gender Stereotypes (2024): https://europa.eu/eurobarometer/surveys/detail/2974

78 European Economic and Social Committee (2024) Opinion SOC/798: Violence against women as a human rights issue: state of play of measures across the EU. https://www.eesc.europa.eu/en/our-work/opinions-information-reports/opinions/violence-against-women-human-rights-issue-state-play-measures-across-eu

79 EU Directive on violence against women and domestic violence (2024): https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32024L1385&qid=1716811631310

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82 EDF (2021) Violence against Women and Girls in the European Union: https://www.edf-feph.org/content/uploads/2021/05/final-EDF-position-paper-on-Violence-against-women-and-girls-with-disabilities-in-the-European-Union.pdf

83 EDF (2025) Transposing the EU Directive on Combating Violence against Women: https://www.edf-feph.org/content/uploads/2025/05/EDF-guidance-on-transposing-the-EU-Directive-on-Combating-Violence-Against-Women.pdf

Mental Health: European Commission's Comprehensive Approach to Mental Health

In June 2023, the European Commission (EC) launched the Comprehensive Approach to Mental Health[84], marking a significant policy milestone by recognising mental health as a priority at EU level. The initiative adopts a cross-sectoral and preventive lens, positioning mental health as integral to public health, social policy, employment, education, and digitalisation. It seeks to address the growing mental health crisis in Europe, exacerbated by the COVID-19 pandemic, the war in Ukraine, economic uncertainty, and wider societal pressures.

The framework is structured around three main pillars: promoting good mental health through prevention and early intervention; ensuring accessible, affordable, and high-quality mental health care and support services; and including people with mental health conditions and psychosocial disability into society, tackling stigma and discrimination. To support its implementation, the EU pledged to repurpose over €1.2 billion in funding from various EU programmes, signalling a political commitment to put mental health on par with physical health in the European policy agenda.

While the communication from the European Commission on the Comprehensive Approach consolidates existing funding allocations and actions for mental health, it must be noted that **it does not constitute a long-term strategy, as no new initiatives or sustained funding have been established**.[85] Nonetheless, it explicitly recognises the social and economic imperative to invest in prevention, early intervention, and promotion, creating momentum for advocacy and further action. Following the launch of the Comprehensive Approach, MHE emphasised the importance of fostering the psychosocial model and developing a Mental Health Strategy with specific objectives, timelines, budgets, and indicators to monitor progress.[86]

The Comprehensive Approach to Mental Health acknowledges the differentiated impacts of mental health challenges on women, men, and vulnerable groups, but it does not yet fully integrate an intersectional lens. While it highlights the importance of tackling stigma, improving access to community-based care, and supporting youth mental health, **stronger links with gender equality frameworks, disability rights, and GBV policies remain necessary to ensure that all women**, including LBTI+ women and women with psychosocial disabilities, are not overlooked. Nevertheless, the Comprehensive Approach initiative presents an opportunity for further alignment between mental health policy and EU strategies on gender equality, disability, and human rights, potentially paving the way for more inclusive, rights-based, and gender-just mental health systems across Europe. It also highlights the importance of co-creation with people with lived experience and key stakeholders, mainstreaming mental health across policy areas, and using inclusive, non-stigmatising language to foster awareness, education, and systemic change.

84 EC's Comprehensive Approach to Mental Health: https://commission.europa.eu/strategy-and-policy/priorities-2019-2024/promoting-our-european-way-life/european-health-union/comprehensive-approach-mental-health_en

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86 MHE (2023) A comprehensive approach to mental health: Europe's first step and action to address the well-being of all. https://www.mentalhealtheurope.org/library/a-comprehensive-approach-to-mental-health-europes-first-step-and-action-to-address-the-well-being-of-all/

Disability Rights: EU Strategy for the Rights of Persons with Disabilities

Adopted in March 2021, the EU Strategy for the Rights of Persons with Disabilities 2021–2030[87] sets out a ten-year framework to advance the inclusion, equality, and participation of persons with disabilities across Europe and beyond. Building on the progress of the 2010–2020 European Disability Strategy, it acknowledges persisting barriers in accessibility, employment, independent living, and protection from discrimination, violence, and abuse, as well as the heightened risks of poverty, social exclusion, and mental health inequalities. Importantly, the Strategy recognises that women and girls with disabilities, including those with psychosocial disabilities, face intersecting forms of discrimination, GBV, and systemic gaps in access to gender-sensitive healthcare and mental health support.

The Strategy is grounded in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which the EU ratified in 2010. The Strategy recognises the multiple disadvantages faced by women, children, older persons, refugees, and others with disabilities, and explicitly emphasises the need to address gendered barriers, psychosocial vulnerability, and the impacts of trauma on mental health and well-being. Its overarching aim is to ensure that all persons with disabilities can fully enjoy their human rights, access opportunities on equal terms, live independently, move freely within the EU, and be protected from discrimination, violence, and mental health inequities.

While the Strategy broadly addresses the challenges encountered by persons with disabilities, **it does not provide detailed, targeted actions or flagship initiatives specifically focused on psychosocial disabilities and mental health conditions**. This omission is notable given the unique barriers faced by individuals, especially women and girls, with psychosocial disabilities, including stigma, discrimination, and limited access to appropriate mental health services.[88] Furthermore, the Strategy's intersectional approach, while commendable, does not fully capture the specific needs and challenges of women with psychosocial disabilities. These nuanced issues require more explicit attention and tailored interventions within the EU's disability rights framework.

87 EU's Strategy for the Rights of Persons with Disabilities (2021–2030): https://commission.europa.eu/strategy-and-policy/policies/justice-and-fundamental-rights/disability/union-equality-strategy-rights-persons-disabilities-2021-2030_en

88 UN Women (2018) The Empowerment of Women and Girls with Disabilities: Towards Full and Effective Participation and Gender Equality. https://www.unwomen.org/sites/default/files/2023-10/empowerment-of-women-and-girls-with-disabilities-en.pdf

A Broader Perspective: European Pillar of Social Rights

The European Pillar of Social Rights (EPSR)[89] sets out 20 key principles to strengthen social rights across the EU, aiming to deliver fair and well-functioning labour markets and welfare systems. The EPSR covers three broad areas: equal opportunities and access to the labour market, fair working conditions, and social protection and inclusion. Its principles encompass vital issues such as gender equality, work-life balance, access to quality and affordable healthcare, adequate social protection, housing and assistance for homeless people, and inclusion of persons with disabilities. The implementation of the Pillar is supported through EU legislation, funding instruments such as the European Social Fund Plus (ESF+), and the Social Scoreboard, which monitors Member States' performance.

For gender and mental health specifically, the EPSR provides a framework that directly addresses many of the social determinants underpinning women's mental health inequalities in the EU. Principles such as the right to equal opportunities regardless of gender, equal pay for work of equal value, and protection from discrimination are crucial for tackling the structural drivers of distress and mental health conditions among women. Equally, provisions on access to affordable healthcare, childcare, and support for persons with disabilities create pathways to reduce barriers for women, particularly those who face intersectional difficulties such as living with psychosocial disabilities or caring responsibilities. By linking gender equality to broader social inclusion and well-being, the EPSR lays the basic groundwork for integrated policy responses that align social, health, and gender equality agendas.

89 European Pillar of Social Rights (2017): https://employment-social-affairs.ec.europa.eu/policies-and-activities/european-pillar-social-rights-building-fairer-and-more-inclusive-european-union_en

Gaps and Silos: Lack of Integration Between Mental Health and Gender Equality Agendas

Despite growing recognition of the importance of both gender equality and mental health at the EU level, these agendas largely continue to evolve in isolation from one another. Current EU frameworks reveal a fragmented approach: while mental health is increasingly prioritised through initiatives such as the Comprehensive Approach to Mental Health (2023), many complex gender perspectives are almost entirely absent. Conversely, gender equality frameworks, including the EU Gender Equality Strategy and commitments under the Istanbul Convention, contain only passing references to health, and mental health is virtually invisible within them.[90] This disconnect is reinforced by the absence of systematic gender integration across EU health policy, funding streams, and data collection.

The tools available to measure progress often fail to capture these intersections. For example, the European Institute for Gender Equality's (EIGE) Gender Equality Index includes only narrow health-related indicators, such as healthy life years, without accounting for structural determinants of gendered health inequalities, especially concerning mental health. While recent EIGE reporting on the Beijing Platform for Action +30[91] has made progress in spotlighting sexual and reproductive health and rights (SRHR), gendered dimensions of mental health remain neglected. Additionally, the Social Scoreboard's limited inclusion of gender considerations highlights a broader gap in EU-level monitoring frameworks, calling for more robust gender-responsive indicators to capture various inequalities. As a result, the **EU lacks the evidence base necessary to address the compounded effects of gender inequality on mental health outcomes**.

These silos extend further when disability rights are considered. The EU's commitments under the UNCRPD and the Strategy for the Rights of Persons with Disabilities have strengthened attention to disability inclusion, yet psychosocial disabilities are often treated solely within a biomedical lens, with little recognition of intersecting gendered experiences.[92] Without an explicitly gendered approach, the EU risks undermining its own goals across three priority areas of mental health, gender equality, and disability rights, by failing to address how these dimensions interact in practice.

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This lack of integration is not only a technical gap but a matter of rights and representation. Women, including LBTI+ women, and particularly women with psychosocial disabilities, remain systematically under-represented in EU policymaking, even though they are among those most affected by healthcare inequalities, medical misogyny, and the current general political backlash against gender equality.[93] Connecting the dots between these agendas is therefore essential if EU strategies are to be both effective and inclusive.

The renewal of the EU Gender Equality Strategy and other equality frameworks provides a critical opportunity to bridge these divides. Future frameworks must move beyond rhetorical commitments to mainstreaming and instead introduce specifications that acknowledge the needs of women and girls in all their diversity. This includes embedding gendered perspectives into mental health policy, expanding data collection and monitoring tools, and ensuring that disability rights frameworks meaningfully address psychosocial dimensions. Only by dismantling these silos can the EU advance a more coherent, rights-based agenda that fully responds to the realities of people's lives.

90 Input by the UN Brussels Team – Gender Working Group (2025) EU Consultation on the Next Gender Equality Strategy: https://unric.org/en/eu-consultation-on-the-next-gender-equality-strategy

91 EIGE (2025) Beijing Platform for Action +30: https://eige.europa.eu/publications-resources/publications/beijing-platform-action-30-impact-driver-marking-milestones-and-opportunities-gender-equality-eu?language_content_entity=en

92 EDF (2025) EDF Recommendations for the EU Gender Equality Strategy 2026-2030: https://www.edf-feph.org/publications/recommendations-for-the-eu-gender-equality-strategy-2026-2030

93 European Economic and Social Committee (2018) Opinion SOC/579: The situation of women with disabilities. https://www.eesc.europa.eu/en/our-work/opinions-information-reports/opinions/situation-women-disabilities-exploratory-opinion-requested-european-parliament

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Conclusion

This is a critical moment for advancing gender justice across mental health and EU social policy. Rising political backlash against gender equality, combined with increasing demands for holistic, rights-based, and recovery-oriented approaches in EU health policy, underscores the urgent need for evidence-informed advocacy. This report responds to that need, providing an EU-level scoping analysis dedicated specifically to the intersection of gender and mental health.

By integrating an intersectional lens, including realities of LBTI+ women and women with psychosocial disabilities, the report highlights groups systematically under-represented in EU policymaking. It offers actionable, policy-relevant recommendations grounded in lived experience, human rights, and social justice.

Reimagining mental health systems through gender justice requires a fundamental transformation in how mental health and mental healthcare are understood, organised, and delivered. It moves beyond the biomedical model of framing distress as individual "pathology" to recognising the psychosocial dimensions and collective responsibility to address structural determinants such as GBV, unequal caregiving roles, restrictive gender "norms", and institutional discrimination.

A gender-just and recovery-oriented approach demands recognition of diverse individual gendered experiences, including those of LGBTQI+ persons, racialised and migrant people, and persons with disabilities, whose mental health is shaped by intersecting systems of oppression, discrimination, and exclusion. Central to this transformation is the elevation of lived experience and survivor leadership. Systems must shift from hierarchical, expert-driven models to participatory structures where people with lived experience co-create policies and services, ensuring that care is trauma- and violence-informed, dignified, and inclusive.

Gender-just mental health systems do not merely treat symptoms: they actively dismantle oppressive structures, prevent harm, and foster equity, autonomy, and well-being for all. Ultimately, gender justice in mental health is inseparable from human rights and EU values. Embedding principles of non-discrimination, participation, and accountability across mental health policy and practice aligns with the UNCRPD, the Istanbul Convention, and broader EU equality and human rights commitments. This report charts a forward-looking path for the European Commission and other institutions to anticipate trends, overcome silos between gender equality, mental health, and disability rights, and advance transformative, inclusive, recovery-oriented, and rights-based mental health systems across Europe.

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Policy Recommendations

The EU has multiple levers to drive meaningful progress on mental health and gender equality. Through shaping legislation and policies, promoting evidence-based approaches and best-practices, funding research and innovation, coordinating data collection and supporting Member States to strengthen rights-based mental health systems, the EU can play a crucial role in improving mental health outcomes.

Recommendations for EU institutions:

1. **Re-affirm commitment to equality** including with a new ambitious Gender Equality Strategy

Adopt a strong new Gender Equality Strategy, that includes a focus on mental health. Renew commitment to the Istanbul Convention and ensure full implementation of the previous Gender Equality Strategy. Strengthen other equality strategies such as the Strategy for Persons with Disabilities with no dilution of previous targets, aims or objectives.

2. **Centre the involvement of people with lived experience**

Ensure the meaningful involvement of people with lived experience and their representative organisations from policy design to implementation, monitoring and evaluation.

3. **Embed an intersectional approach** in policy creation

Ensure mental health and other policies consider intersecting factors such as gender, sexual orientation, age, ethnicity, disability, migration status, and socio-economic conditions. Recognise the impact of violence and trauma, including gender-based violence in policies ranging from housing to healthcare and beyond.

4. **Prioritise prevention & community-based care**

Support Members States in gender-just de-institutionalisation strategies and their implementation, ensuring community-based support is prioritised and easily available. Gather and share information on existing best practices emphasising peer-support and involvement of people with lived experience.

5. **Improve data collection & monitoring on gender and mental health**

Strengthen harmonised, gender- and disability-disaggregated data collection on mental health outcomes, access to services and related structural determinants, building on existing instruments such as the Social Scoreboard, Statistics on Income and Living Conditions (EU-SILC), European Health Interview Survey (EHIS) and the European Semester country assessments. Ensure strong safeguards on privacy and data protection, and use this data to inform policy.

6. **Challenge stigma**

Invest in EU-wide public awareness and education initiatives to reduce stigma regarding mental health, disability, sexual orientation, gender and other intersecting forms of discrimination. Campaigns should be co-designed with people with lived experience and tailored to reach and benefit people most affected by exclusion and inequality for example due to experience of psychosocial disability, gender-based violence or racism.

7. **Prioritise funding for mental health**

Recognise mental health as a form of essential social investment and support Member States to protect, prioritise and expand expenditure on mental health services, prevention and community-based support. Investment in social care and mental health should be strengthened within the new Multiannual Financial Framework (2028–2034), ensuring dedicated and adequate resource including the maintenance of ESF+ and earmarking for social spending including mental health as well as the retention to the link of the European Pillar of Social Rights.

8. Take an integrated, **mental health in all policies** approach

Ensure that mental health is considered in all policy areas including in upcoming initiatives around housing, employment and the upcoming Anti-Poverty Strategy to help address the structural issues that impact mental health and ensure these are all informed by a gender-just and intersectional approach.

9. Develop a **comprehensive EU Mental Health Strategy**

Create and implement a Comprehensive Mental Health Strategy, fully funded with a clear timeline, objectives and review mechanisms to monitor progress. This must be informed by an intersectional approach and commitment to gender-just and rights-based mental health systems. Connect this to a call on the Member States to develop national action plans.

Recommendations for Member States:

1. Close **gaps between policy and practice**

Ensure that commitments on gender equality, anti-discrimination and rights-based mental health systems translate into real access to services with a focus on prevention and early support. Address regional disparities, workforce shortages, and funding gaps. Ensure that mental health and peer-support workers are equipped and well supported.

2. **Ensure implementation of existing commitments to gender equality**

Ratify and implement the Istanbul Convention and ensure other commitments to gender equality are fulfilled.

3. **Prioritise, expand and fund community-level and peer-support initiatives**

These should prioritise prevention and recovery, building on national and international best practice examples.

4. **Improve access to information on support services**

Gather, publish and regularly update basic information on public support services, and third-sector organisations, via digital platforms and printed resources. Ensure materials are available in multiple languages and in easy-read format in local public institutions, government buildings, health and social care settings, police stations, schools and libraries.

5. **Develop and implement extensive training for professionals**

Develop training on gender equality, LGBTQ+ rights, gender-based violence and disability justice and the ways in which these intersect and impact on mental health, help seeking and access to services. This training should be integrated into mandatory initial education and ongoing professional development for healthcare and social care staff, police and emergency services, legal and judicial professionals and educators. This training should equip professionals to recognise and address stigma, unconscious bias and harmful stereotypes and foster safe, inclusive and respectful environments for all.

6. Improve content and availability of **sex and relationship education**

Ensure comprehensive, age-appropriate, evidence-based and LGBTQ+ inclusive sex and relationship education in schools and further education settings. Programmes should include a strong focus on consent, healthy relationships and mental wellbeing and challenge rigid gender norms and harmful stereotypes.

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Annex 1: Methods

Methodology and Ethical Approach

The report is based on desk-based research conducted between July and October 2025, drawing from a wide range of sources including EU policy documents, academic literature, civil society reports, grey literature, and contributions from lived and living experience networks. Particular attention was given to identifying gaps in existing data and policy coverage, where gender and mental health intersect. Source selection was guided by relevance, diversity of perspectives, and the inclusion of underrepresented voices, particularly those who identify as women and members of disability communities.

Throughout the process, the report's direction and framing were refined through ongoing dialogue with the MHE Secretariat, ensuring alignment with current advocacy goals and priorities of lived and living experiences. While the approach does not involve primary data collection, it incorporates qualitative insights from the already published and publicly available testimonies, peer-led and survivor-led publications, and participatory research outputs to illustrate systemic issues and inform policy recommendations.

This report takes a participatory and rights-based approach, rooted in principles of gender justice, trauma-and violence-informed research, and epistemic inclusivity. From the outset, the author co-developed the framing and structure of the report in collaboration with MHE's Policy Team, with input sought on how lived-experience perspectives could be prioritised. Where possible, the report draws on consultations with representatives of key organisations, published testimonies, case studies, and publications by peer-led and survivor-led networks (e.g., advocates for mental health service users, LBTI+ women, and psychosocial disability communities), all of which are integrated with respectful attribution. Additionally, an online co-creation workshop was organised with a wide range of participants, which informed the formulation of the recommendations.

A methodological reflection is included below to acknowledge the positionality of the author, the sources consulted, and the limits of a primarily desk-based exercise. Crucially, early drafts of the report were shared not only with MHE staff but also with individuals and networks with lived experience, to validate key insights and ensure the language, framing, and recommendations resonate with those directly affected. This approach aims to honour the expertise of lived and living experience alongside academic and clinical knowledge, ensuring that advocacy for gender-sensitive and gender-just mental health policy is grounded in both structural analysis and real-world voices.

Reflexivity and Methodological Reflection

This report was developed through a primarily desk-based methodology, drawing on academic literature, EU policy documents, and reports from civil society and lived experience organisations. As such, it reflects both the strengths and limitations of secondary research. The author acknowledges her own positionality as a person with lived experience of mental health conditions, GBV, and use of mental health services, which informs a critical and trauma- and violence-informed lens throughout the analysis. While every effort has been made to amplify the voices of those most affected by gendered mental health inequalities, the absence of formal primary participatory research limits the depth of direct engagement with communities. The report seeks to mitigate this by integrating the already published and publicly available testimonies, peer-led publications, and feedback from lived and living experience advocates engaged by MHE. This reflection is offered in the spirit of reflexivity, transparency, humility, and a commitment to centring lived and living experience in future research and advocacy work.

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Annex 2: Glossary of Terms

Co-creation	Co-creation is a collaborative approach where stakeholders—including people with lived experience, policymakers, service providers, and communities—work as equals to design, implement, and evaluate mental health policies and services. It emphasises inclusivity, mutual respect, and shared power, ensuring diverse perspectives shape outcomes, and requires ongoing engagement and adaptability.[94] [95]
Epistemic injustice	The systematic devaluation and silencing of certain knowledge systems, particularly those of marginalised groups.[96] In clinical contexts, this manifests as the dismissal, minimisation, or pathologisation of patients' lived experiences and subjective knowledge.[97]
Gender-based violence	GBV refers to violence committed against a person because of their gender, or violence that disproportionately impacts people of a particular gender. It encompasses any form of harm directed at an individual or group based on their actual or perceived gender identity. GBV may involve physical, sexual, psychological or economic abuse, domestic violence and intimate partner violence, among other forms stemming from and reinforcing structural inequalities and socially constructed power relations between women and men. It also covers threats of violence, coercion, coercive control, online violence and image-based abuse, and restrictions on liberty, whether occurring in private or public life. [98] [99] [100]
Gender-justice	Defined in global health as encompassing the realisation of universal rights in relation to health equity and gender equality, while also addressing the drivers of gender-based discrimination and exclusion.[101]
Human rights-based approach	A framework grounded in international human rights law that guides legal, policy, and practical actions to promote and protect human rights. It enables state and non-state actors to identify and address inequalities and discrimination, ensures participation of all stakeholders, and provides mechanisms for accountability and redress.[102] [103]
Lived and living experience	In mental health, it refers to the diverse experiences of people who have experienced or are experiencing mental health difficulties. Some prefer 'living experience', as 'lived' can suggest the experience is in the past, though others do not interpret it this way.[104] It encompasses the insights gained from this invaluable expertise, e.g. how it feels, what helps or hinders, what was missing, offering a unique contribution to the field.[105]
Medical misogyny	Can be defined as the pervasive dismissal, minimisation, or pathologisation of women's pain, distress, and embodied experiences.[106] [107]
Psychosocial model of mental health	Instead of treating distress as an individual "deficit" or biological dysfunction, it recognises that barriers in society and systemic injustices play a vital role. This model views mental health as part of the full spectrum of human experience, not merely as the absence of illness or poor health. It highlights the role of social and environmental determinants, such as poverty, inequality, education, housing, violence, and trauma, and how they interact with each other, in shaping mental health outcomes.[108] [109]
Recovery approach	Here, mental health is not simply about "symptom reduction" but about reclaiming autonomy, agency, and a meaningful life in the community. Recovery is self-defined and means different things for different people[110] [111] [112], but always involves choice, respect, and control over one's own journey. Recovery-oriented mental health care moves beyond symptom management to support individuals' overall life goals, centring their participation, choices, and strengths.[113]

General guidance on terminology used in this report was taken from **MHE's Glossary**[114] and the NGO Mental Health Perspectives' publication "**Words are Important**"[115].

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