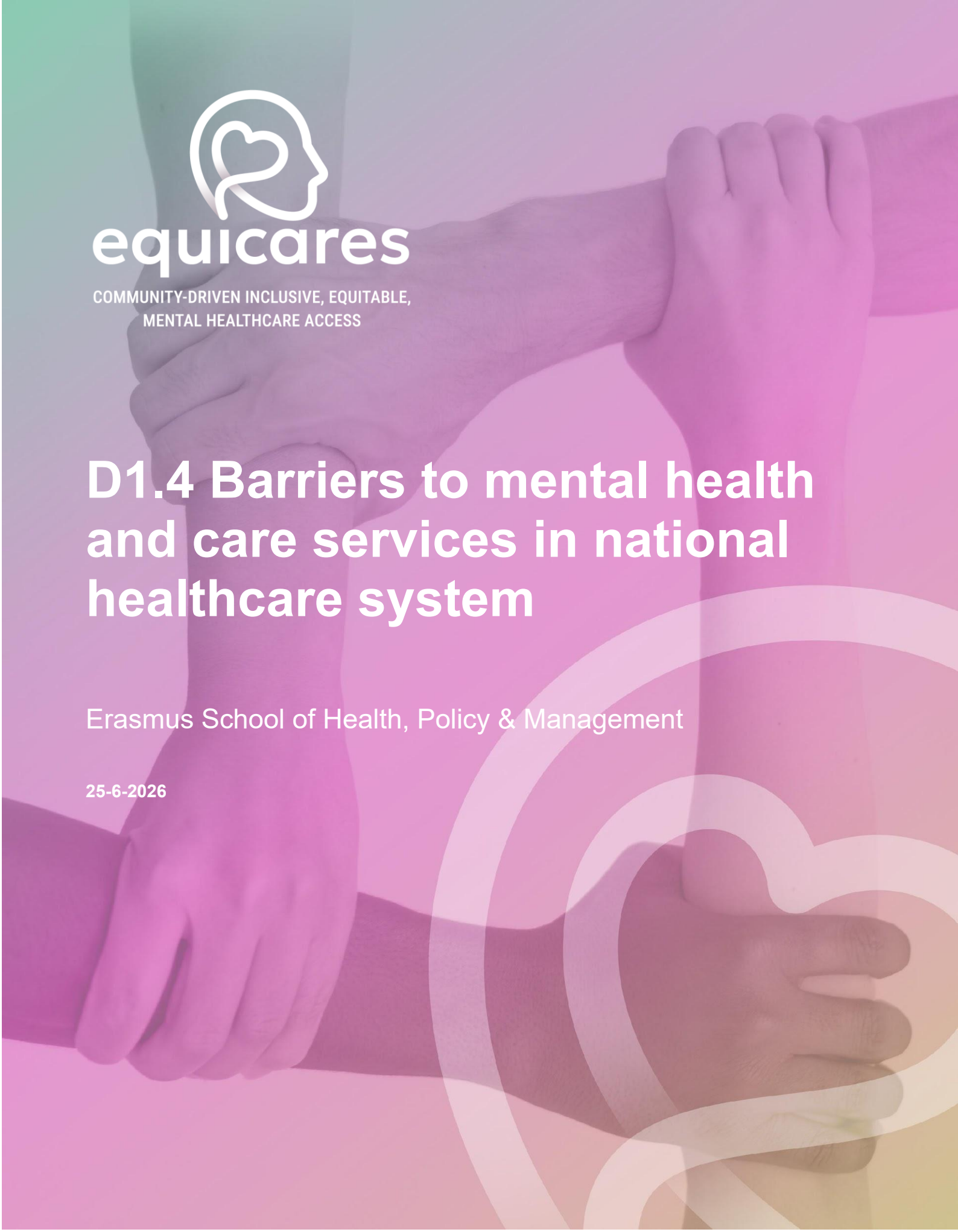

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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

D1.4 Barriers to mental health and care services in national healthcare system

Erasmus School of Health, Policy & Management

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Executive summary

This deliverable examines meso-level barriers and enabling factors affecting access to mental healthcare for people in vulnerable situations across the eight EQUICARES pilot sites. Using the adapted Levesque framework (as developed in T1.2) and a mixed-methods design, the study explored how service organisation, coordination, affordability, availability, responsiveness and cultural fit shape access to mental health services across different countries and vulnerable population groups. The work addressed three main objectives: 1) identifying key meso-level barriers and facilitators affecting access to mental healthcare, 2) examining how these barriers differ across pilot countries and vulnerable groups, and 3) operationalising the adapted Levesque framework at the meso level to ensure conceptual consistency across work package 1.

To achieve this, qualitative stakeholder interviews and national surveys were conducted across all pilot sites. Stakeholder interviews included policymakers, service providers, administrators, civil society organisations, and user representatives, focusing on organisational and structural factors influencing access to care. In parallel, national surveys were conducted among general populations and vulnerable groups, including migrants, Roma communities, LGBTIQ+ populations, older adults, unaccompanied children, people with disabilities, and earthquake survivors. Survey items were structured around the Five Levesque dimensions: approachability, acceptability, availability and accommodation, affordability, and appropriateness.

The deliverable successfully achieved the key performance indicators (KPIs) defined for this task. Across the eight pilot sites, approximately five high-level quadruple helix stakeholder interviews were conducted per pilot country, involving representatives from policy, healthcare provision, administration, financing, and civil society sectors. In addition, each pilot site reached or exceeded the target of at least 200 survey respondents, while ensuring the inclusion of predefined vulnerable population groups through quota-based recruitment strategies. Finally, the quantitative findings were triangulated with a broad range of external datasets and population-level indicators, including EU-SILC, EHIS, Eurostat databases, EQ-5D population norm studies, and national reference datasets. In total, more than 15 secondary datasets and data sources were used to contextualise and interpret the findings, thereby exceeding the project KPI related to the integration of external evidence sources.

The findings show that barriers to mental healthcare are often concentrated at the stage of entering and navigating services rather than within treatment itself. Across countries, many respondents described difficulties identifying where to seek help, understanding how services function, or navigating complex referral and administrative systems. Access to information frequently depended on NGOs, peer workers, schools, mediators, or trusted professionals rather than on clear system-

level communication. This was particularly visible among migrants, Roma communities, youth and LGBTIQ+ populations. Stigma, mistrust, and lack of cultural responsiveness also remained important barriers, especially before people entered care. Several vulnerable groups reported concerns related to discrimination, confidentiality, language barriers, or services not adequately considering their social and cultural context. At the same time, once individuals were able to access sustained support, many respondents described mental health professionals as respectful and services as helpful. Structural barriers related to service organisation were consistently identified across pilot sites. Long waiting lists, shortages of mental health professionals, fragmented referral systems, staff turnover, and unstable project-based funding were common themes in the qualitative interviews. Although some quantitative indicators such as travel time or appointment waiting times did not always differ significantly between groups, vulnerable populations often reported substantially higher levels of unmet need compared with national reference populations. Affordability emerged as a broader issue than treatment costs alone. Transport expenses, housing instability, loss of income, childcare responsibilities, documentation requirements, and difficulties navigating insurance systems frequently acted as barriers to care. This was particularly visible among migrants, people with disabilities, Roma communities, and populations affected by socio-economic precarity or displacement. A major strength of the deliverable is the triangulation of findings across multiple external datasets and indicators. Survey findings were compared with national and European reference data, including EU-SILC, EHIS, Eurostat indicators, and EQ-5D population datasets where available. This allowed the study to contextualise findings on self-perceived health, depressive symptoms, unmet need for care, activity limitations, and health-related quality of life against broader national population trends. Across many pilot sites, vulnerable groups reported higher levels of unmet need and depressive symptom severity than national reference populations, even in contexts where formal coverage for mental health care existed. The deliverable also demonstrates the practical application of the adapted Levesque framework at meso level across diverse national contexts. The framework was used consistently throughout survey development, interview design, analysis, and triangulation, providing a shared conceptual structure for comparing access barriers across countries and vulnerable populations.

Overall, the findings show that inequities in mental health care access are strongly shaped by the way services are organised, coordinated, financed, and communicated. Improving equity therefore requires more than expanding clinical capacity alone. The results highlight the importance of strengthening outreach and navigation support, improving continuity of care, reducing indirect financial barriers, supporting culturally responsive care, and embedding user perspectives within service organisation.

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1. Role of the deliverable in the project

EQUICARES seeks to strengthen inclusive, equitable, and resilient access to mental health and care services for people in vulnerable situations across Europe. A central premise of the project is that persistent inequalities in mental health access are not only driven by individual or community-level factors, but also by how health systems are organised, governed, and delivered in practice. Addressing these systematic challenges requires robust, multilevel evidence that captures both structural conditions and lived realities.

Within this context, Work Package 1 (WP1) establishes the analytical and conceptual foundation of the project by generating harmonised evidence on mental health needs and accessibility barriers at the macro, meso, and micro levels. WP1 integrates epidemiological data, stakeholder perspectives, and user experiences to support the development of tailored indicators, analytical tools, and policy-relevant outputs that inform subsequent work packages and pilot activities.

Deliverable 1.4 contributes to this foundation by operationalising Task 1.4, which focuses on the meso level of access, the organisational and system-level arrangements that shape the provision of mental health and care services within national healthcare systems. While other WP1 tasks address policy and financing frameworks (macro level) and individual (micro level) or community experiences (macro level), D1.4 targets the intermediary level where service delivery is organised, coordinated, and implemented. This includes institutional structures, referral pathways, availability and distribution of services, information flows, affordability mechanisms, and responsiveness to diverse user needs.

Specifically, this deliverable documents the design and implementation of a mixed-methods research approach combining semi-structured stakeholder interviews and national surveys across the EQUICARES pilot countries. Guided by an adapted version of the Levesque framework and complemented by country-specific Health System Performance Assessment (HSPA) indicators, D1.4 generates comparative evidence on meso-level barriers and enabling factors affecting access to mental health care for people in vulnerable situations.

The findings produced through this deliverable serve multiple functions within the project. First, they provide empirical input for the refinement and validation of accessibility metrics developed in WP1. Second, they inform the EQUICARES Dashboard, by translating meso-level insights into actionable indicators and system-level recommendations. Finally, the evidence generated under D1.4 supports the co-design and piloting of interventions in later work packages by identifying critical organisational bottlenecks and leveraging points within national mental health systems.

2. Introduction

2.1 Background

Mental health conditions are among the leading causes of disability and yeas lived with disability in Europe, accounting for a substantial share of the overall disease burden and generating significant individual, social and economic costs[1,2]. Despite increasing recognition of mental health as a public health priority across European countries, access to timely, appropriate, and high-quality mental health care remains highly unequal both across and within countries, with persistent gaps in service availability, treatment coverage, and quality of care[3,4].

These disparities are not solely driven by individual-level factors such as stigma, health literacy, or personal resources. A growing body of literature highlights the role of structural and organisational determinants embedded within healthcare systems, including fragmented service delivery, workforce shortages, long waiting times, limited geographic availability of services, administrative complexity, and insufficient cultural responsiveness [5,6]. Such system-level constraints can disproportionately affect people in vulnerable situations, reinforcing and compounding existing social and economic disadvantages. In this context, access to mental healthcare is increasingly understood as a multidimensional and dynamic process shaped by interactions between individuals and health systems operating at multiple levels. Macro-level factors, such as national policies, financing arrangements, and governance frameworks, set the overall conditions for service provision, while micro-level factors influence individual help-seeking behaviours and care experiences. Between these levels lies the meso level, where services are organised, coordinated, and delivered, and which plays a critical intermediary role in shaping real-world access [7,8]. Meso-level arrangements encompass referral pathways, coordination between primary, secondary, and community-based care, information provision, appointment systems, and institutional practices that determine the responsiveness of services to diverse needs.

Despite its central importance, the meso level remains comparatively underexplored in mental health research, particularly with regard to equity and access for people in vulnerable situations [6,8]. Available evidence indicates that even where inclusive policies and formal entitlements are in place, weaknesses in service organisation and delivery can substantially undermine equitable access in practice[3,4,9]. Poor coordination between services, limited continuity of care, and poor communication between patients and care personnel have been repeatedly identified as key barriers to timely and appropriate mental health care, especially for individuals with complex or intersecting needs [5,10,11]. Against this backdrop, there is a need for comparative and empirically grounded analyses that

examine how mental health services are organised and delivered across different national contexts, and how these organisational arrangements shape equitable access for people in vulnerable situations.

2.2 Objectives

The objective of this deliverable is to identify and analyse meso-level barriers to accessing mental health and care services for people in vulnerable situations across the EQUICARES pilot countries. By focusing on the organisation and delivery of services within national healthcare systems, this deliverable aims to generate comparative, policy-relevant evidence on how system-level arrangements shape equitable access to mental healthcare.

Specifically, the objectives are to:

1. Identify key meso-level barriers and enabling factors affecting access to mental health and care services for people in vulnerable situations, with particular attention to service organization, coordination, availability, affordability, and responsiveness
2. Operationalise and apply the adapted Levesque framework (as refined under task 1.2) to the analysis of mental health care access at the meso level, ensuring conceptual consistency across WP1.

3. Methods

3.1 Study design

Task 1.4 employed a mixed-methods research design combining semi-structured stakeholder interviews with survey questionnaires. This approach was chosen to generate a comprehensive and comparative understanding of meso-level barriers to accessing mental health and care services across the EQUICARES pilot countries. By integrating qualitative and quantitative data, the study captures both institutional perspectives on service organisation and user experiences of navigating mental health systems, thereby enabling triangulation across data sources.

The focus of this task lies on the meso level of healthcare systems. The meso level refers to the organisational and service-delivery structures that translate policy frameworks and financing arrangements into actual care provision. This includes referral pathways, coordination between primary, secondary, and community-based care, appointment systems, waiting times, geographic distribution of services, administrative procedures, and institutional responsiveness to diverse needs. The analytical framework guiding this research is based on the Levesque et al. (2013) [7] framework for access to healthcare. The five dimensions; approachability, acceptability, availability and accommodation, affordability, and appropriateness, were operationalised specifically at the meso level. This allowed the analysis to focus on how organisational arrangements shape the visibility of services, cultural and social responsiveness, system capacity and flexibility, financial accessibility, and continuity and coordination of care. The adapted version of the framework developed under Task 1.2 was applied to ensure conceptual consistency within Work Package 1.

3.1.1 Eligibility Criteria

Inclusion criteria were defined in accordance with the EQUICARES framework and adapted to the specific context of each pilot country. For the survey component, respondents were eligible if they were residents of the respective pilot country and had either direct experience with mental health services or relevant experience navigating the national healthcare system. While the primary target population consisted of adults (aged 18 years and above), certain pilot countries also included unaccompanied minors, where this was contextually relevant and ethically approved.

A central objective of the sampling strategy was to ensure adequate representation of people in vulnerable situations, as defined within the EQUICARES project. These groups include, depending on the national context, migrants and refugees, ethnic minorities, Roma communities, LGBTQIA+

persons, people with disabilities, older adults, and in selected countries unaccompanied children. The specific vulnerable groups included in each pilot country are presented in the table below.

Country	Organisation	Group 1	Group 2	Group 3
Turkey	Koc University	2023 Earthquake survivors (Women)	2023 Earthquake survivors (Youth)	General population
Ireland	LGBT Ireland	LGBTQIA+ community	General population	
Spain	FISEVI	Roma community	Latin American migrants	General population
Greece / Albania	SEERC	Older adults (65+)	Migrant community	General population
Greece	GIVMED	Youth (18 – 25)	Unaccompanied children	General population
France	LADAPT	Intellectual disabilities	Physical disabilities	General population
Bulgaria	AMALIPE	Roma community	Ethnic and religious minorities	General population
Germany	ZI Mannheim	Older adults (65+) without migration background	Older adults (65+) with migration background	General population

For the stakeholder interviews, inclusion criteria required participants to hold a professional role directly related to the governance organisation, financing, provision, or advocacy of mental health services at national or regional level. Stakeholders were selected to reflect diverse meso-level perspectives, including policymakers, health system administrators, service managers, healthcare professionals, and representatives of civil society or patient organisations. Individuals without direct involvement in mental health service organisation or delivery were excluded.

Exclusion criteria for the survey included incomplete responses, duplicate entries, and responses not meeting minimum data quality standards. In countries where minors were included, participation complied with national ethical requirements and consent procedures. Across all pilot sites, participation was voluntary and based on informed consent in accordance with applicable ethical and data protection regulations.

3.1.2 Data collection

Data collection was conducted across the eight EQUICARES pilot countries using two complementary methods: semi-structured stakeholder interviews and a national survey.

For the qualitative component, each pilot site was asked to conduct five or more semi-structured interviews following a quadruple helix approach. Stakeholders were purposively selected by the pilot partners based on their involvement in mental health service organisation, delivery, financing, or representation of service users. Participants included policymakers at regional level, health system administrators, managers of mental health services, healthcare professionals, representatives of financing bodies, and civil society or patient advocacy organisations. The interviews explored organisational bottlenecks, referral mechanisms, coordination challenges, implementation gaps, and structural constraints affecting access to mental health services, with particular attention to their impact on people in vulnerable situations. Interview guides (Appendix B) were structured around the adapted Levesque dimensions and complemented by relevant elements from national Health System Performance Assessment (HSPA) frameworks. Specifically, pilot sites were asked to consider HSPA domains related to access to care, equity, continuity and coordination of services, referral pathways, service availability, and user-centredness when adapting the interview guide to their national context. These elements were primarily used as contextual probes to facilitate discussion of country-specific organisational arrangements and performance challenges within the broader Levesque access dimensions, rather than as a separate analytical framework. Interviews were conducted by members of the respective pilot teams in the local language. Due to differences in local organisational procedures and ethical requirements, recruitment procedures varied across countries. All pilot sites were instructed to recruit participants with expertise or experience relevant to the organisation and delivery of mental health services. To protect anonymity, quotations in the qualitative results are attributed only by pilot site and stakeholder role (e.g. Koç University, Academic) and no personal characteristics such as gender, age, or specific institutional affiliation are reported. Because each site recruited from a slightly different stakeholder ecosystem, the exact role labels and abbreviations used in the attributions vary between countries. A full country-specific overview of the interviewees conducted at each pilot site, together with the attribution conventions used, is provided in Appendix C.

For the quantitative component, a national survey questionnaire was administered in each pilot country. The target sample size was a minimum of 200 respondents per country. A quota-based sampling approach was used to ensure the inclusion of both respondents from the general population and respondents belonging to one or more vulnerable population groups identified by each pilot site. These groups included, among others, migrants, older adults, Roma communities, people with

disabilities, LGBTIQA+ individuals, unaccompanied children, and earthquake survivors. Survey recruitment was conducted by the pilot partners using locally appropriate approaches, including dissemination through community organisations, healthcare providers, advocacy groups, social media, and existing stakeholder networks. Both online and offline data collection modalities were used where necessary to reduce barriers to participation. For unaccompanied children, questionnaires were completed by a legal guardian where required by ethical procedures. All responses were subsequently entered into the Qualtrics platform to ensure standardised data management across countries. The survey (Appendix A) captured participant-reported experiences related to mental health service access across the five dimensions of the adapted Levesque framework, including service visibility and information, waiting times, referral processes, administrative complexity, affordability, continuity of care, and responsiveness of services.

3.1.3 Data analysis

Qualitative data were analysed using a structured thematic analysis approach. A deductive coding framework was developed based on the adapted Levesque framework and the corresponding interview questions (Appendix A). Interview transcripts and notes were coded according to the five access dimensions: approachability, acceptability, availability and accommodation, affordability, and appropriateness. This ensured conceptual consistency across pilot countries and alignment with the analytical framework developed under Task 1.2. In addition, inductive coding was used to identify emerging themes that were not fully captured by the predefined framework, particularly country-specific organisational arrangements, implementation challenges, and contextual factors influencing access to care. Quantitative analyses were conducted separately for each country. Descriptive statistics were used to summarise participant characteristics and survey responses. Frequencies and percentages were calculated for categorical variables, while means and standard deviations were calculated for continuous variables where appropriate. Comparative analyses were subsequently performed to examine differences between the general population group and vulnerable population groups within each country. Depending on the distribution of the variables and cell sizes, Pearson's chi-squared tests or Fisher's exact tests were used to assess group differences for categorical variables. Where overall differences were identified, pairwise post-hoc comparisons were conducted using adjusted p-values to account for multiple testing. Effect sizes were assessed using Cramer's V and interpreted according to conventional thresholds. The analyses focused on variables representing the five dimensions of the adapted Levesque framework, including awareness of services, access to information, waiting times, travel requirements, affordability of care, financial support mechanisms, continuity of care, communication with providers, cultural responsiveness, and perceived appropriateness of services. To further contextualise the findings, survey results were triangulated with external datasets where available, including indicators from the European Health Interview Survey (EHIS), the European Union Statistics on Income and Living Conditions (EU-SILC), EQ-5D

population norms, and other relevant national reference datasets. This enabled comparison of participant-reported health status, activity limitations, unmet need for care, and mental health outcomes with broader population estimates. Finally, findings from the qualitative and quantitative components were triangulated to identify converging and diverging patterns between stakeholder-reported system characteristics and user-reported experiences of mental health service access.

4. Main results

4.1 Turkey

4.1.1 Quantitative results

Descriptive characteristics by group are presented in Table 1 and Table 2. Mean age varied across groups, reflecting the population definitions. Participants in the General group had a mean age of 30.6 years (SD 13.9), while youth survivors were considerably younger, with a mean age of 20.1 years (SD 2.4). Women survivors were older on average, with a mean age of 42.8 years (SD 11.4). Most respondents in the General group completed the questionnaire independently (73.4%). In contrast, self-completion was less common among youth and women survivors, where questionnaires were more often completed with assistance (44.4% among youth and 54.1% among women) or by another person.

Table 1: Distribution of participants across the included groups in Turkey

General group	2023 Earthquake survivors (women)	2023 Earthquake survivors (Youth 18-24)
N = 79	N = 133	N = 27

Distributions of sex at birth and gender corresponded closely to the group definitions (Table 2). The General group consisted predominantly of males (63.3%), whereas youth survivors included a slight female majority (55.6%). Nearly all women survivors identified as female at birth (99.2%), with one respondent reporting a non-binary sex. Across all groups, gender identity generally aligned with sex assigned at birth. Sexual orientation was predominantly heterosexual, reported by 81.0% of respondents in the General group, all youth survivors, and 97.7% of women survivors. A small number of respondents in the General and women survivor groups selected “other” or preferred not to disclose their orientation. The vast majority of respondents resided in Turkey and were also born there. Turkey was reported as the country of residence by 98.7% of participants in the General group and by all respondents in the youth and women survivor groups. Similarly, birth in Turkey was reported by 97.5% of the General group, 100% of youth survivors, and 99.2% of women survivors.

All participants held Turkish citizenship. The reported duration of residence in Turkey reflected age differences between groups, with mean durations of 30.4 years (SD 14.0) in the General group, 20.1 years (SD 2.4) among youth survivors, and 42.5 years (SD 11.7) among women survivors. Educational attainment, classified according to ISCED levels, showed clear group differences. In the General group, lower and upper secondary education were most common (ISCED 2: 29.1%; ISCED 3: 32.9%), while smaller proportions reported tertiary education. Youth survivors were mainly concentrated in upper secondary education (59.3% ISCED 3), consistent with their age group, with some still completing lower secondary education (18.5%). Among women survivors, primary education was most frequently reported (38.3% ISCED 1), followed by upper secondary education (24.1% ISCED 3), and only a small proportion reported tertiary qualifications. Across groups, recent use of mental health services within the past 12 months was reported by 13.9% of the General group, 7.4% of youth survivors, and 17.3% of women survivors. Earthquake-related experiences, summarized in Table 2, indicate substantial impact across all groups. A very large proportion of respondents reported having been forced to leave their homes following the earthquake, including 88.6% of the General group, 96.3% of youth survivors, and 99.2% of women survivors. The main source of income or employment was reported as permanently affected by 31.6% of respondents in the General group, 25.9% of youth survivors, and 44.4% of women survivors. For many others, employment disruptions were temporary or the question was not applicable. Experiences of loss and bereavement were widespread. The death of close family members due to the earthquake was reported by 35.4% of the General group, 44.4% of youth survivors, and 59.4% of women survivors. In addition, 10.5% of women survivors reported that close family members were both deceased and missing. Loss of close friends was also frequently reported, with more than half of respondents in the General group (57.0%) and women survivor group (57.1%), and 40.7% of youth survivors, indicating that at least some friends had passed away. Additional respondents reported both deceased and missing friends. Physical injuries related to the earthquake were reported across all groups. Approximately one quarter to one third of respondents indicated that they had been injured and received rehabilitation services (25.3% in the General group, 29.6% among youth survivors, and 24.1% among women survivors). The need for assistive devices was also reported, particularly among women survivors (12.8%). Hospitalization, limb loss, or permanent disability were reported less frequently but remained present in small yet notable proportions. Similar patterns were observed for injuries among close family members. While around half of respondents reported no injuries among relatives, others indicated that family members required rehabilitation, assistive devices, hospitalization, or experienced limb loss. Most respondents indicated that they were not primarily responsible for caring for another person following the earthquake; however, between 11% and 15% reported caring for one individual, and a smaller proportion reported caring for multiple individuals.

Table 2: Descriptive statistics of the different included groups in Turkey

Demographic variable	General group	2023 Earthquake survivors (Youth 18-24)	2023 Earthquake survivors (Women)	Overall
Age, *mean (sd)*	30.6 (13.9)	20.1 (2.4)	42.8 (11.4)	36.2 (14.2%)
Questionnaire completed by, *n (%)*				
Respondent alone	58 (73.4%)	12 (44.4%)	50 (37.6%)	120 (50.2%)
Respondent with help	19 (24.1%)	12 (44.4%)	72 (54.1%)	103 (43.1%)
Someone else	2 (2.5%)	3 (11.1%)	11 (8.3%)	16 (6.7%)
Sex at birth, *n (%)*				
Female	29 (36.7%)	15 (55.6%)	132 (99.2%)	197 (82.4%)
Male	50 (63.3%)	12 (44.4%)	0 (0.0%)	41 (17.2%)
Non-binary	0 (0.0%)	0 (0.0%)	1 (0.8%)	1 (0.4%)
Prefer not to say	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Gender the same as assigned at birth, *n (%)*				
Yes	78 (98.7%)	27 (100%)	133 (100%)	238 (99.6%)
No	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Prefer not to say	1 (1.3%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Sexual orientation, *n (%)*				
Heterosexual	64 (81.0%)	27 (100%)	130 (97.7%)	221 (92.5%)
Gay	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Lesbian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Bisexual	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other	2 (2.5%)	0 (0.0%)	0 (0.0%)	2 (0.8%)
Prefer not to say	13 (16.5%)	0 (0.0%)	3 (2.3%)	16 (6.7%)
Country of residence, *n (%)*				
Turkey	78 (98.7%)	27 (100%)	133 (100%)	238 (99.6%)
Other	1 (1.3%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Country of birth, *n (%)*				
Born in the country of residence	77 (97.5%)	27 (100%)	132 (99.2%)	236 (98.7%)

In another country in the EU	1 (1.3%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Born in another country outside the EU	1 (1.3%)	0 (0.0%)	1 (0.8%)	2 (0.8%)
Citizen of country, *n (%)*				
Citizen of the country of residence	79 (100%)	27 (100%)	133 (100%)	239 (100%)
No citizenship of the country of residence but that of another EU member state	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
No citizenship of the country of residence but that of a country outside the EU	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing				
Duration of stay in the country of residence, *mean years (SD)*	30.4 (14.0)	20.1 (2.4)	42.5 (11.7)	36.0 (14.3)
Highest level of education completed (ISCED), *n (%)*				
Early childhood education (ages 3 and above), including pre-primary education and early childhood educational development	0 (0.0%)	0 (0.0%)	13 (9.8%)	13 (5.4%)

(under 3). (ISCED 0)				
Primary education (also known as elementary or basic education). (ISCED 1)	12 (15.1%)	2 (7.4%)	51 (38.3%)	65 (27.2%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	23 (29.1%)	5 (18.5%)	15 (11.3%)	43 (18.0%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	26 (32.9%)	16 (59.3%)	32 (24.1%)	74 (31.0%)
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	0 (0.0%)	0 (0.0%)	2 (1.5%)	2 (0.8%)
Short-cycle third level education (programs typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's	4 (5.1%)	2 (7.4%)	11 (8.3%)	17 (7.1%)

degree). (ISCED 5)				
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	12 (15.2%)	2 (7.4%)	9 (6.8%)	23 (9.6%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	2 (2.5%)	0 (0.0%)	0 (0.0%)	2 (0.8%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Use of mental health care in the previous 12 months, *n (%)*				
Yes	11 (13.9%)	2 (7.4%)	23 (17.3%)	36 (15.1%)
No	68 (86.1%)	25 (92.6%)	110 (82.7%)	203 (84.9%)
Earthquake impact questions for Hatay				
Forced to leave the home, *n (%)*				
Yes	70 (88.6%)	26 (96.3%)	132 (99.2%)	228 (95.4%)
No	7 (8.9%)	0 (0.0%)	1 (0.8%)	8 (3.3%)
Missing	2 (2.5%)	1 (3.7%)	0 (0.0%)	3 (1.3%)
The earthquake affected the main job or source of income				
No	11 (13.9%)	3 (11.1%)	9 (6.8%)	23 (9.6%)
Temporarily	28 (35.4%)	9 (33.3%)	28 (21.1%)	65 (27.2%)

Permanently	25 (31.6%)	7 (25.9%)	59 (44.4%)	91 (38.1%)
Not applicable	12 (15.2%)	6 (22.2%)	33 (24.8%)	51 (21.3%)
Missing	3 (3.8%)	2 (7.4%)	4 (3.0%)	9 (3.8%)
Any close family members have died or gone missing as a result of the earthquake				
No	47 (59.5%)	13 (48.1%)	37 (27.8%)	97 (40.6%)
Yes, some people passed away	28 (35.4%)	12 (44.4%)	79 (59.4%)	119 (49.8%)
Yes, some people are missing	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Yes, there are both deceased and missing persons	1 (1.3%)	0 (0.0%)	14 (10.5%)	15 (6.3%)
Missing	3 (3.8%)	2 (7.4%)	3 (2.3%)	8 (3.3%)
Any close friends have died or missing as a result of the earthquake				
No	20 (25.3%)	6 (22.2%)	34 (25.6%)	60 (25.1%)
Yes, some people passed away	45 (57.0%)	11 (40.7%)	76 (57.1%)	132 (55.2%)
Yes, some people are missing	0 (0.0%)	1 (3.7%)	1 (0.8%)	2 (0.8%)
Yes, there are both deceased and missing persons	11 (13.9%)	7 (25.9%)	19 (14.3%)	37 (15.5%)
Missing	3 (3.8%)	2 (7.4%)	3 (2.3%)	8 (3.3%)
Physically injured as a result of the earthquake				
No	53 (67.1%)	14 (51.9%)	76 (57.1%)	143 (59.8%)
Yes, rehabilitation	20 (25.3%)	8 (29.6%)	32 (24.1%)	60 (25.1%)
Yes, assistive device	1 (1.3%)	2 (7.4%)	17 (12.8%)	20 (8.4%)
Severe (was hospitalized)	1 (1.3%)	1 (3.7%)	5 (3.8%)	7 (2.9%)

Limb loss or permanent disabled	1 (1.3%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Missing	3 (3.8%)	2 (7.4%)	3 (2.3%)	8 (3.3%)
Currently receiving rehabilitation services or using assistive devices (e.g., prosthetics, crutches, wheelchair)				
No	73 (92.4%)	25 (92.6%)	100 (75.2%)	198 (82.8%)
Minor (bruise, cut)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Moderate (required outpatient treatment)	2 (2.5%)	0 (0.0%)	0 (0.0%)	2 (0.8%)
Both	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Missing	4 (5.1%)	2 (7.4%)	33 (24.8%)	39 (16.3%)
Any close family members (spouse, child, mother, father, sibling) suffer an injury or limb loss due to the earthquake.				
No	50 (63.3%)	16 (59.3%)	64 (48.1%)	130 (54.4%)
Yes, rehabilitation	14 (17.7%)	5 (18.5%)	20 (15.0%)	39 (16.3%)
Yes, assistive device	8 (10.1%)	4 (14.8%)	19 (14.3%)	31 (13.0%)
Severe (was hospitalized)	2 (2.5%)	0 (0.0%)	12 (9.0%)	14 (5.9%)
Limb loss or permanent disabled	2 (2.5%)	0 (0.0%)	15 (11.3%)	17 (7.1%)
Missing	3 (3.8%)	2 (7.4%)	3 (2.3%)	8 (3.3%)
Primarily responsible for the care of any person who requires care after the earthquake				
No	64 (81.0%)	20 (74.1%)	104 (78.2%)	188 (78.7%)
Yes, one person	9 (11.4%)	2 (7.4%)	20 (15.0%)	31 (13.0%)
Yes, more than one person	3 (3.8%)	2 (7.4%)	6 (4.5%)	11 (4.6%)
Missing	3 (3.8%)	3 (11.1%)	3 (2.3%)	9 (3.8%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Within the Availability and Accommodation dimension, most indicators did not differ significantly between the groups. Specifically, no statistically significant differences were observed for time required to travel to mental health services, availability of a private space for receiving care and talking openly, time required to obtain an appointment when mental healthcare was needed, or knowledge of where to seek immediate help during a mental health crisis (Figure 1; all p-values > 0.05).

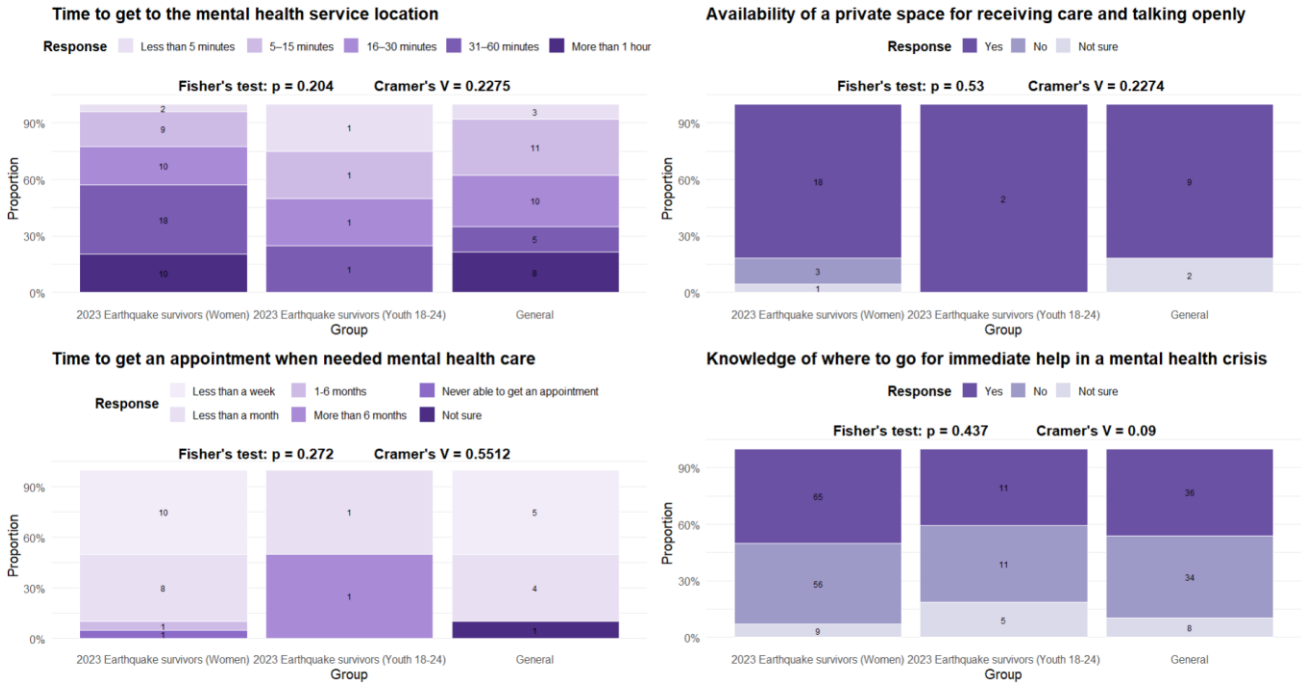


Figure 1: Non-significant differences across groups for the availability and accommodation dimension in Turkey

In contrast, awareness of mental health services in the area differed significantly between groups (Figure 2) Pairwise comparisons (Table 3) showed a statistically significant difference between the general group and youth earthquake survivors aged 18–24 years (p = 0.018, Cramer's V = 0.293), as well as between women earthquake survivors and youth earthquake survivors (p = 0.048, Cramer's V = 0.186). No statistically significant difference was observed between the general group and women earthquake survivors (p = 0.304, Cramer's V = 0.107). Descriptively, youth earthquake survivors appeared less aware of available mental health services compared with the other groups. The corresponding effect sizes suggest small to moderate associations, particularly for comparisons involving youth earthquake survivors, indicating that differences in service awareness were

meaningful but not large in magnitude.

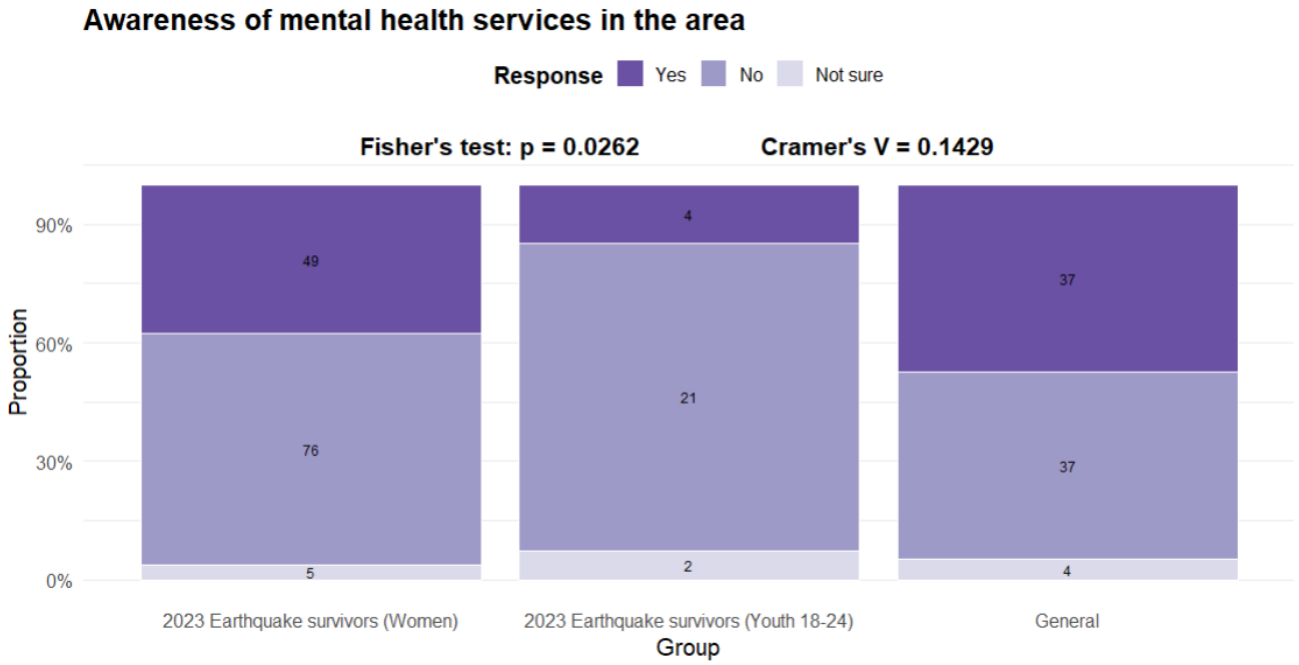


Figure 2: Fisher's exact test of awareness of mental health services in the area in Turkey

Table 3: Pairwise comparison of awareness of mental health services in the area in Turkey

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: 2023 Earthquake survivors (Women)	0.304	0.107
General group : 2023 Earthquake survivors (Youth 18-24)	0.018	0.293
2023 Earthquake survivors (Women) : 2023 Earthquake survivors (Youth 18-24)	0.048	0.186

Approachability

Within the Approachability dimension, none of the assessed items showed statistically significant differences between the groups. This included whether participants had encountered information on accessing mental health support, as well as their reported ease of understanding spoken or written information about mental health services and ease of finding reliable information (Figures 3 & 4; all p-values > 0.05). Similarly, no differences were observed in relation to being asked about mental well-being during encounters with a family doctor, school counsellor, or social worker, nor in

exposure to outreach programs or information about the experiences of other patients. In addition, invitation to participate in research related to mental health did not differ significantly between groups.

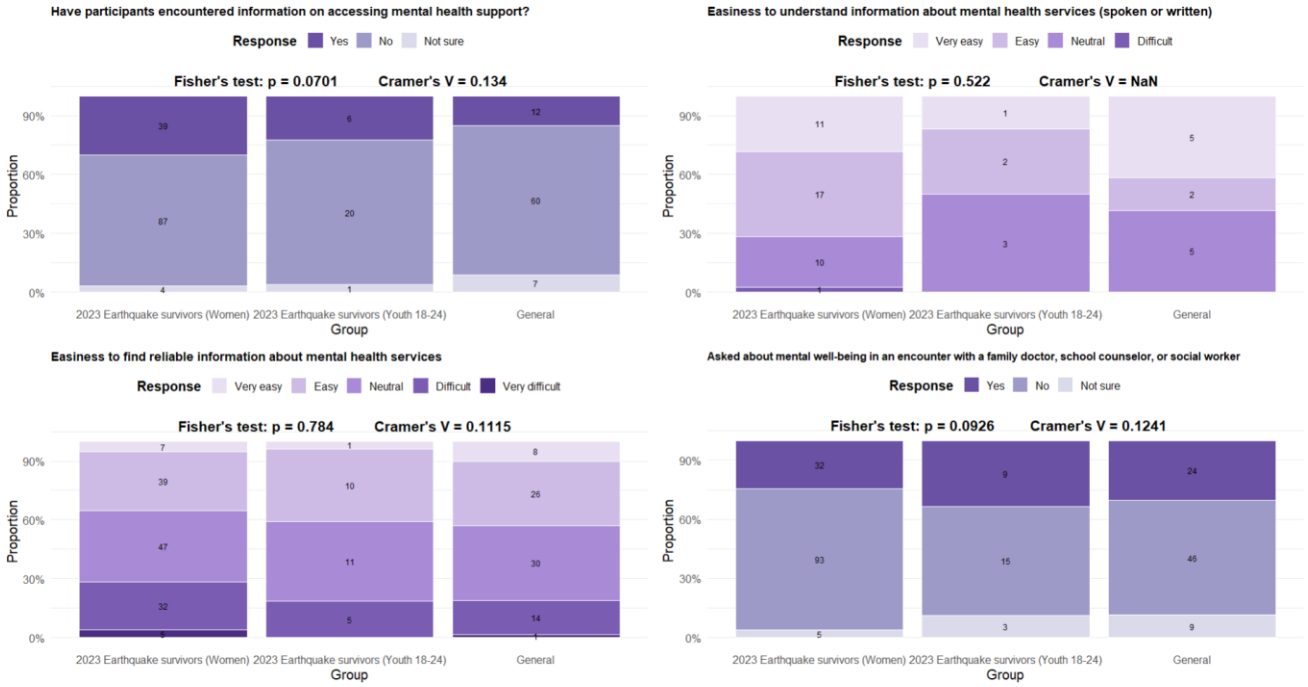


Figure 3: Non-significant differences across groups for the approachability dimension in Turkey (1)

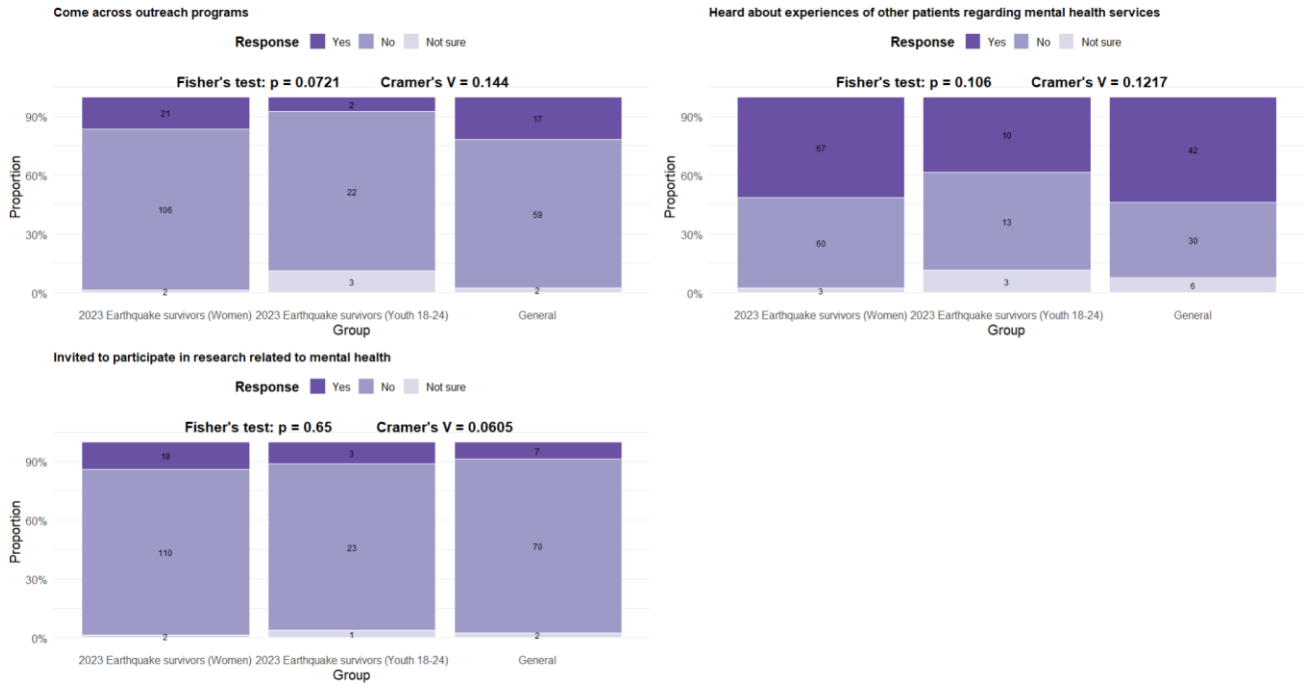


Figure 4: Non-significant differences across groups for the approachability dimension in Turkey (2)

Acceptability

Within the Acceptability dimension, no statistically significant differences were observed between the groups across any of the assessed items (Figures 5 & 6; all p-values > 0.05). This included the option to communicate with mental health providers in a preferred language, perceptions that mental health workers communicated respectfully, and the possibility to choose one's own doctor or therapist. In addition, respondents across all groups reported similar perceptions regarding whether their rights were protected against mistreatment or abuse and whether mental health services were considered trustworthy. These findings suggest that core aspects related to respectful care, autonomy in provider selection, and perceived trust in services were experienced similarly across groups.

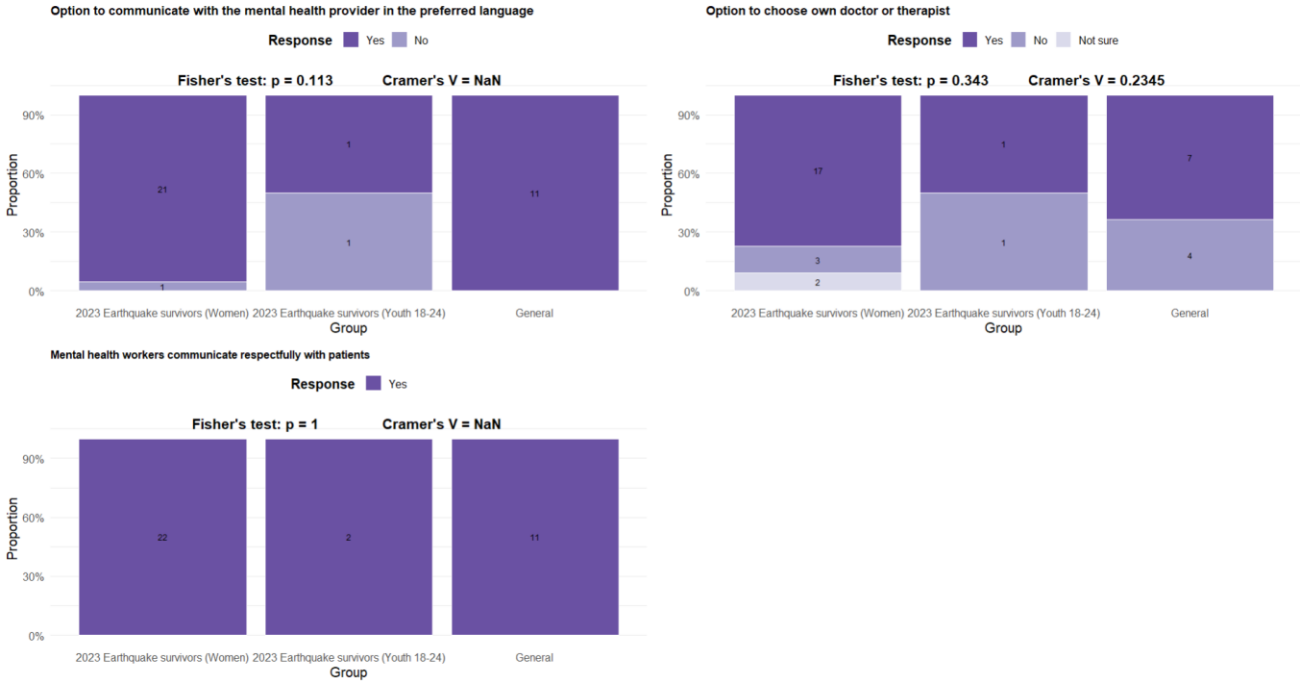


Figure 5: Non-significant differences across groups for the acceptability dimension in Turkey (1)

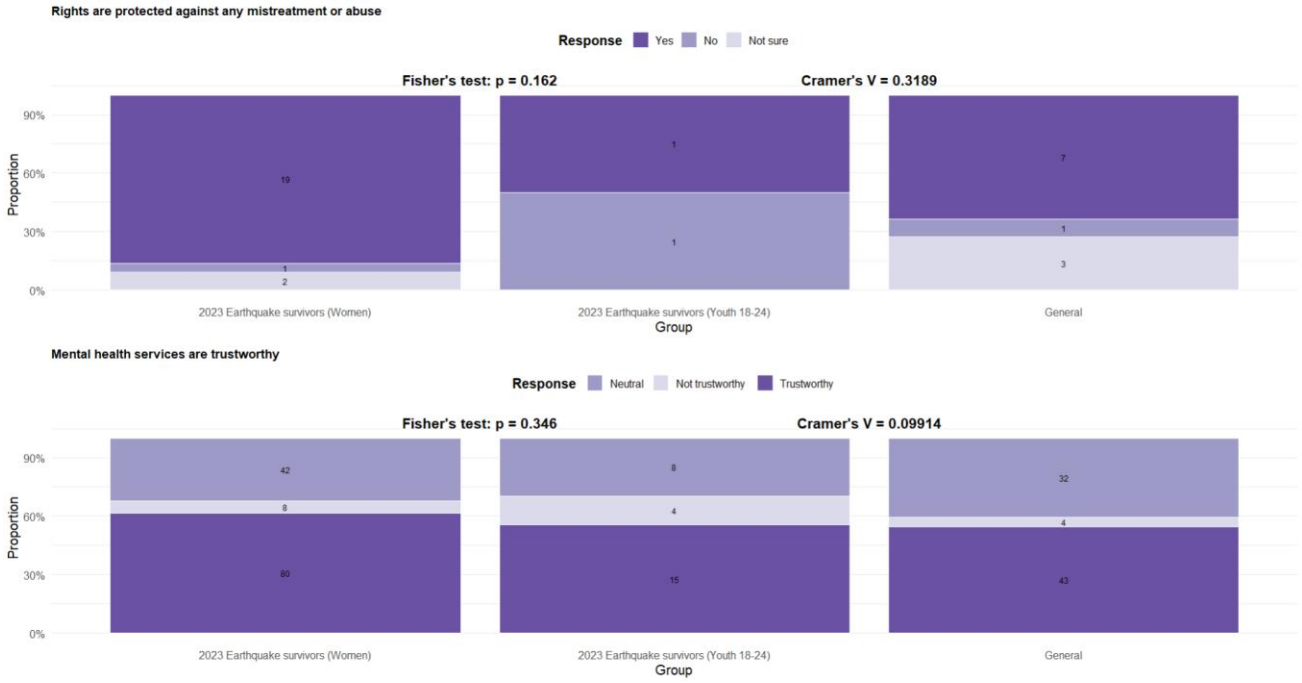


Figure 6: Non-significant differences across groups for the acceptability dimension in Turkey (2)

Affordability

Within the Affordability dimension, most items did not show statistically significant differences between the groups (Figures 7 & 8; all p-values > 0.05). These included the possibility of accessing mental health services through public programs or free or low-cost services, availability of health insurance covering mental health services, and whether respondents had ever not taken prescribed medication due to cost. Similarly, no differences were observed regarding difficulties accessing care due to loss of income, additional costs, or whether respondents had been offered financial support or discounts to reduce or cover treatment costs. These findings suggest that several direct financial barriers to care were reported at comparable levels across the general population, women earthquake survivors, and youth earthquake survivors.

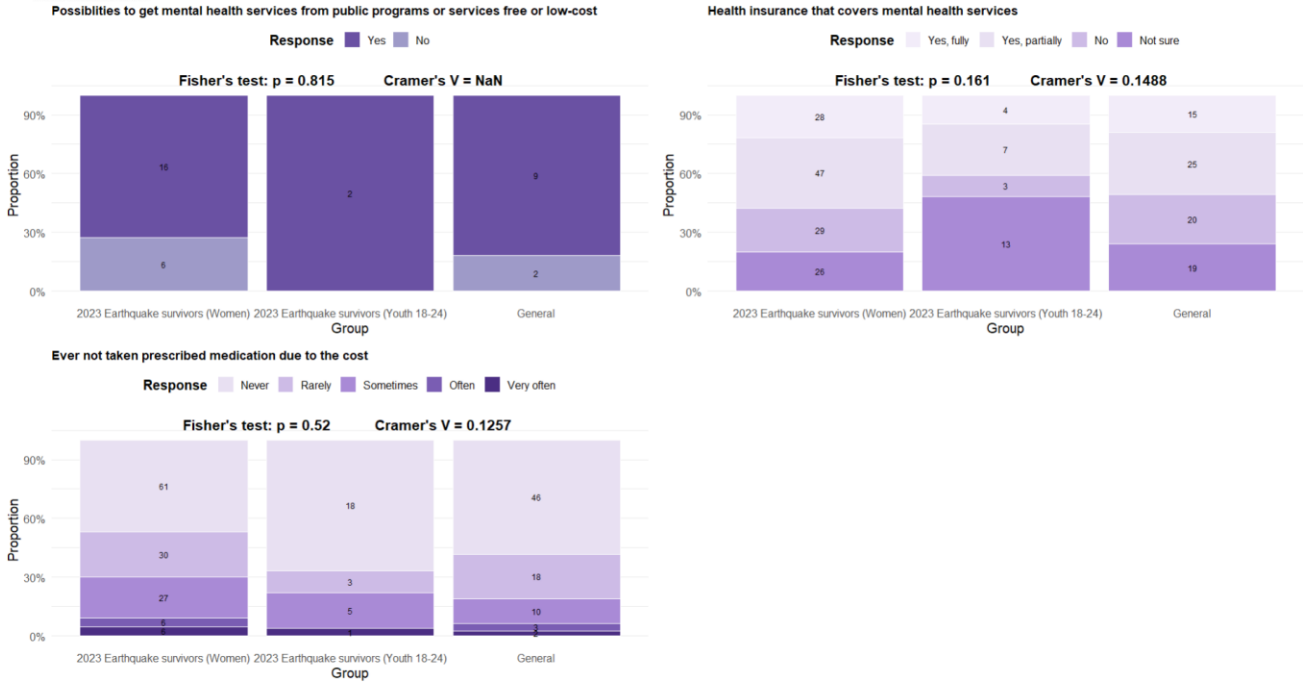


Figure 7: Non-significant differences across groups for the Affordability dimension in Turkey (1)

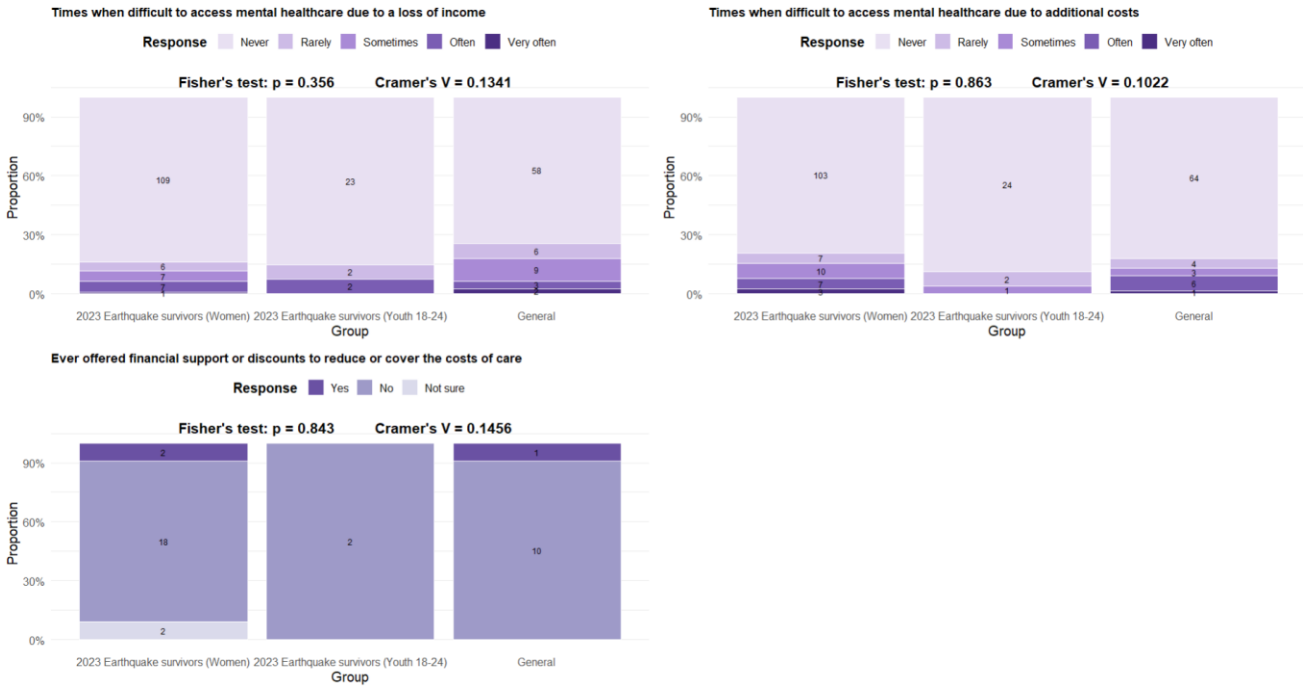


Figure 8: Non-significant differences across groups for the Affordability dimension in Turkey (2)

However, delayed or avoided mental healthcare due to cost in the past 12 months differed significantly between groups (Figure 9). Pairwise comparisons (Table 4) indicated significant differences between the general population and youth earthquake survivors aged 18–24 years (p = 0.004, Cramer's V = 0.318), as well as between women earthquake survivors and youth earthquake survivors (p = 0.015, Cramer's V = 0.247). No statistically significant difference was observed between the general population and women earthquake survivors (p = 0.920, Cramer's V = 0.057). Descriptively, youth earthquake survivors reported more frequent delays or avoidance of care due to financial reasons compared with the other groups. The observed effect sizes indicate moderate associations, particularly for comparisons involving youth.

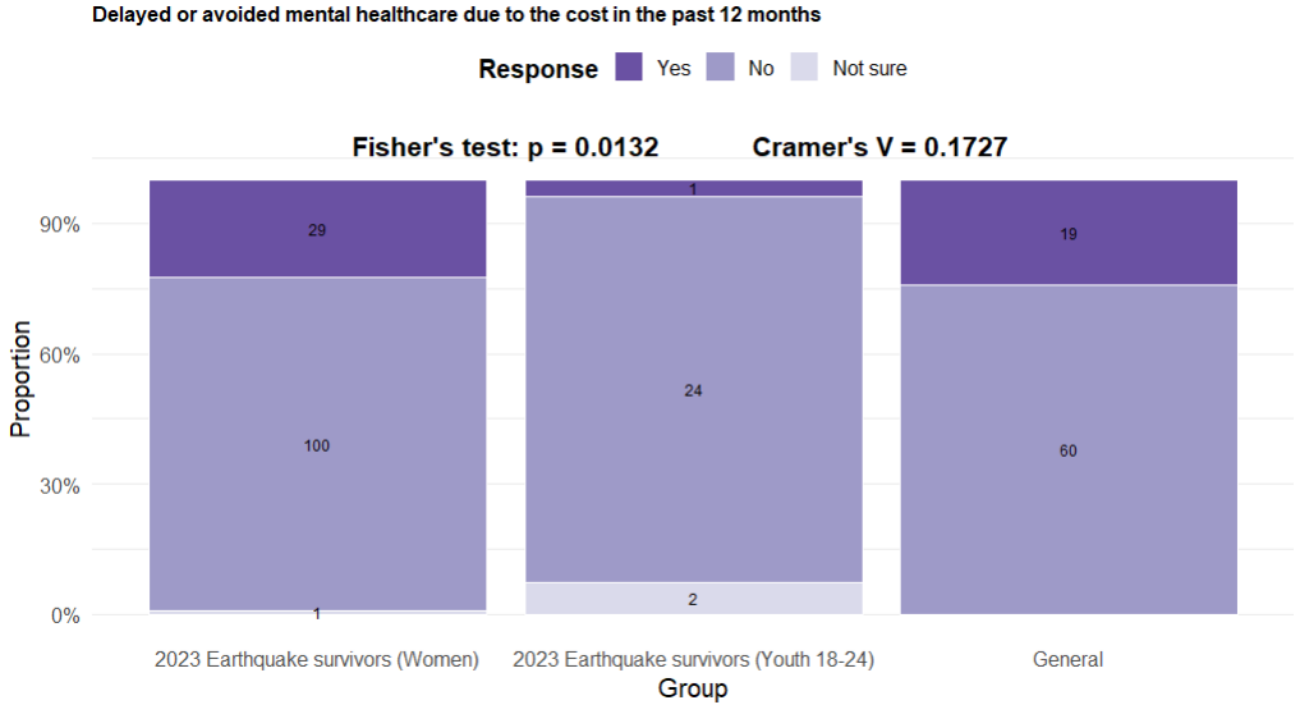


Figure 9: Fisher's exact test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Turkey

Table 4: Pairwise comparison of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Turkey

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: 2023 Earthquake survivors (Women)	0.920	0.057
General group : 2023 Earthquake survivors (Youth 18-24)	0.004	0.318

2023 Earthquake survivors (Women) : 2023 Earthquake survivors (Youth 18-24)	0.015	0.247

In addition, differences were observed regarding whether someone from the service helped with payment options, insurance questions, or financial assistance (Figure 10). However after pairwise comparison, no differences between the specific groups were found.

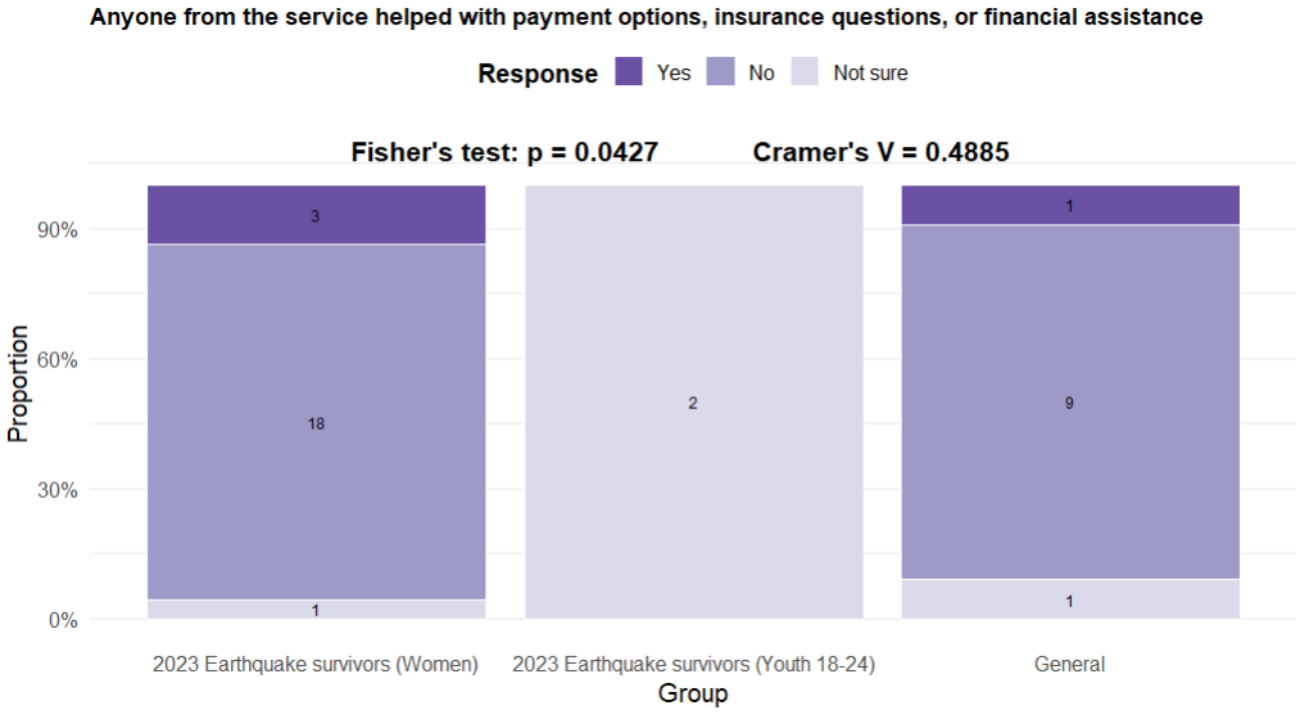


Figure 10: Fisher's exact test of the anyone from the service helped with payment options, insurance questions, or financial assistance item in Turkey

Table 5: Pairwise comparison of the anyone from the service helped with payment options, insurance questions, or financial assistance item in Turkey

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: 2023 Earthquake survivors (Women)	1.000	0.107
General group : 2023 Earthquake survivors (Youth 18-24)	0.108	0.778
2023 Earthquake survivors (Women) : 2023 Earthquake survivors (Youth 18-24)	0.054	0.798

Within the Appropriateness dimension, the majority of assessed items did not demonstrate statistically significant differences between the groups (Figures 11, 12 & 13; all p-values > 0.05). These included experiences related to being treated with courtesy and respect, providers spending sufficient time, and receiving explanations that were easy to understand. In addition, no differences were observed regarding whether mental health services were perceived as helpful or relevant, whether cultural beliefs and practices were considered, or whether respondents were involved in setting goals or making plans for their care. Similarly, comparable experiences were reported across groups in relation to providers considering broader life experiences, smooth referrals between services without repeated explanations, and the possibility of seeing the same doctor or therapist consistently during treatment. Perceptions that feedback was used to improve services, as well as whether support was offered to caregivers or family members, also remained consistent across groups. Taken together, these findings indicate broadly similar experiences of care quality and continuity among the general population, women earthquake survivors, and youth earthquake survivors.

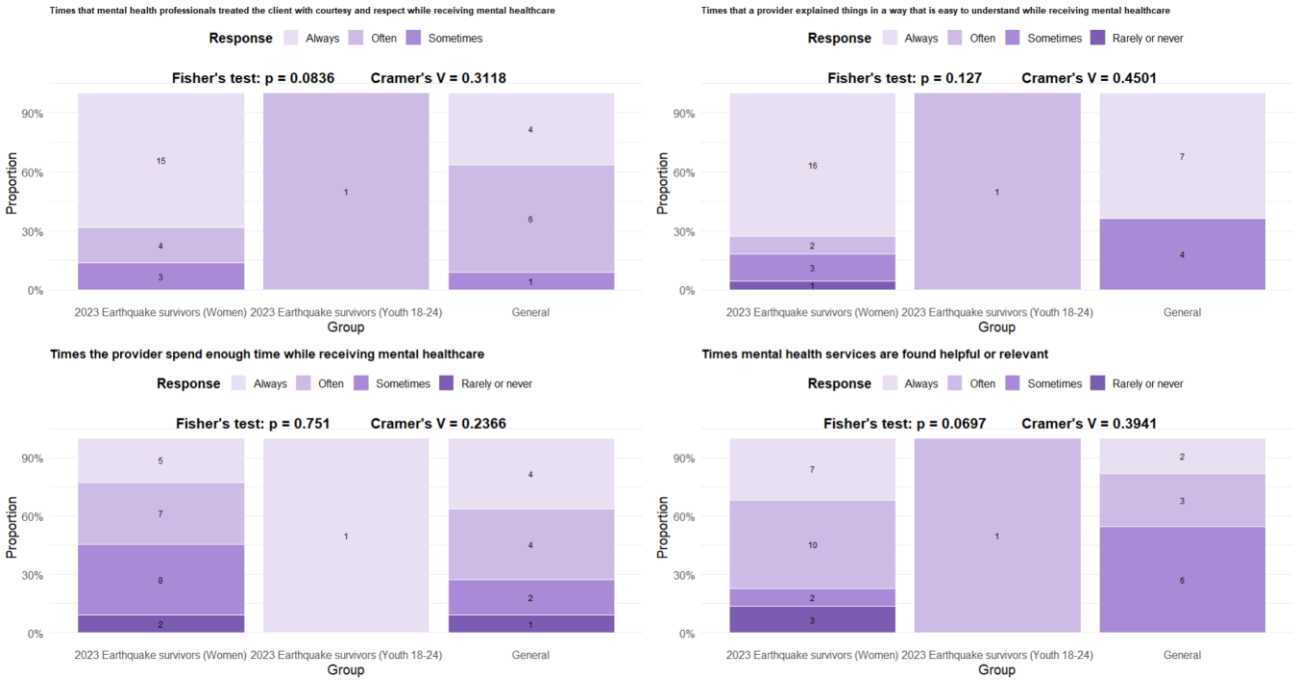


Figure 11: Non-significant differences across groups for the appropriateness dimension in Turkey (1)

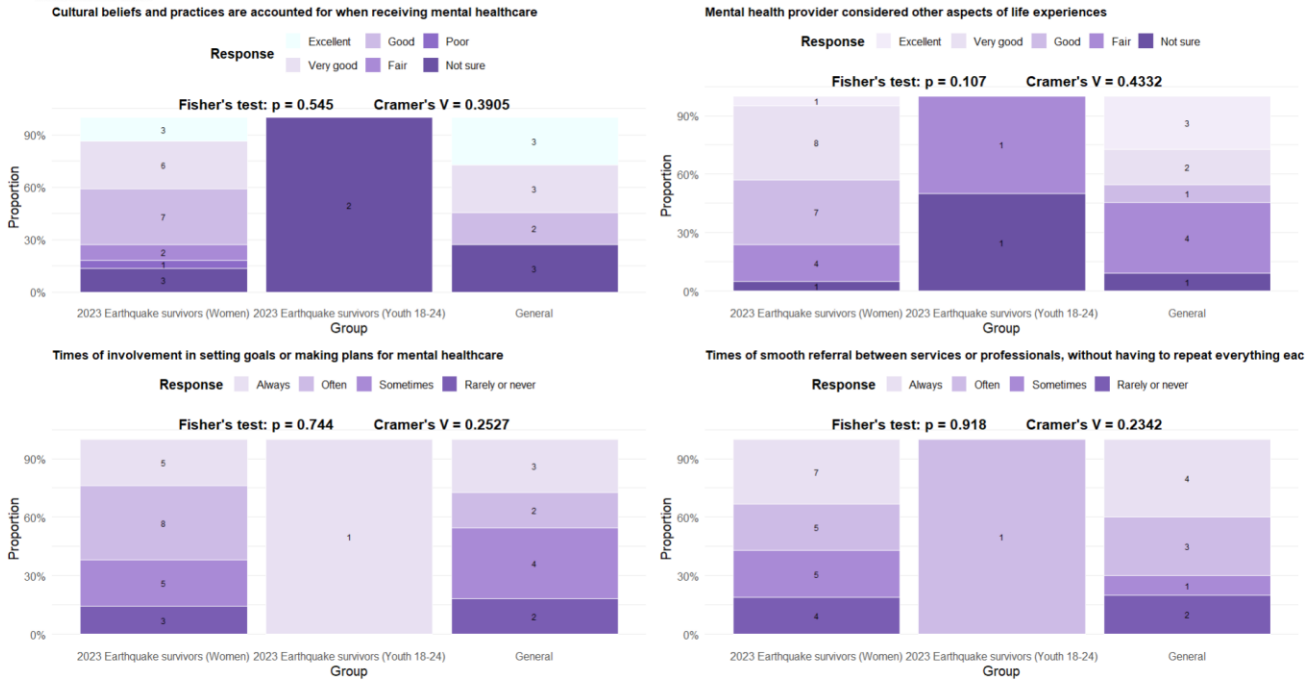


Figure 12: Non-significant differences across groups for the appropriateness dimension in Turkey (2)

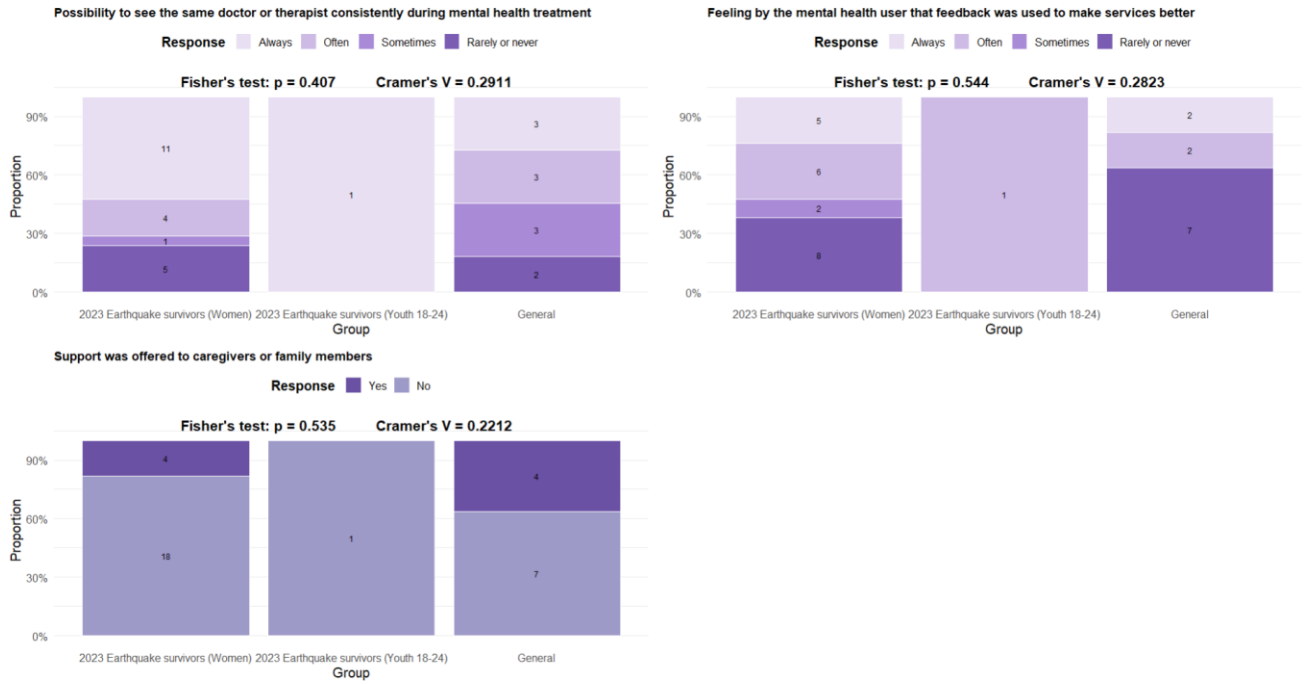


Figure 13: Non-significant differences across groups for the appropriateness dimension in Turkey (3)

Despite the overall similarity across most items, easiness to schedule follow-up appointments when required showed a statistically significant difference in the overall group comparison (Figure 14) However, subsequent pairwise comparisons (Table 6) did not identify statistically significant differences between specific group pairs (all adjusted p-values ≥ 0.0675). This suggests that while minor variation may exist across the sample as a whole, no clear group-specific differences could

be identified.

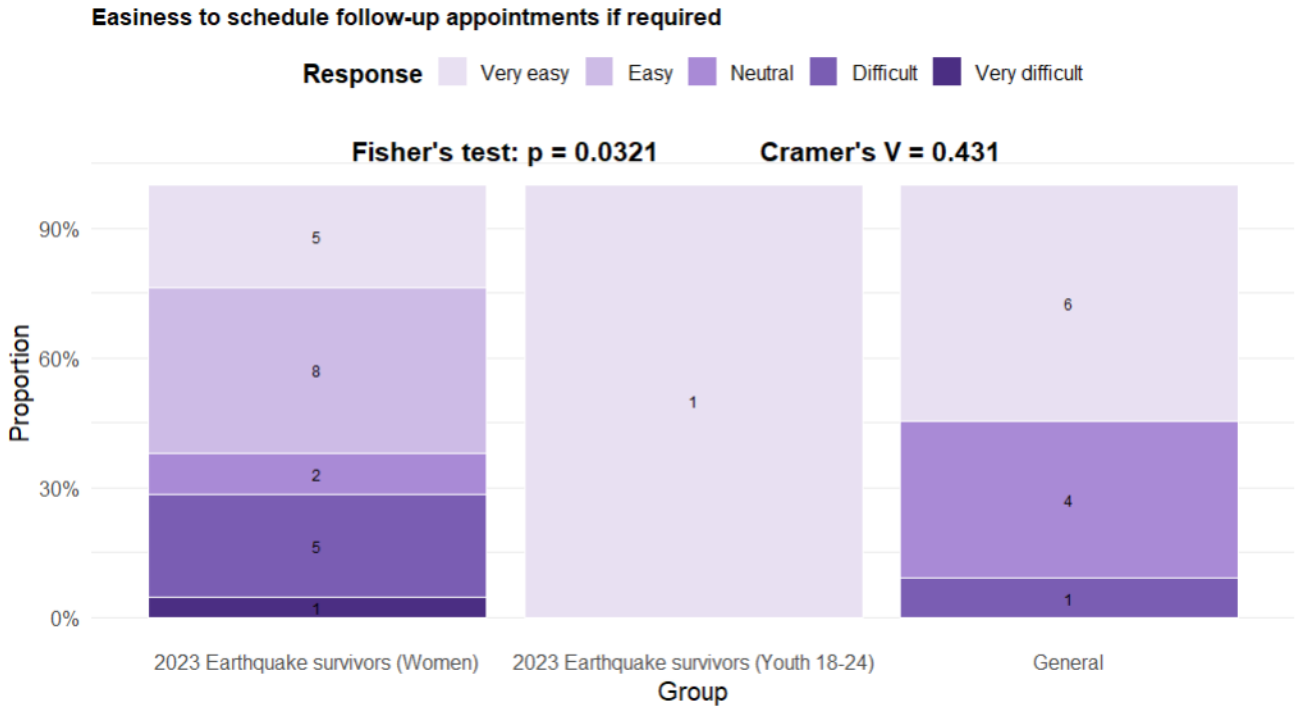


Figure 14: Fisher's exact test of the easiness to schedule follow-up appointments if required item in Turkey

Table 6: Pairwise comparison test of the easiness to schedule follow-up appointments if required item in Turkey

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: 2023 Earthquake survivors (Women)	0.0675	0.567
General group : 2023 Earthquake survivors (Youth 18-24)	1.000	NC
2023 Earthquake survivors (Women) : 2023 Earthquake survivors (Youth 18-24)	0.945	0.356

A similar pattern was observed for whether mental health users received invitations to provide feedback regarding their treatment (Figure 15) Although the overall comparison indicated differences between groups, pairwise analyses did not confirm statistically significant differences between individual group combinations (all adjusted p-values ≥ 0.186; Table 7)

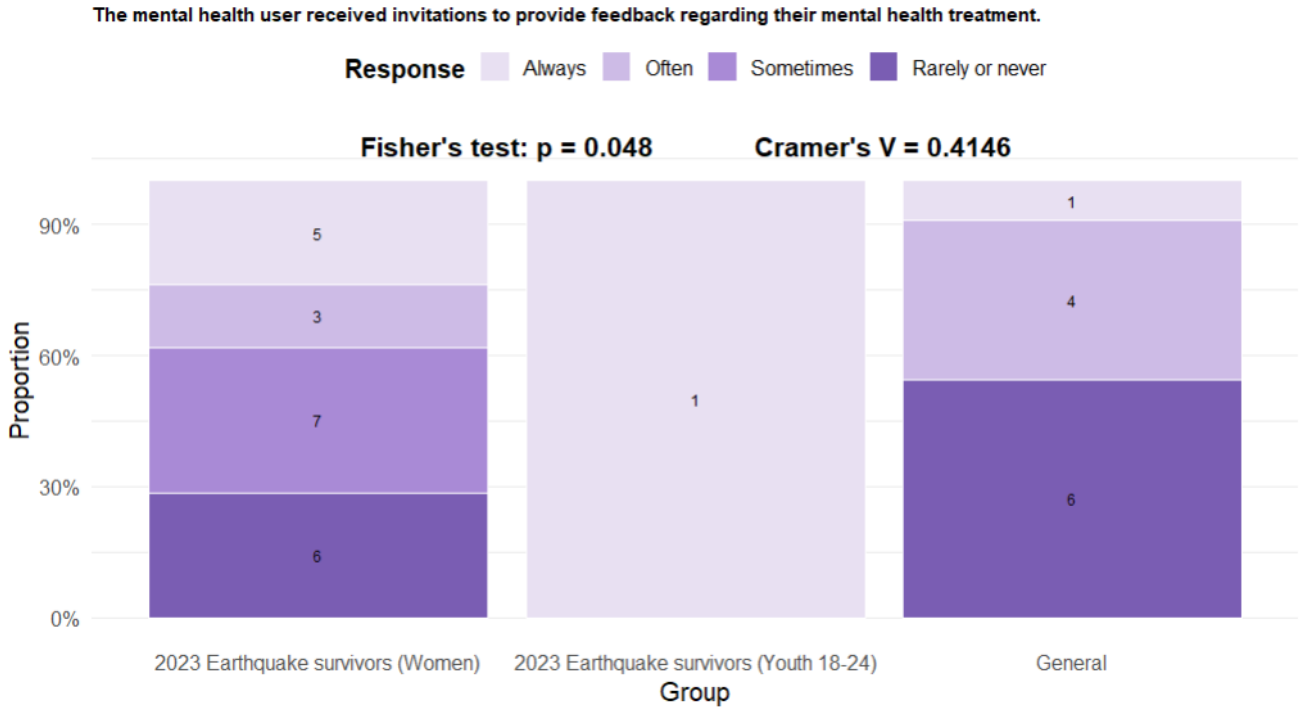


Figure 15: Fisher's exact test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Turkey

Table 7: Pairwise comparison test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Turkey

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: 2023 Earthquake survivors (Women)	0.186	0.481
General group : 2023 Earthquake survivors (Youth 18-24)	0.232	NC
2023 Earthquake survivors (Women) : 2023 Earthquake survivors (Youth 18-24)	0.699	0.356

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, could not be directly compared with national reference values for Turkey, as no nationally validated EQ-5D-5L value set or population norm dataset specific to Turkey was available at the time of analysis.

Self-perceived health

Self-perceived health was evaluated using items aligned with those included in the EU Statistics on Income and Living Conditions (EU-SILC) Turkey dataset, enabling comparison with national distributions reported through Eurostat EU-SILC Turkey data. As subgroup-specific national estimates for earthquake survivors were not available within EU-SILC Turkey, comparisons were conducted primarily at the overall population level.[12] Across the study groups, perceptions of health varied notably. Within the general group, the majority of respondents reported good (39.2%) or very good (19.0%) health, reflecting a relatively positive self-assessment. Youth earthquake survivors showed a similar pattern, with 44.4% reporting good health and 22.2% reporting very good health, indicating relatively favourable perceptions within this subgroup. In contrast, women earthquake survivors more frequently reported fair health (65.4%), while relatively small proportions reported good (15.8%) or very good (3.0%) health (Table 8). When compared with national distributions derived from the EU-SILC Turkey dataset, the study sample demonstrated lower proportions of good health and higher proportions of fair health, particularly among women earthquake survivors. National estimates indicate that 57.8% of the population report good health, whereas this proportion was lower in the present dataset across all groups (Table 9).

Table 8: Self-perceived health in the dataset of Turkey

	General group	2023 Earthquake survivors (Youth 18-24)	2023 Earthquake survivors (Women)
Very bad, *n (%)*	0 (0.0)	1 (3.7)	6 (4.5)
Bad, *n (%)*	3 (3.8)	1 (3.7)	15 (11.3)
Fair (neither good nor bad), *n (%)*	30 (38.0)	7 (25.9)	87 (65.4)
Good, *n (%)*	31 (39.2)	12 (44.4)	21 (15.8)
Very good, *n (%)*	15 (19.0)	6 (22.2)	4 (3.0)
Missing, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)

Table 9: Self-perceived health in the dataset of EU-SILC Turkey

	Total country
Very bad, %	0.7
Bad, %	6.7
Fair (neither good nor bad), %	30.2
Good, %	57.8

Very good, %	4.7

Activity limitations

Functional limitations were assessed using indicators corresponding to those included in the EU-SILC Turkey dataset, allowing comparison with national activity limitation distributions.[13] Within the study sample, most respondents reported no activity limitations, particularly among youth earthquake survivors (70.4%). In the general group, 55.7% reported no limitations, while 38.0% reported moderate limitations. Women earthquake survivors reported comparatively higher levels of functional limitation, with 48.1% reporting moderate limitations and 12.0% reporting severe limitations, representing the highest proportion of severe limitations among the groups (Table 10) Comparison with national estimates from EU-SILC Turkey suggests that activity limitations were reported more frequently in the study population, particularly among women earthquake survivors. National data indicate that 74.9% of respondents report no limitations, whereas lower proportions of respondents in the present dataset reported being free from limitations. (Table 11).

Table 10: Activity limitations in the dataset of Turkey

	General group	2023 Earthquake survivors (Youth 18-24)	2023 Earthquake survivors (Women)
Severely limited, *n (%)*	5 (6.3)	1 (3.7)	16 (12.0)
Limited, *n (%)*	30 (38.0)	7 (25.9)	64 (48.1)
Not limited, *n (%)*	44 (55.7)	19 (70.4)	53 (39.8)
Missing, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)

Table 11: Activity limitations in the dataset of EU-SILC Turkey

	Total country
Severely limited, %	4.7
Limited, %	20.4
Not limited, %	74.9

Unmet need for care

Unmet need for healthcare was assessed using indicators aligned with those included in the EU-SILC Turkey dataset, enabling triangulation with national estimates reported through Eurostat EU-SILC Turkey data[14]. Several barriers to accessing care were reported across the study groups. Among the general group, commonly reported barriers included travel distance (12.7%), waiting lists (11.4%), and cost-related barriers (11.4%). Youth earthquake survivors reported relatively lower levels of cost-related unmet need (3.7%), although waiting lists (11.1%) and delays while waiting for improvement of symptoms (14.8%) were reported. Women earthquake survivors reported higher levels of unmet need across several categories, including travel distance (21.8%), cost-related barriers (19.5%), and waiting lists (18.8%). Across groups, the proportion reporting no unmet healthcare needs ranged from 58.6% among women earthquake survivors to 74.1% among youth earthquake survivors(Table 12). When compared with national EU-SILC Turkey estimates, where approximately 96.0% of respondents report no unmet healthcare needs, the present dataset indicates substantially higher levels of unmet need, particularly among women earthquake survivors. (Table 13).

Table 12: Unmet need for care in the dataset of Turkey

	General group	2023 Earthquake survivors (Youth 18-24)	2023 Earthquake survivors (Women)
Too expensive, *n (%)*	9 (11.4)	1 (3.7)	26 (19.5)
Too far to travel, *n (%)*	10 (12.7)	2 (7.4)	17 (21.8)
No time, *n (%)*	2 (2.5)	1 (3.7)	5 (3.8)
Didn't know any good doctor or specialist, *n (%)*	3 (3.8)	1 (3.7)	7 (5.3)
Waiting list, *n (%)*	9 (11.4)	3 (11.1)	25 (18.8)
Fear of doctor, hospital examination or treatment, *n (%)*	2 (2.5)	1 (3.7)	15 (11.3)
Wanted to wait and see if problem got	10 (12.7)	4 (14.8)	21 (15.8)

better on its own, *n (%)*			
Other reason, *n (%)*	6 (7.6)	2 (7.4)	19 (14.3)
No unmet needs to declare, *n (%)*	54 (68.4)	20 (74.1)	78 (58.6)
Missing, *n (%)*	0 (0.0)	0 (0.0)	1 (0.8)

Table 13: Unmet need for care in the EU-SILC dataset of Turkey

	Total country
Too expensive, %	0.4
Too far to travel, %	0.0
No time, %	0.0
Didn't know any good doctor or specialist, %	0.0
Waiting list, %	0.0
Fear of doctor, hospital examination or treatment, %	0.0
Wanted to wait and see if problem got better on its own, %	0.9
Other reason, %	2.7
No unmet needs to declare, %	96.0

Depression severity

Depressive symptom severity was assessed using indicators aligned with those included in the European Health Interview Survey (EHIS) Turkey dataset, enabling comparison with national mental health distributions reported through Eurostat EHIS Turkey data [15]. Across the study population, depressive symptoms were reported at varying levels of severity. Within the general group, mild depressive symptoms were most common (35.4%), followed by moderate symptoms (24.1%) and minimal symptoms (22.8%). Youth earthquake survivors demonstrated a broadly similar pattern, with moderate symptoms (25.9%) and mild symptoms (33.3%) frequently reported. Women earthquake survivors reported comparatively higher levels of symptom severity, with 20.3% reporting moderately severe symptoms and 7.5% reporting severe symptoms, representing the highest proportions across groups (Table 14). National reference values derived from the EHIS Turkey dataset indicate that the majority of the population reports none or minimal depressive

symptoms (70.4%), with substantially smaller proportions reporting moderate or severe symptoms. Compared with these national estimates, the present dataset suggests elevated levels of depressive symptom severity, particularly among women earthquake survivors (Table 15).

Table 14: Depression severity in the dataset of Turkey

	General group	2023 Earthquake survivors (Youth 18-24)	2023 Earthquake survivors (Women)
Severe, *n (%)*	3 (3.8)	1 (3.7)	10 (7.5)
Moderately severe, *n (%)*	11 (13.9)	3 (11.1)	27 (20.3)
Moderate, *n (%)*	19 (24.1)	7 (25.9)	30 (22.6)
Mild, *n (%)*	28 (35.4)	9 (33.3)	51 (38.3)
None or minimum, *n (%)*	18 (22.8)	7 (25.9)	15 (11.3)
Missing, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)

Table 15: Depression severity in the EHIS dataset of Turkey

	Total country
Severe, %	1.1
Moderately severe, %	1.8
Moderate, %	3.6
Mild, %	23.1
None or minimum, %	70.4

4.1.2 Qualitative results

Approachability

Information awareness and access

Information about mental health services in post-earthquake Hatay did not circulate through any coherent or proactive system. Across all five interviews, awareness is found to depend on informal word-of-mouth and messaging groups rather than on structured public communication. The academic frames the problem at its most fundamental level: help-seeking requires two prior steps that many survivors have not completed: recognising that one has a problem and believing that help is possible. As the academic states: *"First, recognizing the problem. "Yes, I have experienced a problem. I have*

a problem. This problem needs to be solved." So, the first stage is the person deciding this within themselves. An awareness. So first, it is important to make people aware of what psychiatric problems are, what psychological problems are" (Koç University, Academic). A second layer of disengagement compounds this: even among those who recognise their distress, many have concluded that professional help cannot address losses of the magnitude they have experienced: "*No one can help me. What can be done? My father died. My mother died. My sibling died. My child died. What can they possibly do about that?*" (Koç University, Academic).

In the acute phase, the complete destruction of hospital infrastructure meant that even health workers themselves did not know where services were. The provider describes this directly: *"There were groups. Employee groups, and relocation groups and so on. Everybody was asking everything there. Because nothing was in place and nobody knew where to get what from. Including us. We were learning from those groups"* (Koç University, Provider). The civil society respondent confirms that information spread exclusively through informal channels: *"one neighbour told another, an older brother told a younger one, a sibling told a cousin, so these services spread through hearsay information"* (Koç University, Civil Society).

The policymaker identifies a range of formal communication mechanisms established over time, such as social media announcements, brochures, family physician referrals, the MHRS appointment system, and the 182 telephone line. These represent meaningful facilitators in the post-acute period. However, the policymaker simultaneously acknowledges that visibility remains low: *"In these areas, we could be supported in order to improve visibility"* (Koç University, Policymaker). A specific and analytically barrier unique to this context is identified by the civil society respondent: young earthquake survivors actively avoided psychosocial services for fear that contact with psychiatric services would be recorded in the national e-Nabız health record system and damage future career prospects in state employment. *"Yes, I know I need it, but it will be recorded in my file, so I won't go, it might affect something in the future, like my career choice, so I don't want to go"* (Koç University, Civil Society).

The academic and the policymaker both propose proactive outreach to container settlements as the most promising underutilised information channel. The academic goes furthest in proposing targeted SMS campaigns modelled on prescription reminder systems: *"send SMS messages to people living there, the way we get prescription messages. Something like: "We know that some time has passed since the earthquake, but that there may still be things you have not forgotten. If you are not feeling well psychologically, please do not hesitate to apply. You can reach us through 182"* (Koç University, Academic). This proposal is consistent with the civil society respondent's observation that the most effective information strategy was sustained one-to-one contact within the container city environment, which is only possible through physical presence.

Barriers to recognising or seeking help

Barriers to recognising and seeking help operate across individual, cultural, and structural dimensions simultaneously, and the post-earthquake context has both intensified pre-existing barriers and introduced new ones. The academic, policymaker, and provider all converge on three prominent barriers: non-recognition of distress as a mental health problem; not knowing how or where to go; and stigma.

Transport was a universally identified structural barrier across all five interviews. Even survivors who had overcome psychological barriers to help-seeking could not physically reach services. The provider describes a patient who walked from a bus stop to the field hospital and still could not find a doctor: *"They came from Altınözü and got off at a place we call the village garages. From there, there was Kocaeli Field Hospital. I remember that the patient walked there. They walked and could not find a doctor. They called me asking where they should go"* (Koç University). The civil society respondent quantifies the current transport situation: a single minibus line connecting Umutkent container city to the centre, running once per hour and stopping entirely in the evening: *"even simply going to a theatre, a cinema, or some social activity from here takes two hours"* (Koç University, Civil Society).

A barrier specific to youth survivors that was absent from all other pilot sites is the e-Nabız record concern: the fear that a psychiatric contact would permanently damage employment prospects in the military, police, or civil service. This is a structurally produced barrier rooted in the intersection of mental health stigma and public sector employment requirements in Turkey. The civil society respondent describes it as the primary barrier encountered over two and a half years of field work with youth aged 15 to 24.

The anti-psychiatry movement on social media is identified by the academic as a newly significant and spreading barrier: *"There is a group that believes in conspiracy theories. There is an anti-psychiatry movement, and it has expanded. … There are thousands of people on social media who believe them. These people's voices are very loud on platforms"* (Koç University, Academic). The policymaker corroborates this from clinical observation, noting that patients frequently conflate psychologists with psychiatrists and resist engagement because they do not want a psychiatric label: *"When people hear the word psychologist, they immediately think of a psychiatrist. They cannot really distinguish between them. As a result, the number of people applying to psychosocial support services can also remain low"* (Koç University, Policymaker). Together, these findings point to a population in which help-seeking requires overcoming not just personal stigma but an actively hostile information environment.

Stigma and societal dimensions

Stigma is across all five interviews identified as a powerful and persistent barrier to mental health care access in Hatay, predating the earthquake and deepened by it. Its mechanisms are consistent: fear of social labelling, family interference with treatment, fear of career consequences, and a cultural context in which mental health difficulties are equated with being “crazy.” What is distinctive about the Hatay context compared to other pilot sites is the degree to which stigma is amplified by the area’s close-knit social structure. The academic identifies this explicitly: *"Even though Hatay has metropolitan status, culturally it is more like a place where family ties are strong, everyone knows each other, a small settlement area. … The person thinks, “If I go to the hospital, someone will definitely recognize me, and I may be stigmatized”* (Koç University, Academic).

Family-level interference with treatment is documented across multiple interviews as a specific mechanism through which stigma operates. The academic describes a patient whose husband instructed her to stop psychiatric medication: *"Her husband had told her, “Stop these medicines, deal with it yourself a bit, get better,” and then the patient came back with panic attacks"* (Koç University, Academic). The provider documents a patient who refused home visits from the community mental health team because of the stigma consequences within their container city neighbourhood: *"I live there in a rented house by myself. When I rented this house, I had already been exposed to many things before. Children threw stones at me. They ran after me shouting crazy. The neighbourhood did not want me. They stoned my house and my windows. Because of that, I do not want you to come to my house here either"* (Koç University, Provider). This represents one of the most extreme stigma manifestations documented across all Koç University interviews.

Stigma also extends to healthcare professionals themselves. The academic notes that even specialist doctors hold stigmatising beliefs about psychiatry: *"I have also seen an anaesthesiologist friend say, “What are psychiatrists, what are psychologists anyway?” Now when a specialist doctor says that, you cannot really blame the public"* (Koç University, Academic). The policymaker corroborates this at the institutional level, noting that families resist even autism diagnoses out of fear of labelling: *"A child may have been diagnosed with autism, but the family does not want that on record because they do not want it to affect the child in the future"* (Koç University, Policymaker).

A meaningful point of differentiation across interviews is the trajectory of stigma over time. The academic identifies a generational dynamic: stigma is decreasing among younger populations while remaining intense among older groups and those with lower education. Word-of-mouth spread of positive service experiences is identified as the most effective organic mechanism for stigma reduction: *"A patient comes, benefits, then sees a relative’s condition. They say, “It helped me a lot, I did not have a problem with antidepressants, let me take you too.” Sometimes one person can bring*

10 patients like that" (Koç University, Academic). The civil society respondent documents systematic stigma reduction work at the centre level through zero-discrimination policies, group sessions on coexistence, and private one-to-one conversations with youth showing signs of distress. These approaches produced measurable changes in help-seeking behaviour within the centre population. By contrast, no systematic stigma reduction policy exists at the provincial or national level.

Cultural and social fit

Cultural fit of mental health services is compromised in the Hatay context by two overlapping problems: providers who are themselves earthquake survivors, and the disruption of neighbourhood social structures through irregular container city placement. Both are identified uniquely within this interview set and represent post-earthquake-specific acceptability failures that have no parallel in other EQUICARES pilot sites.

The civil society respondent identifies the shared trauma of providers and clients as the most significant cultural appropriateness failure of the acute phase. When providers were earthquake survivors themselves, the professional distance necessary for effective support collapsed: *"the person in front of me was also an earthquake survivor, and the story I was telling was very familiar to them. So in those processes, we were harming each other more than helping each other"* (Koç University, Civil Society). This produced sessions in which both parties cried together, a well-documented secondary traumatisation dynamic that the civil society respondent argues could have been avoided through better programme design, specifically by prioritising the deployment of psychologically stable providers from outside the earthquake zone rather than relying on local personnel who had not yet processed their own losses.

Language barriers are identified as a specific cultural accessibility challenge, particularly for older Arabic-speaking women and Syrian refugees. The academic describes a case in which a Syrian patient's account passed through three languages via two interpreters, with each translation consuming a minute of the already-compressed appointment time: *"when I asked one question, by the time it was translated into three languages and an answer came back, a minute had passed. Now look at the quality of that examination"* (Koç University, Academic). The civil society respondent adds that culturally embedded expressions of distress, such as the Arabic phrase "my heart hurts" meaning emotional pain rather than physical cardiac symptoms, could be misread by providers unfamiliar with the cultural context: *"someone who does not know the culture interprets it as physical pain and asks, did you go to the hospital, did you get tested, did you get an ECG? But actually what they are trying to say is that there is a brokenness in their heart, there is longing there, there is yearning there"* (Koç University, Civil Society).

Gender dynamics within the youth population represent a specific acceptability barrier documented exclusively by the civil society respondent. Male youth in the 15–24 age group consistently requested female psychologists, reflecting a cultural norm in which adult Turkish men were assumed to find male emotional expression strange or inappropriate. Simultaneously, an LGBTQ+ young person refused to engage with a headscarved provider out of fear of judgement regarding their identity. These findings illustrate that cultural fit for vulnerable youth subgroups requires not only sensitivity to Turkish cultural norms but attention to intersecting vulnerabilities, such as gender, sexuality, and religious expression, that mainstream service design does not address.

Availability

Distribution and sufficiency of services

All five interviews converge on a diagnosis of severe structural under-provision, though with different emphases. The immediate post-earthquake collapse of hospital infrastructure is documented by the academic and provider as total: bed capacity dropped to zero, access to doctors was severely restricted, and access to medication was disrupted. Community mental health centres, which had been the most important mechanism for reducing psychiatric hospitalisations through active follow-up, dropped from four to two: *"We had four centers, then it dropped to two. What happened? Fifty percent of these groups could no longer access services"* (Koç University, Academic). Three years after the earthquake, the CMHC has still not reopened in Antakya, a failure that the provider identifies as the single most consequential ongoing availability gap: *"Right now there is nothing, still nothing"* (Koç University, Provider).

The policymaker presents the most complete picture of current provision: 16 psychosocial support centres, 13 psychologists across district health directorates, 8 psychologists in migrant health services, and coverage in 13 of 15 districts. This represents a meaningful facilitator built under very difficult conditions. However, the policymaker immediately qualifies this with a critical staffing ratio problem: one psychologist serves a district population exceeding 100,000 in some areas, far below any viable standard: *"One of my districts has only one psychologist post, but the district population is over 100,000. In some respects, that is not enough"* (Koç University, Policymaker).

The civil society respondent provides the starkest description of the current availability situation in the container city where this respondent works: *"There is no adult psychologist. We are four institutions. One provides services specifically for women, one works with children, one is us and we work with youth, and another also works with children. So in fact two institutions work with children, one with youth, one with women, and there is no adult psychologist in the field at the moment"* (Koç University, Civil Society). This is particularly striking because the academic's own research identifies that 30% of the earthquake survivor population has PTSD and nearly 40% depression, meaning that the

population with the highest documented mental health burden has effectively no adult psychologist serving it.

NGO coordination failure is identified by the civil society respondent as a major availability problem in the acute phase: multiple organisations concentrated in the same locations while other areas received nothing. The civil society respondent also identifies an ideologically driven distribution distortion, with service concentration shaped by staff members redirecting NGO resources toward their own family neighbourhoods. These disparities were only partially addressed through a cross-NGO WhatsApp coordination group in Adıyaman, a locally improvised solution with no national precedent or institutional backing.

Timing, format, and continuity of services

The format and delivery model of mental health services is structurally misaligned with the needs of the post-earthquake population in ways that all five interviews document, though from different angles. The most fundamental mismatch is appointment duration. The academic is unambiguous: *"psychiatric appointments are given every 10 minutes. … That is a very short time. It is too short even for what we might consider simpler anxiety disorders or depression, let alone trauma. For a trauma patient, it is much worse"* (Koç University, Academic). The policymaker identifies a performance-based payment system requiring nine clients per day as a structural driver of this inadequacy: *"They need to see nine clients to get a high performance score. I feel that is a bit unrealistic. … Even if you do not take a lunch break, nine sessions are not possible. Definitely not"* (Koç University, Policymaker).

Continuity of care is identified across four of the five interviews as the most clinically damaging structural failure. Doctors completing compulsory service left immediately upon finishing their assigned period, destroying therapeutic relationships before treatment was complete. The policymaker captures the clinical consequence precisely: *"A person finally begins to trust the psychologist after the fifth or sixth session, finally begins to open up, and then the psychologist is transferred elsewhere. That trust is lost entirely, and the person gives up. After that, people no longer want to come. This really happens"* (Koç University, Policymaker). The provider corroborates this from lived clinical experience, noting that follow-up was only possible through the CMHC model - which no longer exists - and that without it, patients return to hospital only when in acute episode, often three to five months after their previous contact.

Container-based service delivery is identified by both the policymaker and the civil society respondent as undermining acceptability through physical conditions. The policymaker notes that containers signal impermanence and erode trust: *"Because it is container-based, people's perceptions are different. Their sense of trust decreases somewhat. Coming into a container to have such a conversation can negatively affect how people view the service"* (Koç University, Policymaker). The

civil society respondent adds a privacy dimension: containers placed side by side mean clients can hear sessions in adjacent rooms, destroying the confidentiality that therapeutic disclosure requires. Planned Healthy Life Centres, fifteen in the investment programme and expected to be operational in one and a half to two years, represent a future structural facilitator but are not yet operational.

Affordability

Direct and indirect cost of access

Direct healthcare costs are not identified as a primary barrier across the Koç University interviews. Public mental health services are formally free, and the policymaker confirms that approximately 13,000 people were reached through free primary care psychosocial services in 2025. The financial barriers that do operate are indirect, structural, and compounding.

Transport costs represent a concrete financial barrier for container city residents. A single bus ride costs 30 lira, and the only connection from Umutkent to the city centre runs once per hour before stopping entirely: *"especially from Umutkent there is only one minibus line going to the center. And that one only runs maybe once an hour. Beyond that, after a certain time it stops entirely, so they cannot go"* (Koç University, Civil Society). For a population dealing with unemployment and financial hardship, this cost multiplied across return trips and repeated appointments, adds a tangible economic threshold to what is nominally a free service. The academic provides a macro-level framing of the financial context: even those with employment face multiplied economic pressure in Hatay, where the minimum wage covers less than it does elsewhere in the country and where rent has increased tenfold since the earthquake. The economic difficulties that a person elsewhere in Turkey feels are, as the academic states, *"felt 3–4 times more strongly here, multiplied"* (Koç University, Academic).

The labour exploitation dimension is identified by the civil society respondent as an underacknowledged indirect barrier: *"In Hatay employers are not really aware of the existence of insurance. In the earthquake region, unfortunately, there is a reality of labor exploitation. People are employed very cheaply in very heavy jobs, and unfortunately they often do not have the luxury of disrupting the work"* (Koç University, Civil Society). This means that even free services are inaccessible to those whose employment conditions do not permit them to take time off. Women with sole caregiving responsibilities face an additional indirect cost in arranging alternative childcare to attend appointments.

The academic's research finding that unemployment is the strongest predictor of PTSD, exceeding even direct earthquake exposure such as being trapped under rubble, reframes the affordability dimension in a fundamental way. Financial hardship is not merely a barrier to accessing care: it is itself the primary driver of the mental health need that care is intended to address. This means that

no mental health intervention, however accessible, can be sufficient without parallel economic stabilisation of the earthquake survivor population.

Support mechanisms

Financial support mechanisms for mental health care are limited and not specifically targeted at the post-earthquake survivor population as a distinct group. Disability allowances and caregiver allowances exist for those with recognised psychiatric disabilities, but the provider notes that awareness of these mechanisms is uneven: *"Not every patient may be aware of this, may not know that they can receive it"* (Koç University, Provider). No mechanism exists for subsidising private psychological care for earthquake survivors who do not meet the disability threshold.

The civil society respondent is direct about the absence of financial support for accessing private mental health care: *"I honestly have not heard of an NGO saying go and receive the service and we will somehow cover the cost"* (Koç University, Civil Society). NGOs fund their own staff rather than subsidising access to external services. The policymaker confirms that the free public system is the only realistic financial access mechanism for most survivors, and that this system's coverage has expanded significantly but its quality remains constrained by staffing ratios and appointment durations that prevent it from meeting the population's actual needs.

A two-tier quality divide produced by financial barriers is identified by the civil society respondent: those with resources sought qualified private practitioners with trauma experience, while those without were served by newly graduated NGO-hired psychologists with no field experience: *"NGOs, in order to hire more cheaply, took on newly graduated surprise psychologists. They had no field experience, did not know earthquake trauma, did not know how to work in a trauma field. So a person with money truly said, I will not entrust myself to a newly graduated young psychologist"* (Koç University, Civil Society). This is a structural quality failure embedded within the affordability dimension: the same financial hardship that makes people most vulnerable also directs them toward the least qualified care.

Appropriateness

Fit and usefulness of care

The central appropriateness finding across all five Koç University interviews is a profound mismatch between the scale and complexity of post-earthquake mental health need and the format of care that has been delivered. The civil society respondent articulates this most directly in relation to session duration: *"I think young people should by now have been receiving their 38th or 39th psychotherapy sessions, and they should still continue. Ten sessions, 3 sessions, 5 sessions — these are very ridiculous numbers"* (Koç University, Civil Society). The academic confirms the research basis for this assessment: the population has depression prevalence of nearly 40% and PTSD of 30%, and when

grief is added, combined prevalence reaches 60–70%. The service response of three to six sessions from volunteer NGO providers, followed by withdrawal bears no relationship to the therapeutic dose required for conditions of this severity.

The absence of a trauma centre three years after the earthquake is identified by the academic as the most critical ongoing appropriateness failure in the Hatay context: *"there really needs to be a place like a trauma center. At least somewhere we could allocate half an hour to one person, and if possible where more competent people in this field provide care, whether psychiatrist or psychologist"* (Koç University, Academic). Patients who have overcome every access barrier to reach a clinician still feel unheard, because ten-to-twelve minute appointment intervals prevent genuine listening.

The neglect of psychological rehabilitation in favour of physical rehabilitation is identified as a systemic appropriateness failure specific to the Turkish context. Physical rehabilitation was delivered swiftly and effectively, prostheses were fitted, entrepreneurship centres opened. Psychological rehabilitation received no equivalent investment: *"But psychological rehabilitation? We are still at a very early stage in that. We are very far behind in psychological rehabilitation"* (Koç University, Academic). Amputees and people with limb loss are identified as a particularly invisible population: their physical rehabilitation is tracked and documented, but they almost never appear in psychiatric outpatient data, presumably because they cannot reach services.

Where sustained care was delivered, particularly through the CMHC model before the earthquake and through the civil society respondent's programme in the container city, outcomes are described positively across both provider and user perspectives. Families reported reduced domestic conflict, improved communication, and improved wellbeing: *"the peace within the home has increased, we do not fight anymore, we sit together, we play games, we sit together, we talk"* (Koç University, Civil Society). This indicates that the appropriateness problem is not primarily one of clinical quality when care is delivered, but of the structural conditions that prevent adequate duration, frequency, and continuity.

Quality of interaction and respect

The quality of provider-patient interaction is shaped by two structural conditions unique to the post-earthquake setting: shared trauma between providers and clients, and co-location in container cities. These conditions cut in both directions enabling an unusual degree of mutual understanding and relational closeness, while simultaneously creating professional boundary challenges that compromise therapeutic quality.

The civil society respondent identifies co-location as a double-edged phenomenon. The majority of young people valued it: *"if you did not live here, we probably would not be able to tell you things comfortably, because you would not understand"* (Koç University, Civil Society). But co-location also

created an impossible ethical dilemma for social workers who witnessed domestic violence in neighbouring containers: *"they know I live here, if I report it they will know it was me, and because I disrupted the family structure they will not meet with me again, but I also have to report it; if I do not report it, then I will be betraying my profession"* (Koç University, Civil Society).

The academic and provider both identify ten-minute appointment intervals as the most significant structural driver of poor interaction quality. What patients experience as not being listened to is not primarily a reflection of provider attitudes but of a system that allocates insufficient time for genuine listening: *"They have overcome all these barriers and come, and then they think, "Still, I will not be listened to." This is neither the doctor's fault nor the patient's fault. Both sides lose"* (Koç University, Academic).

The provider draws a clear distinction between individual professional motivation and systemic conditions. Motivation among mental health workers in the post-earthquake period was genuinely high: *"Everyone was quite eager. There was going to be a new environment, new arrangements would be made. Everyone was saying what a beautiful ward this became. … Everyone was very enthusiastic"* (Koç University, Provider). However, the absence of nursing specialisation means that staff reassigned from other departments lack the clinical foundation to provide appropriate psychiatric care regardless of their personal motivation: *"A colleague who worked in intensive care for seventeen years comes to the psychiatry ward, naturally they struggle. They do not know this patient group. They may not be able to predict what will happen, what they will do"* (Koç University, Provider).

The integrated referral network the policymaker describes, linking primary care psychologists to psychiatrists at the secondary level and the NGO social support, represents the most significant structural facilitator for appropriate care in the current period. The policymaker acknowledges this is unprecedented in Turkey: *"There is no other example of this psychological counselling network and systematic referral structure in Türkiye"* (Koç University, Policymaker). However, its sustainability is threatened by the absence of institutionalisation: it depends on the personal commitment of current staff, and staff transfers could dissolve it entirely. The policymaker acknowledges this with characteristic directness: *"The person who comes after me may attach greater importance to communicable diseases and develop a different policy"* (Koç University, Policymaker). This is the defining structural vulnerability of the appropriateness landscape: genuine innovation that has not yet been embedded in durable systems.

4.2 Ireland

4.2.1 Quantitative results

Descriptive results

A total of 242 respondents participated (General group: N = 119; LGBTIQ+ community: N = 123), exceeding the KPI of n > 200 (Table 16).

Table 16: Distribution of participants across the included groups in Ireland

General group	LGBTIQ+ community
N = 119	N = 123

The mean age was 46.7 years (SD 15.7) in the General group and 38.3 years (SD 11.7) in the LGBTIQ+ community. Questionnaires were almost entirely self-completed in both groups (118/119 and 122/123, respectively), with one respondent in each group completing the questionnaire with assistance.

In the General group, 69 respondents reported female sex at birth and 50 male. In the LGBTIQ+ community, 55 reported female, 51 male, 14 non-binary, one “other,” and two preferred not to say. Gender identity matched sex assigned at birth for all respondents in the General group and for 97 respondents in the LGBTIQ+ group; 23 respondents in the LGBTIQ+ group reported a different gender identity and three preferred not to say. All respondents in the General group reported a heterosexual orientation. In the LGBTIQ+ community, three respondents reported heterosexual orientation, 37 gay, 28 lesbian, 37 bisexual, 11 another orientation, and seven preferred not to say.

All respondents in the General group lived in Ireland, as did 121 of 123 respondents in the LGBTIQ+ community. In the General group, 92 respondents were born in Ireland, 14 in the UK/Northern Ireland, eight in another EU country, and five outside the EU. In the LGBTIQ+ community, 82 respondents were born in Ireland, four in the UK/Northern Ireland, 11 in another EU country, and 26 outside the EU. Irish citizenship was reported by 105 respondents in the General group and 93 in the LGBTIQ+ group, while four and 20 respondents respectively reported citizenship of a non-EU country. Additional respondents reported citizenship of the UK/Northern Ireland or another EU member state. The mean duration of residence in Ireland was 40.2 years (SD 21.1) in the General group and 29.0 years (SD 18.4) in the LGBTIQ+ community.

Educational attainment (ISCED) ranged across secondary and tertiary levels in both groups. Bachelor’s and Master’s degrees were the most common qualifications: 40 and 21 respondents in

the General group, and 39 and 41 respondents in the LGBTIQ+ community, respectively. Doctoral degrees were reported by three respondents in the General group and eight in the LGBTIQ+ community.

In the previous 12 months, use of mental health services was reported by 45 respondents in the General group and 82 in the LGBTIQ+ community. Additional details are provided in Table 17

Table 17: Descriptive statistics of the different included groups in Ireland

Demographic variable	General group	LGBTIQ+ community	Overall
Age, *mean (sd)*	46.7 (15.7)	38.3 (11.7)	42.4 (14.4)
Questionnaire completed by, *n (%)*			
Respondent alone	118 (99.2%)	122 (99.2%)	240 (99.2%)
Respondent with help	1 (0.8%)	1 (0.8%)	2 (0.8%)
Someone else	0 (0%)	0 (0%)	0 (0%)
Sex at birth, *n (%)*			
Female	69 (58.0%)	55 (44.7%)	124 (51.2%)
Male	50 (42.0%)	51 (41.5%)	101 (41.7%)
Non-binary	0 (0%)	14 (11.4%)	14 (5.8%)
Other	0 (0%)	1 (0.8%)	1 (0.4%)
Prefer not to say		2 (1.6%)	2 (0.8%)
Gender the same as assigned at birth, *n (%)*			
Yes	119 (100%)	97 (78.9%)	216 (89.3%)
No	0 (0%)	23 (18.7%)	23 (9.5%)
Prefer not to say	0 (0%)	3 (2.4%)	3 (1.2%)
Sexual orientation, *n (%)*			
Heterosexual	119 (100%)	3 (2.4%)	122 (50.4%)
Gay	0 (0%)	37 (30.1%)	37 (15.3%)
Lesbian	0 (0%)	28 (22.8%)	28 (11.6%)
Bisexual	0 (0%)	37 (30.1%)	37 (15.3%)
Other	0 (0%)	11 (8.9%)	1 (0.4%)
Prefer not to say	0 (0%)	7 (5.7%)	2 (0.8%)
Country of residence, *n (%)*			
Ireland	119 (100%)	121 (98.4%)	240 (99.2%)

Other	0 (0%)	2 (1.6%)	2 (0.8%)
Country of birth, *n (%)*			
Born in the country of residence	92 (77.3%)	82 (66.7%)	174 (71.9%)
Born in the UK/ Northern Ireland	14 (11.8%)	4 (3.3%)	18 (7.4%)
In another country in the EU	8 (6.7%)	11 (8.9%)	19 (7.9%)
Born in another country outside the EU	5 (4.2%)	26 (21.1%)	31 (12.8%)
Citizen of country, *n (%)*			
Citizen of the country of residence	105 (88.2%)	93 (75.6%)	198 (81.8%)
No citizenship of the country of residence but that of the UK/Northen Ireland	3 (2.5%)	3 (2.4%)	6 (2.5%)
No citizenship of the country of residence but that of another EU member state	7 (5.9%)	7 (5.7%)	14 (5.8%)
No citizenship of the country of residence but that of a country outside the EU	4 (3.4%)	20 (16.3%)	24 (9.9%)
Duration of stay in the country of	40.2 (21.1)	29.0 (18.4)	34.5 (20.5)

residence, *mean years (SD)*			
Highest level of education completed (ISCED), *n (%)*			
Early childhood education (ages 3 and above), including pre-primary education and early childhood educational development (under 3). (ISCED 0)	0 (0%)	0 (0%)	0 (0%)
Primary education (also known as elementary or basic education). (ISCED 1)	1 (0.8%)	0 (0%)	1 (0.4%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	10 (8.4%)	2 (1.6%)	12 (5.0%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	19 (16.0%)	8 (6.5%)	27 (11.2%)
Post-secondary non-third level education (education between	12 (10.1%)	13 (10.6%)	25 (10.3%)

secondary and tertiary levels). (ISCED 4)			
Short-cycle third level education (programs typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)	13 (10.9%)	12 (9.8%)	25 (10.3%)
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	40 (33.6%)	39 (31.7%)	79 (32.6%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	21 (17.6%)	41 (33.3%)	62 (25.6%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	3 (2.5%)	8 (6.5%)	11 (4.5%)
Use of mental health care in the previous 12 months, *n (%)*			

Yes	45 (37.8%)	82 (66.7%)	127 (52.5%)
No	74 (62.2%)	41 (33.3%)	115 (47.5%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

For the Availability and Accommodation dimension, all indicators did not show statistically significant differences between the population groups. Specifically, no group differences were identified regarding awareness of mental health services in the local area, the availability of a private space for receiving care and discussing concerns openly, the time required to obtain an appointment when mental health care was needed, knowledge of where to seek immediate help during a mental health crisis, or time to get to the mental health service location (Figure 16 ; all p-values > 0.05).

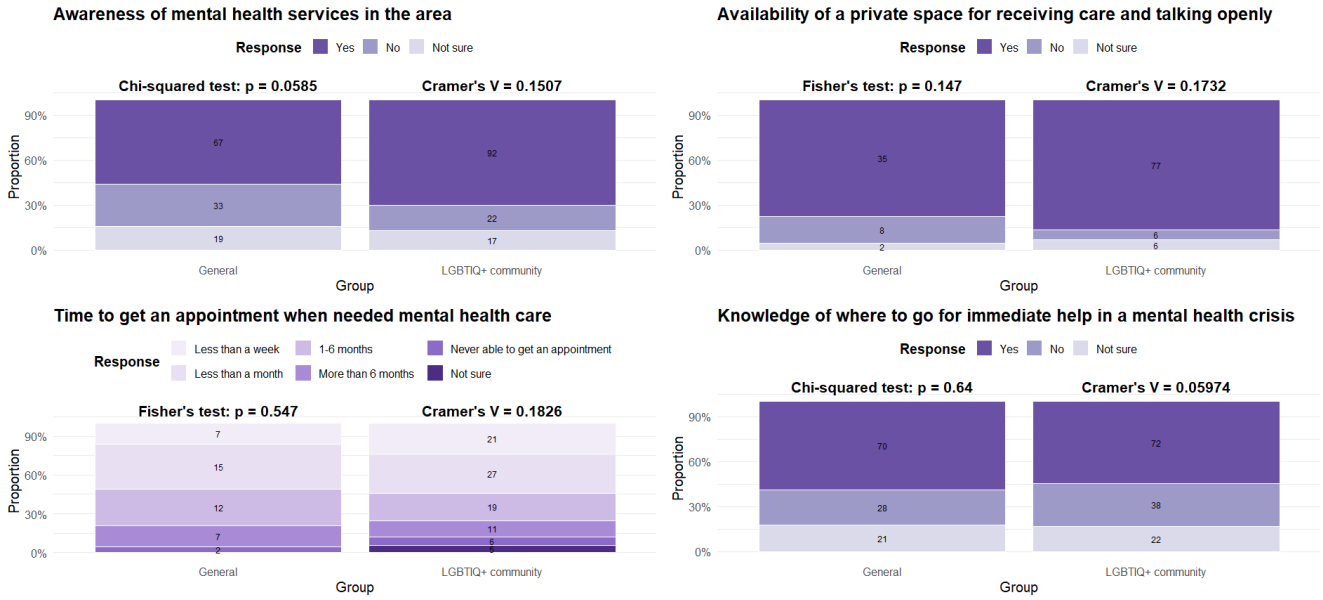


Figure 16: Non-significant differences across groups for the availability and accommodation dimension in Ireland

Approachability

Within the Approachability dimension, several indicators did not demonstrate statistically significant differences between the population groups. These included whether participants had encountered information on accessing mental health support, the ease of understanding spoken or written information about mental health services, and whether respondents had been asked about their mental wellbeing during encounters with a family doctor, school counsellor, or social worker (Figure 18; all p-values > 0.05).

For approachability are the; have participants encountered information on accessing mental health support, easiness to understand information about mental health services (spoken or written) and

asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker not significantly different between the groups. Easiness too find reliable information about mental health services (p = 0.00541, Cramer's V = 0.2453), Came across outreach programs (p = 0.0357 & Cramer's V = 0.1653), heard about experiences of other patients regarding mental health services (p = 0.0346, Cramer's V = 0.166) and invited to participate in research related to mental health (p = 0.00778 & Cramer's v = 0.1999) were significantly different between the groups

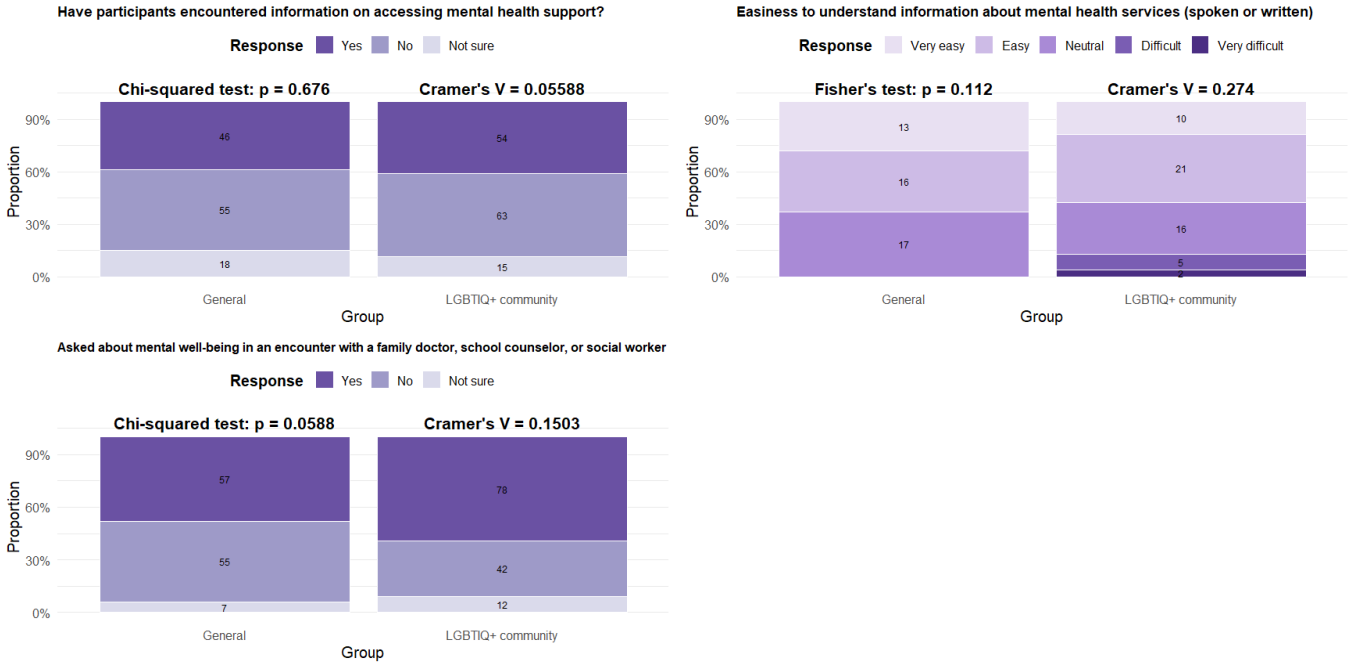


Figure 17: Non-significant differences across groups for the approachability dimension in Ireland

In contrast, several other indicators related to information accessibility and engagement showed statistically significant differences between groups. A significant difference was observed for the ease of finding reliable information about mental health services (Figure 19; p = 0.00541, Cramer's V = 0.2453). This suggests that respondents from the LGBTIQ+ community reported different experiences in locating reliable information compared to the general population. The effect size indicates a small to moderate association, suggesting a meaningful difference in perceived access to trustworthy information sources.

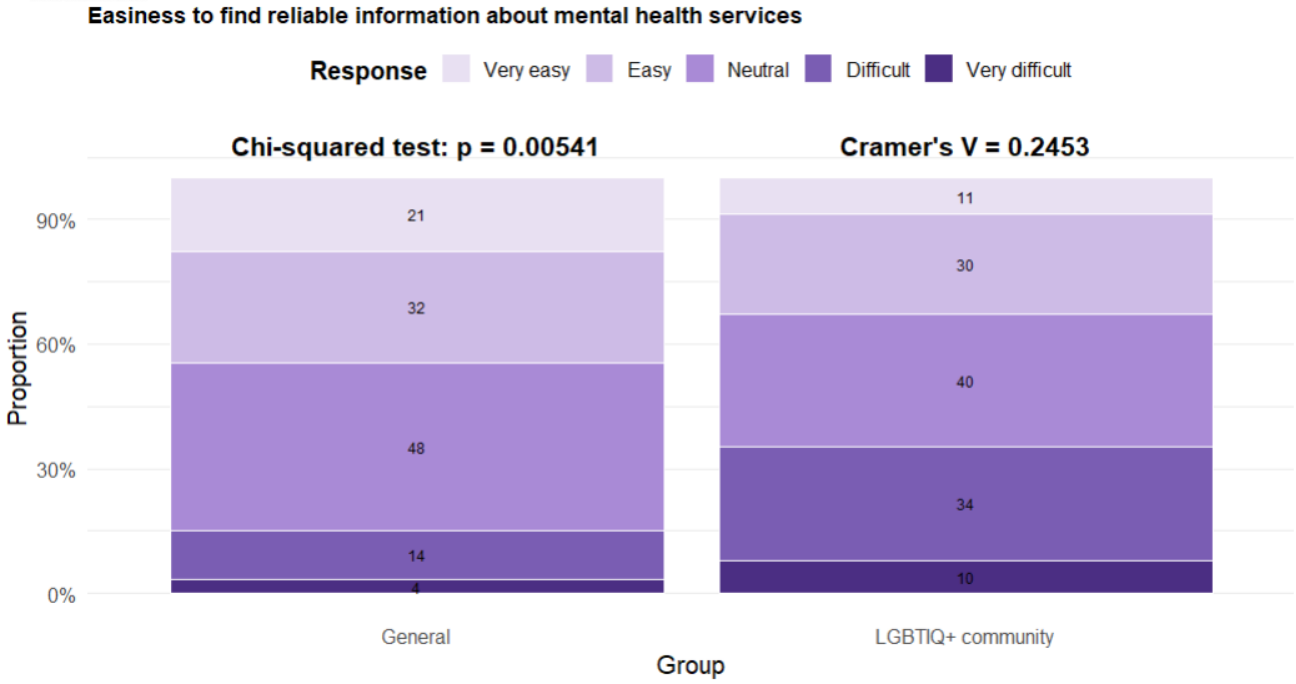


Figure 18: Chi-squared test of the easiness to find reliable information about mental health services item in Ireland

Significant differences were also found for exposure to outreach programs (Figure 20; p = 0.0357, Cramer's V = 0.1653), awareness of experiences shared by other patients (Figure 21; p = 0.0346, Cramer's V = 0.166), and invitations to participate in mental health-related research (Figure 22; p = 0.00778, Cramer's V = 0.1999). These results indicate variation between groups in opportunities for engagement with mental health-related information and services. The corresponding effect sizes for these items indicate small associations, suggesting that while statistically significant differences exist, their magnitude is relatively modest.

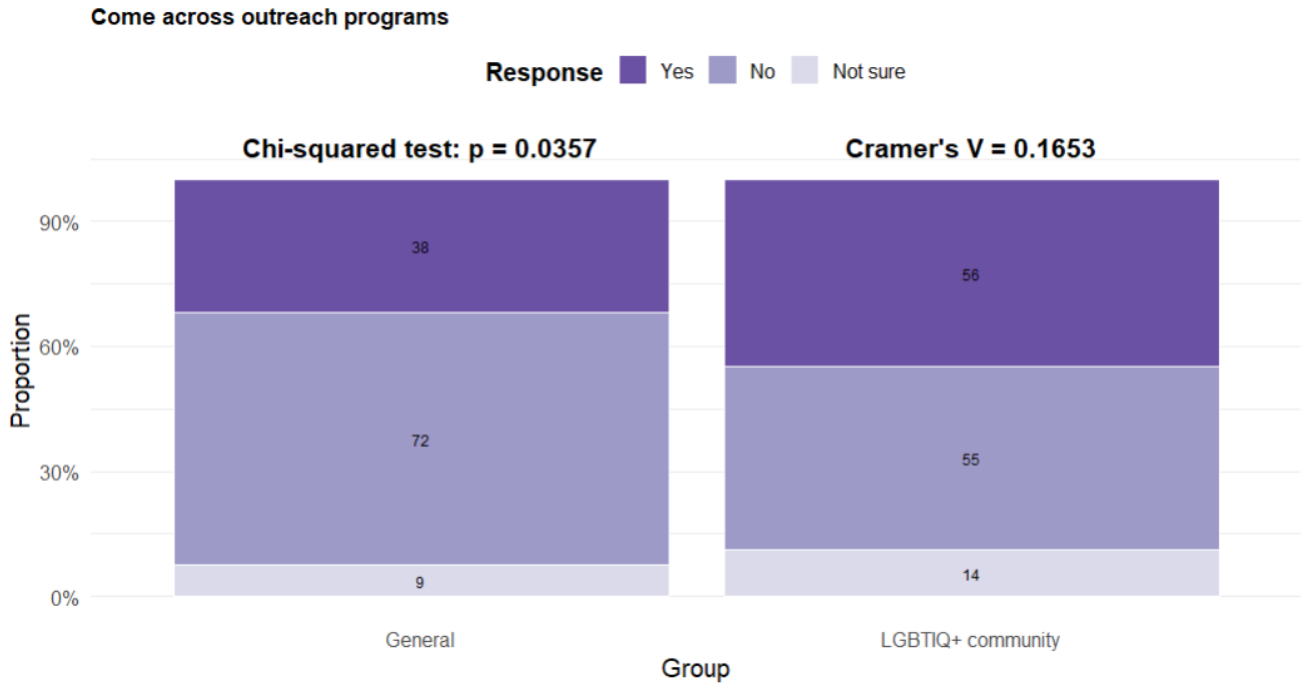


Figure 19: Chi-squared test of the come across outreach programs item in Ireland

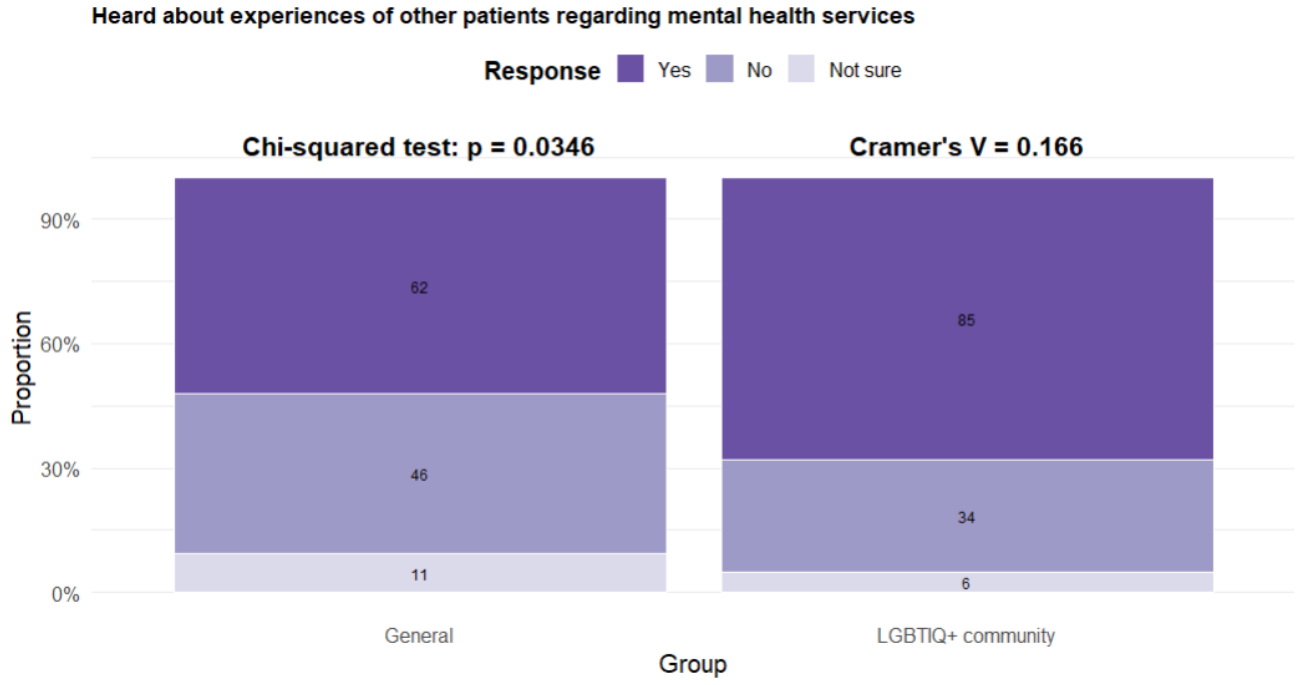


Figure 20: Chi-squared test of the heard about experiences of other patients regarding mental health services item in Ireland

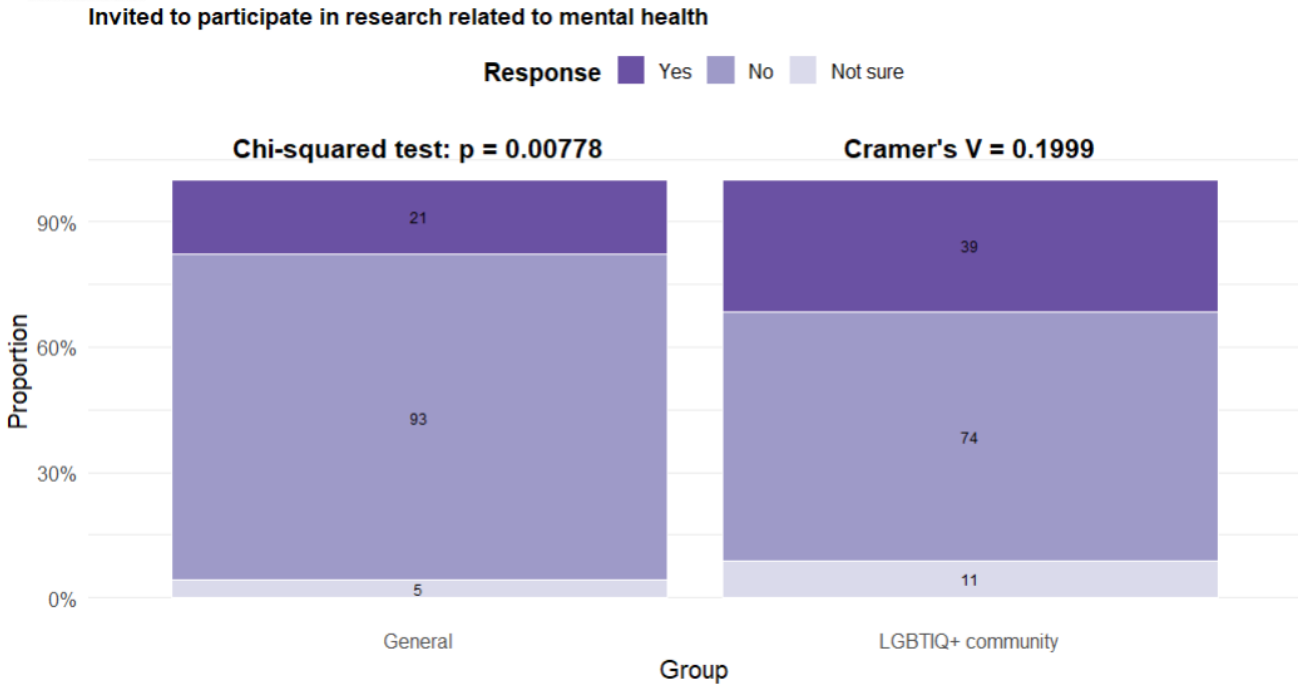


Figure 21: Chi-squared test of the invited to participate in research related to mental health item in Ireland

Acceptability

Across the Acceptability dimension, most indicators did not demonstrate statistically significant differences between the population groups. These included perceptions that mental health services are sensitive to cultural beliefs and practices, the option to communicate with providers in a preferred language, the possibility to choose one's own doctor or therapist, whether mental health professionals communicate respectfully with patients, and whether patients' rights are protected against mistreatment or abuse (Figure 23 & Figure 24; all p-values > 0.05).

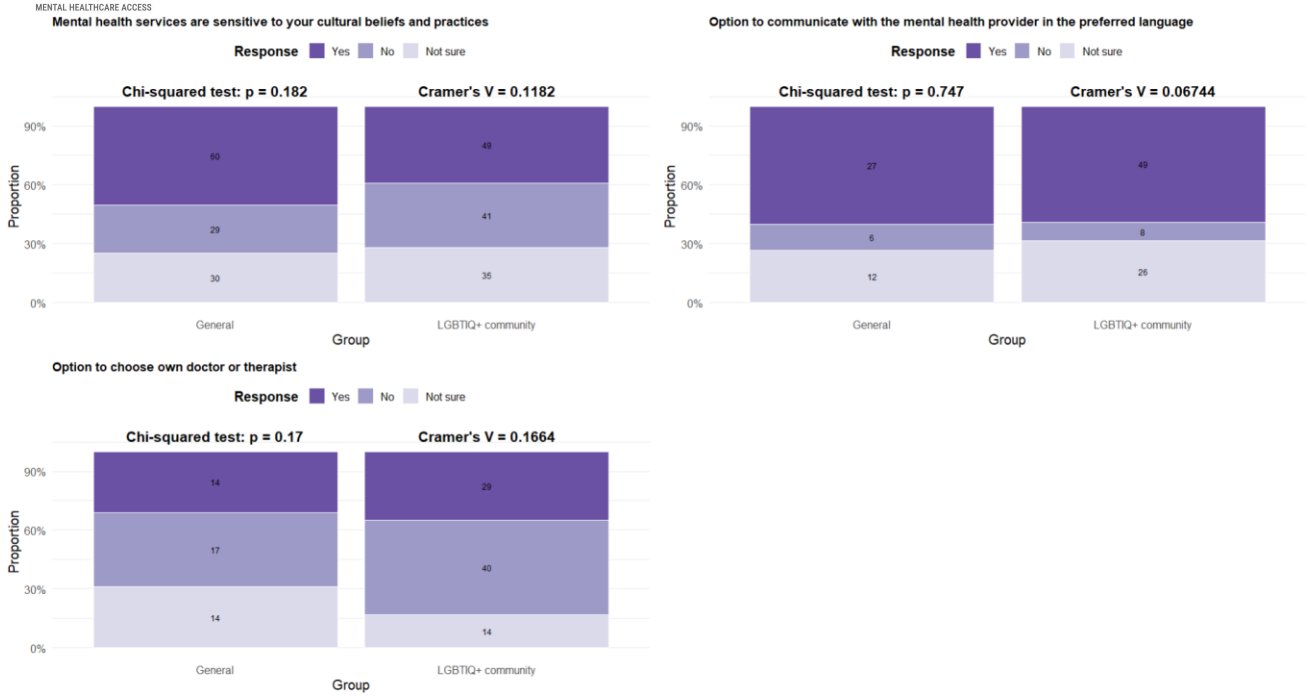


Figure 22: Non-significant differences across groups for the acceptability dimension in Ireland (1)

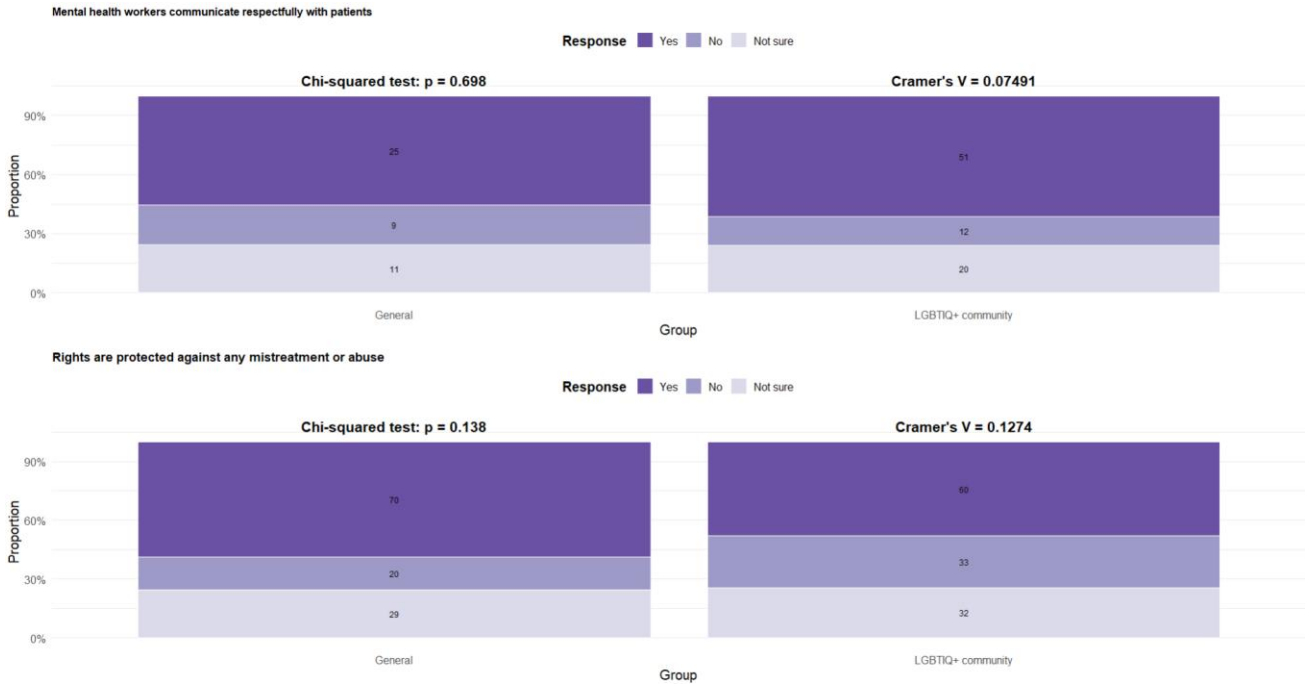


Figure 23: Non-significant differences across groups for the acceptability dimension in Ireland (2)

However, one element within this dimension demonstrated a statistically significant difference between groups. Perceptions that mental health services are trustworthy differed significantly between the groups (Figure 25; p = 0.00367, Cramer's V = 0.2148). This result indicates that levels

of trust in mental health services were not uniform across groups. The corresponding effect size suggests a small to moderate association, indicating a meaningful difference in perceived trustworthiness between the general population and the LGBTIQ+ community.

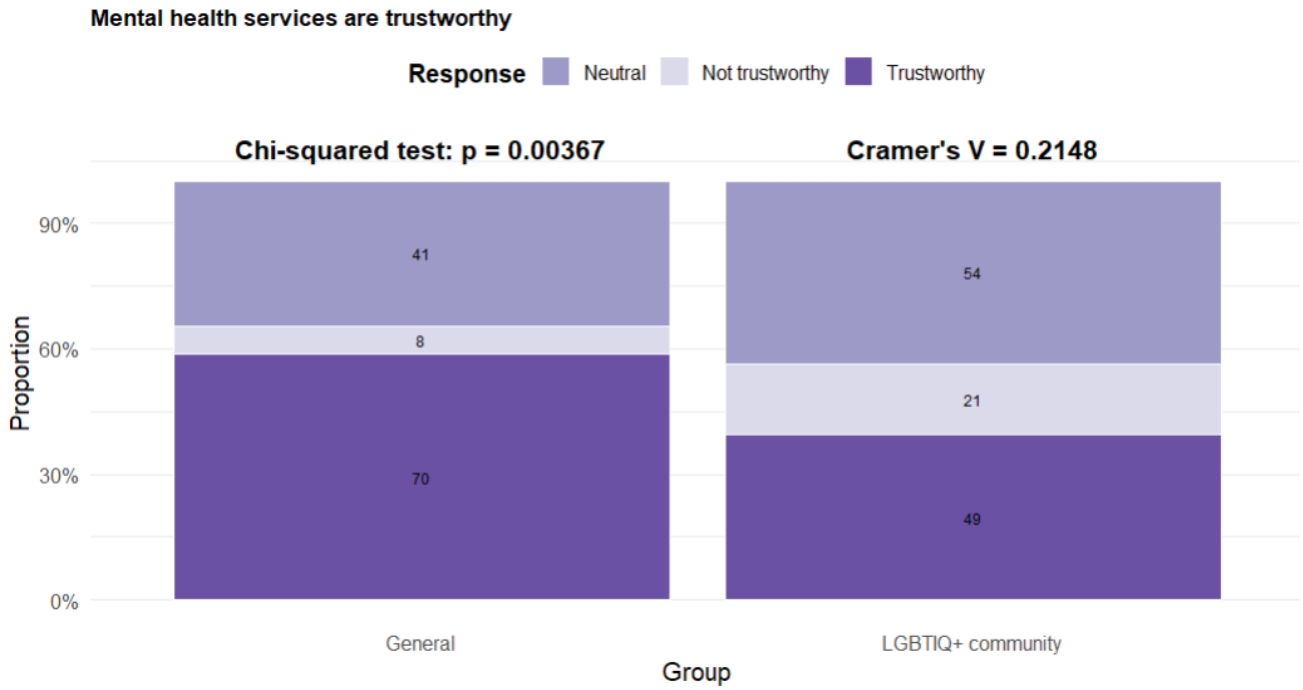


Figure 24: Chi-squared test of the mental health services are trustworthy item in Ireland

Affordability

Within the Affordability dimension, three indicators did not demonstrate statistically significant differences between the population groups. These included whether respondents had ever not taken prescribed medication due to cost, whether they had been offered financial support or discounts to reduce or cover the costs of care and whether anyone from the service helped with payment options, insurance questions, or financial assistance (Figure 26; all p-values > 0.05).

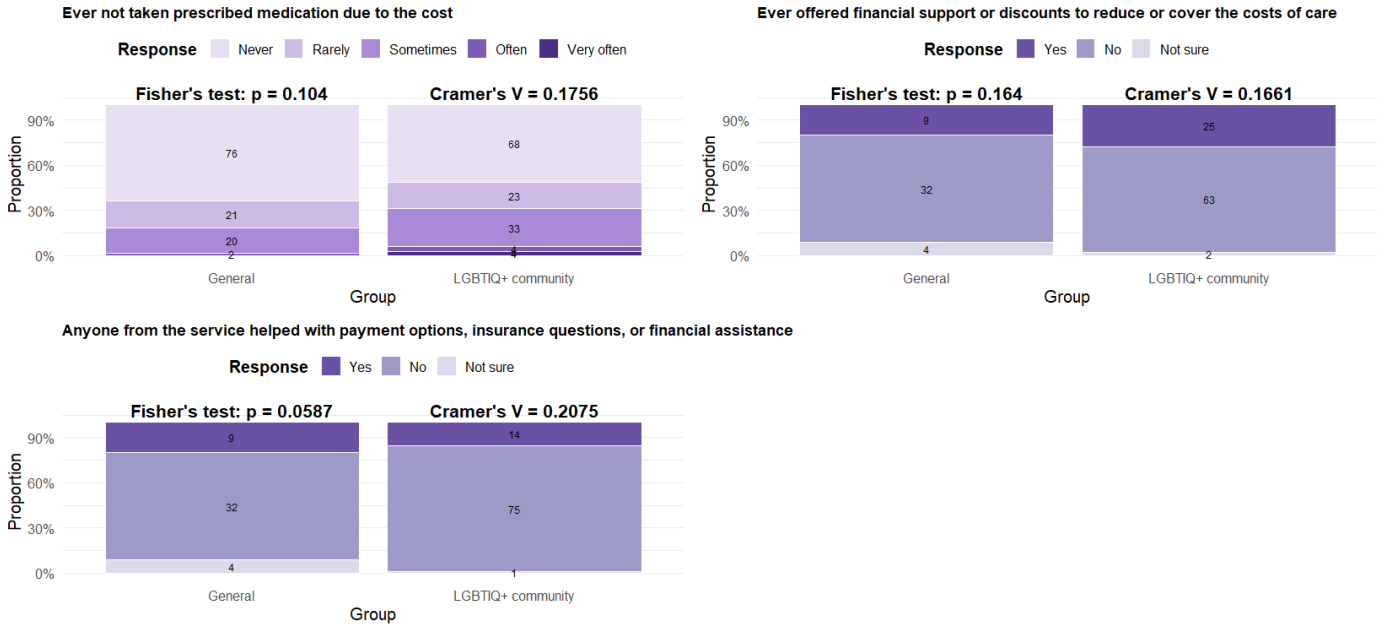


Figure 25: Non-significant differences across groups for the Affordability dimension in Ireland

In contrast, several other affordability-related indicators showed statistically significant differences between groups. Differences were observed regarding the possibility of obtaining mental health services through public programs or services free of charge or at low cost (Figure 27; p = 0.0165, Cramer's V = 0.2533), indicating variation between groups in access to subsidized services. The corresponding effect size indicates a small to moderate association, suggesting a meaningful difference in the perceived accessibility of publicly funded care.

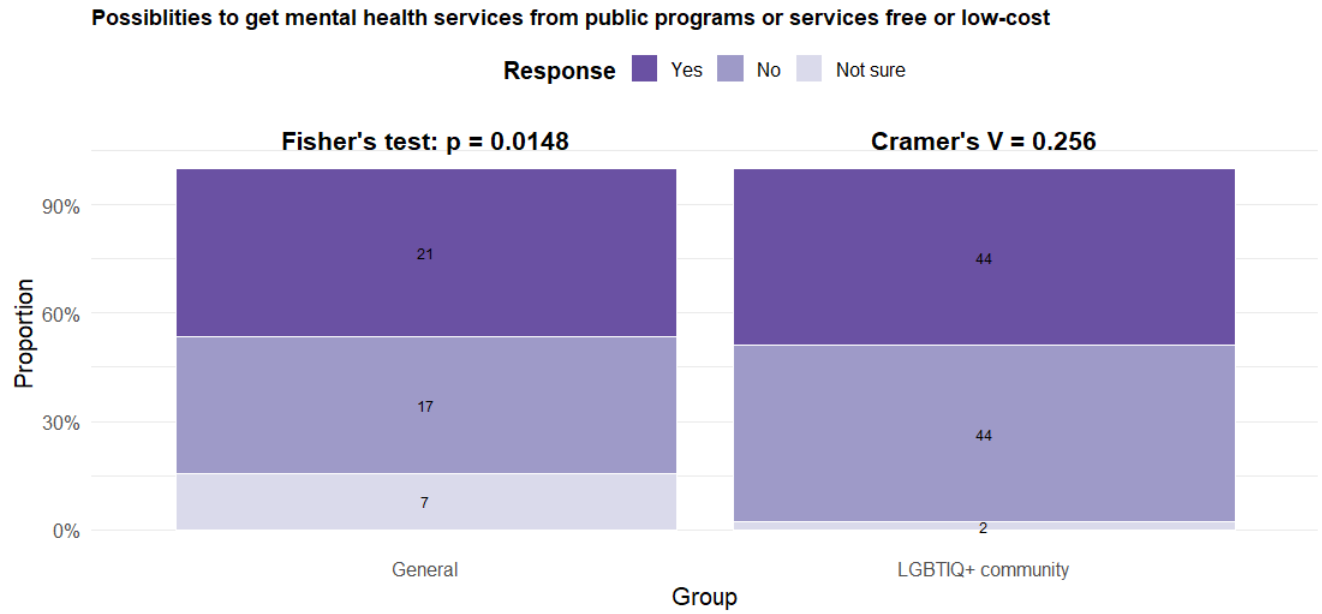


Figure 26: Fisher's test of the possibilities to get mental health services from public programs or services free or low-cost item in Ireland

Similarly, perceptions of health insurance coverage for mental health services differed significantly between groups (Figure 28; p = 0.0346, Cramer's V = 0.1881). This finding suggests variation in perceived coverage levels, although the corresponding effect size indicates a small association, reflecting modest differences between groups.

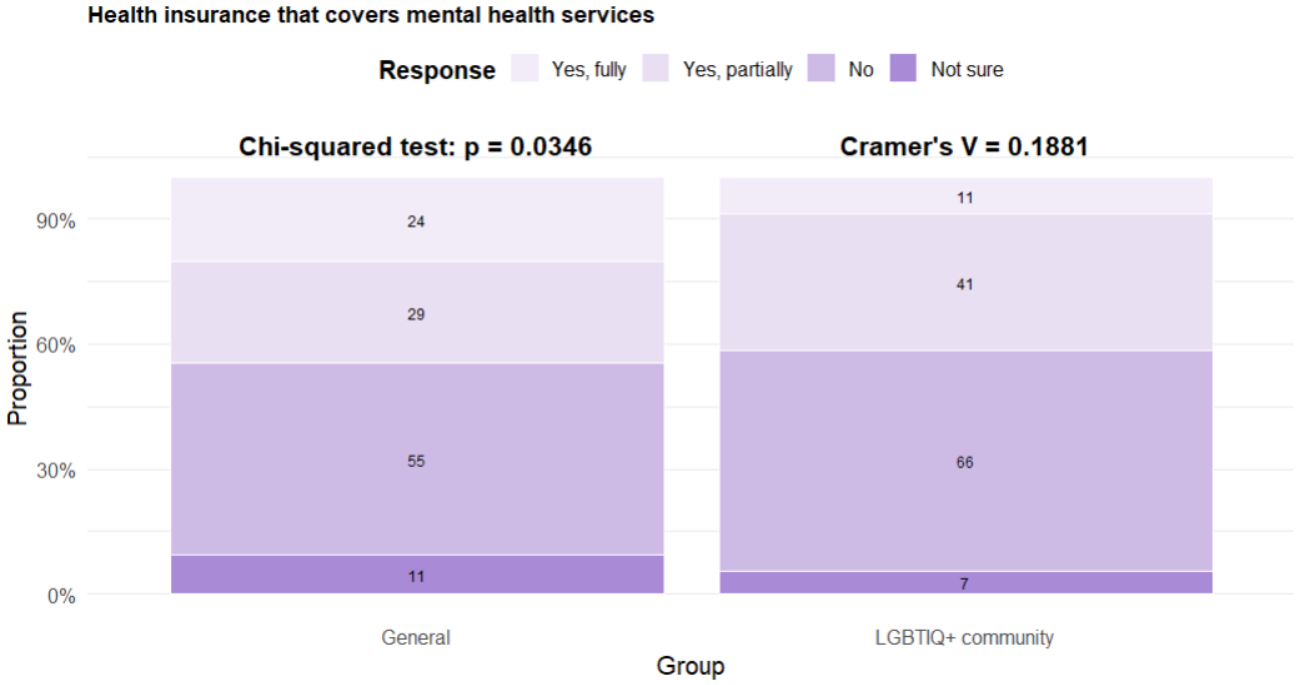


Figure 27: Chi-squared test of the health insurance that covers mental health services item in Ireland

Notably, significant differences were also observed regarding delayed or avoided mental health care due to financial constraints within the past 12 months (Figure 29; p = 0.00116, Cramer's V = 0.2353). Descriptive findings indicated that delayed or avoided care due to cost was reported more frequently among respondents from the LGBTIQ+ community compared to the general population. This suggests that financial barriers may have a stronger impact on service utilization within this group.

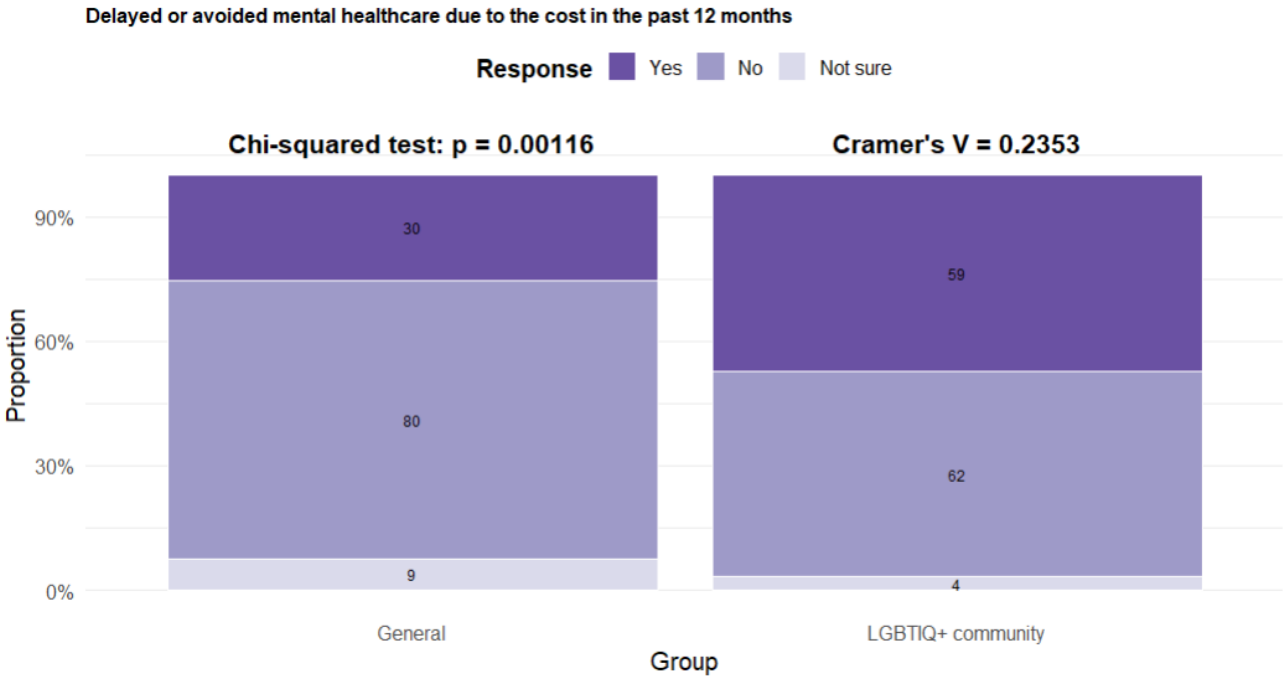


Figure 28: Chi-squared test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Ireland

Further differences were identified in relation to difficulty accessing mental health care due to loss of income (Figure 30; p = 0.000802, Cramer's V = 0.2787). Descriptive results indicated that such financial barriers were reported less frequently among respondents from the general population, suggesting relatively greater financial stability compared to the LGBTIQ+ community. The effect size indicates a small to moderate association, suggesting meaningful differences in income-related access barriers.

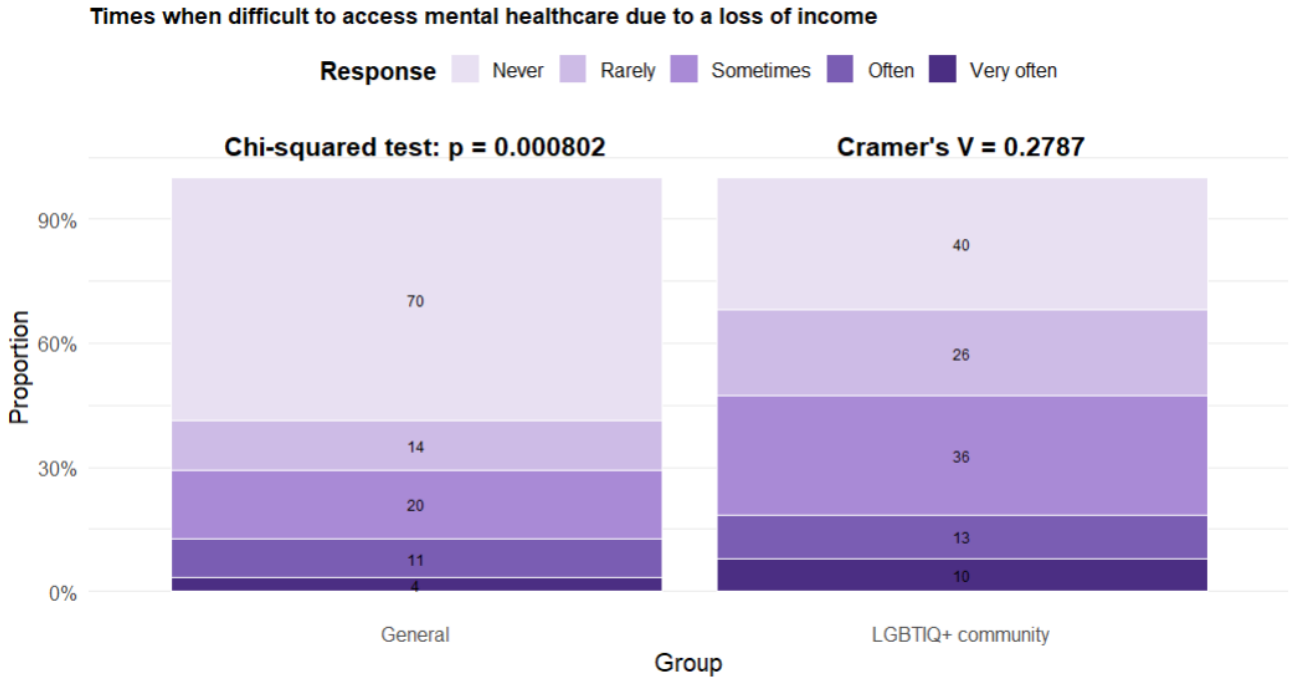


Figure 29: Chi-squared test of the times when difficult to access mental healthcare due to a loss of income item in Ireland

Finally, a similar pattern was observed for difficulty accessing mental health care due to additional costs (Figure 31; p = 0.0221, Cramer's V = 0.2165), with descriptive findings indicating that respondents from the LGBTIQ+ community reported these barriers more frequently than respondents from the general population. The effect size indicates a small association, reflecting moderate but meaningful differences.

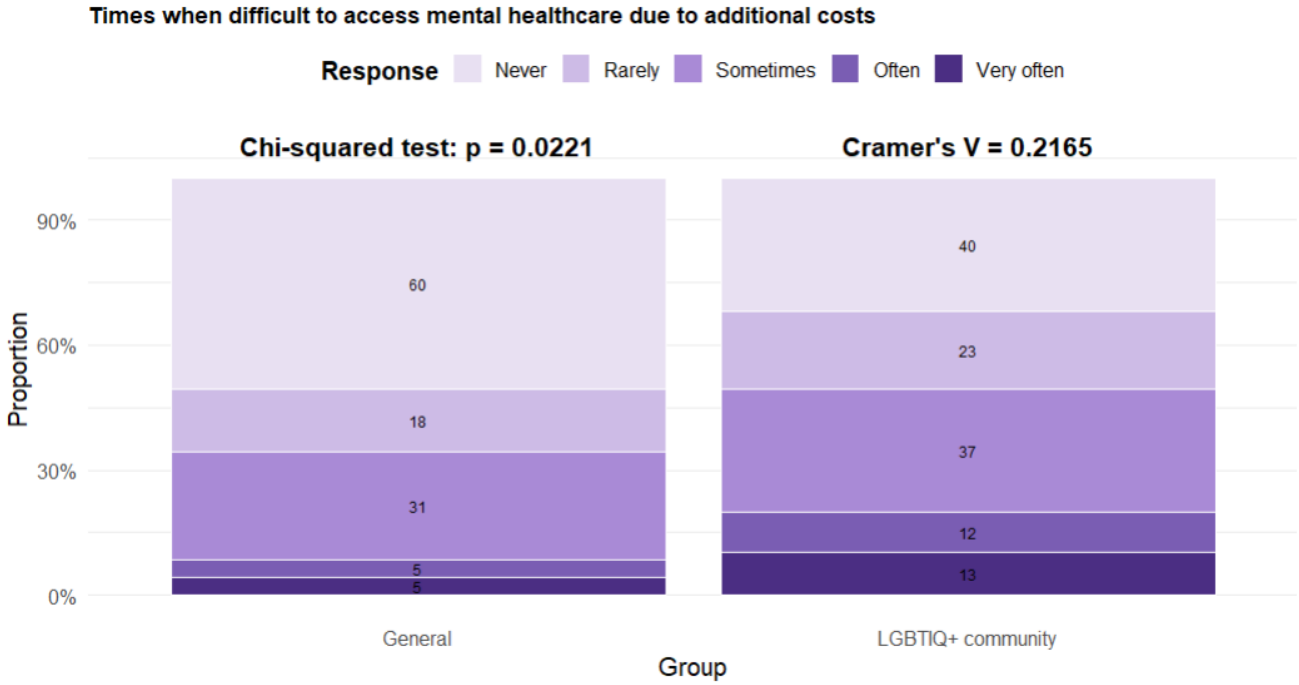


Figure 30: Chi-squared test of the times when difficult to access mental healthcare due to additional costs item in Ireland

Appropriateness

Within the Appropriateness dimension, the majority of indicators did not demonstrate statistically significant differences between the population groups. These included perceptions related to courteous and respectful treatment by mental health professionals, whether providers explained information clearly, whether sufficient time was spent during consultations, and whether services were perceived as helpful or relevant. In addition, no statistically significant differences were observed regarding whether cultural beliefs and practices were considered, whether providers took broader life circumstances into account, involvement in setting treatment goals, or the possibility of consistently seeing the same provider during treatment (Figure 33 & Figure 34; all p-values > 0.05).

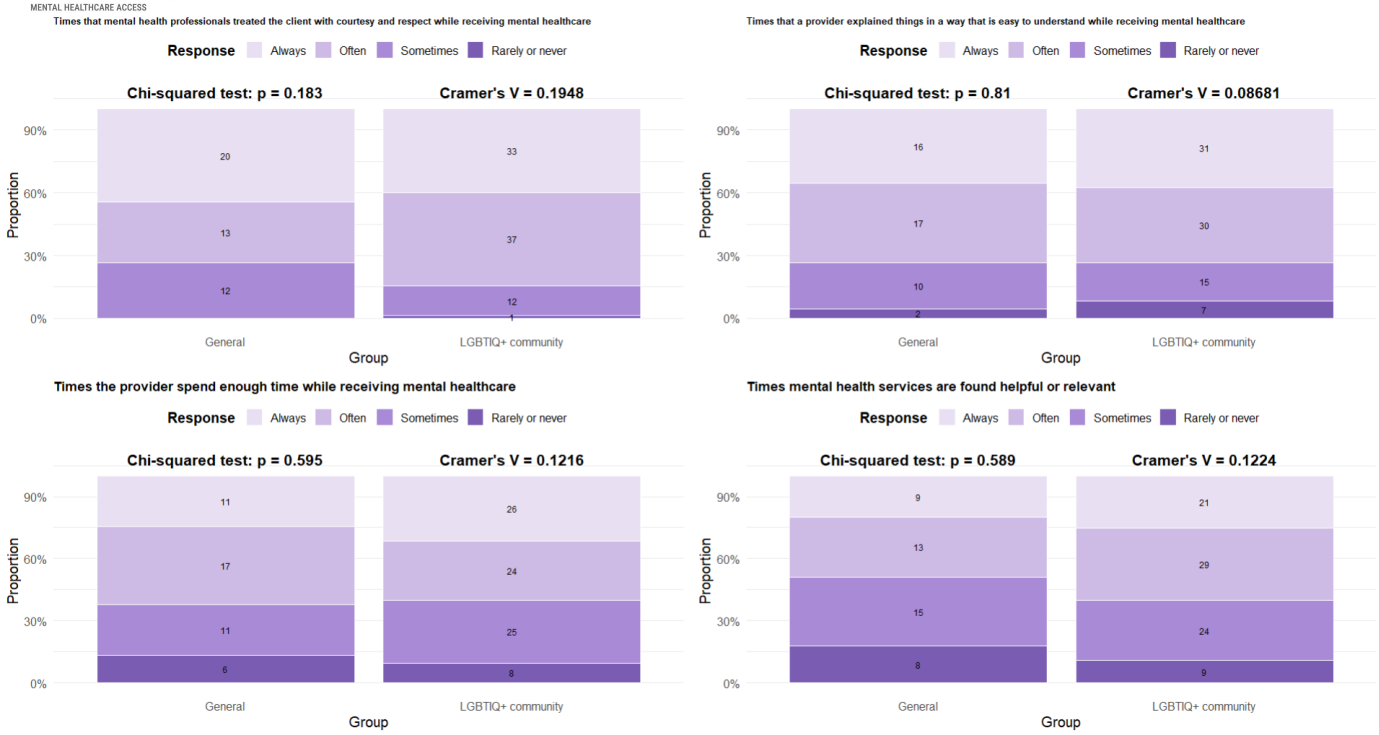


Figure 31: Non-significant differences across groups for the Appropriateness dimension in Ireland (1)

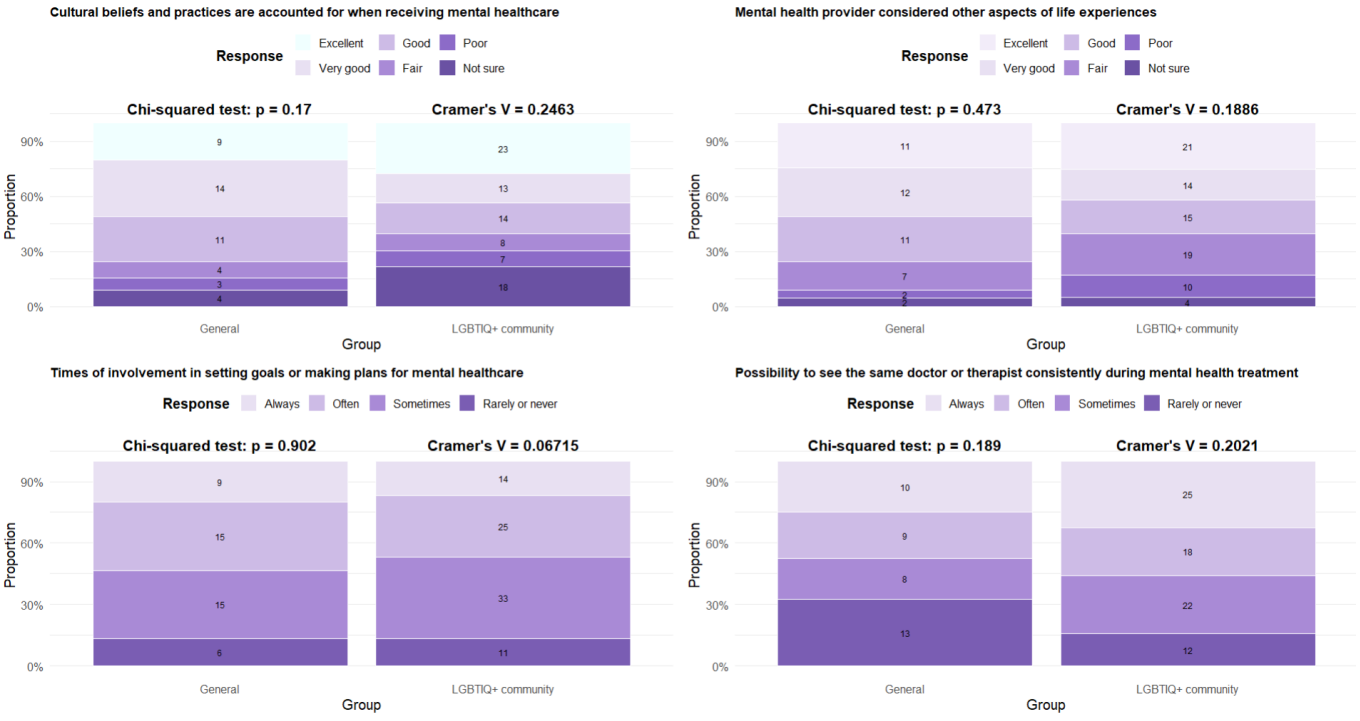


Figure 32: Non-significant differences across groups for the Appropriateness dimension in Ireland (2)

However, several indicators related to coordination of care, user engagement, and support mechanisms showed statistically significant differences between groups. A significant difference was identified for smooth referral between services or professionals, without requiring users to

repeatedly explain their situation (Figure 35; p = 0.00832, Cramer's V = 0.3444). This finding indicates meaningful variation in perceived continuity and coordination of care between groups. The corresponding effect size indicates a moderate association, suggesting that referral processes were experienced differently between the general population and the LGBTIQ+ community.

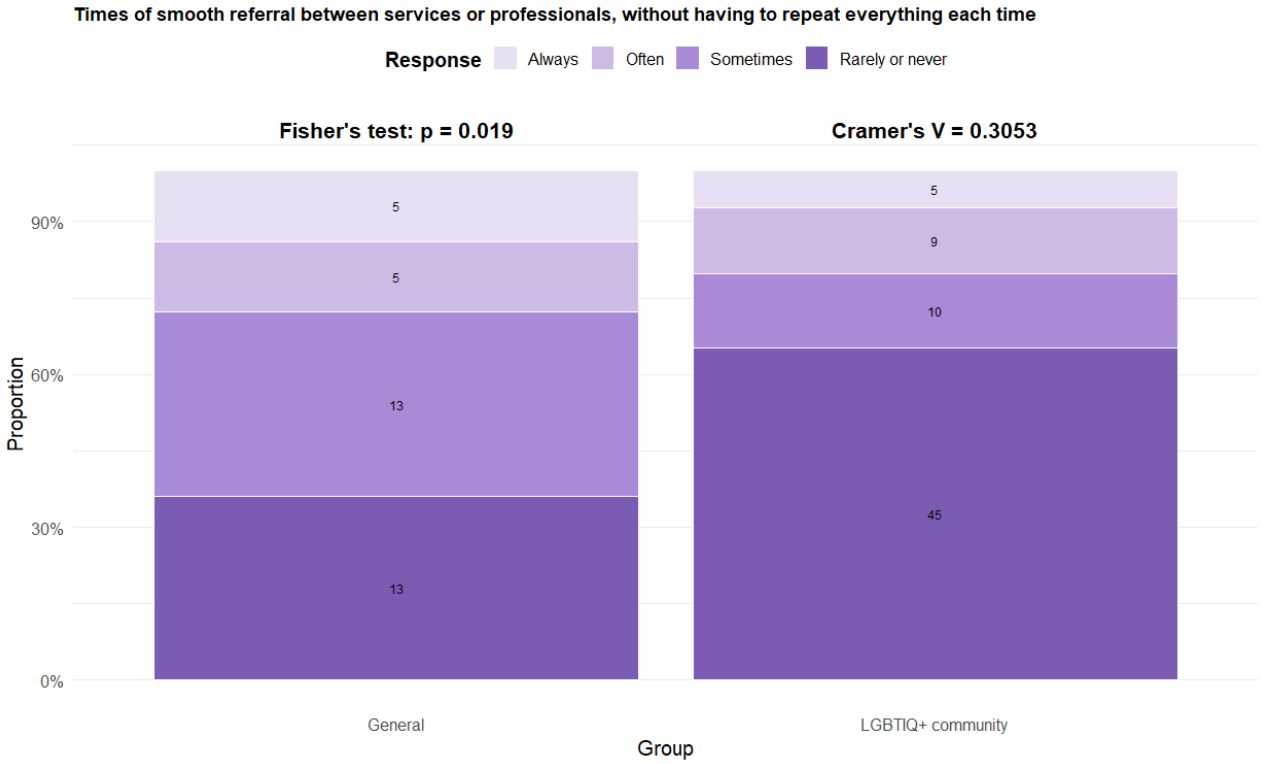


Figure 33: Chi-squared test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Ireland

Significant differences were also observed regarding invitations to provide feedback about mental health treatment (Figure 36; p = 0.024, Cramer's V = 0.2777). This result indicates variation in opportunities for service users to share their experiences and contribute to service evaluation. The corresponding effect size indicates a small to moderate association, suggesting meaningful but not large differences between groups.

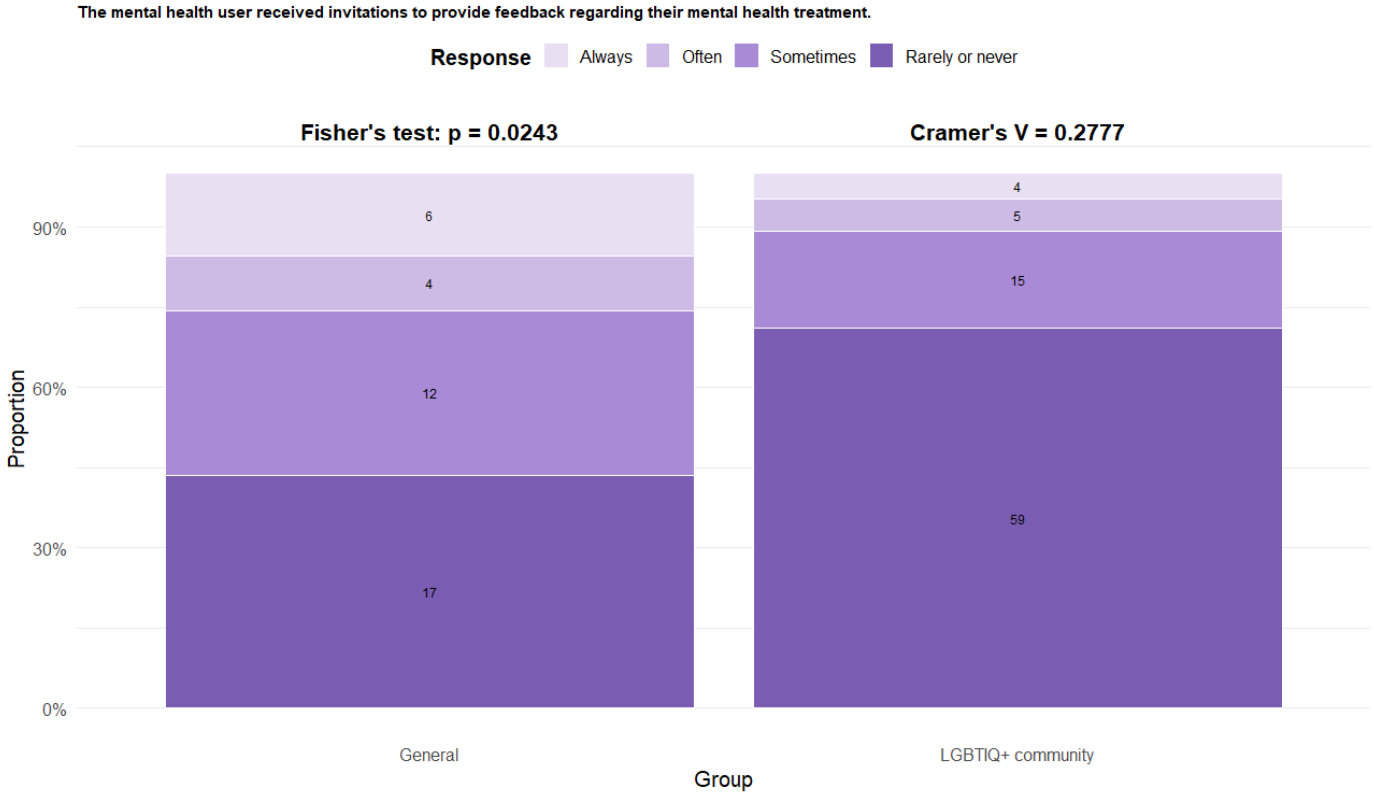


Figure 34: Fisher's exact test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Ireland

Furthermore, perceptions that user feedback was used to improve services differed significantly between groups (Figure 37; p = 0.0232, Cramer's V = 0.3405). This finding reflects differences in perceived responsiveness of services to user input. The observed effect size indicates a moderate association, suggesting notable differences in perceived service responsiveness.

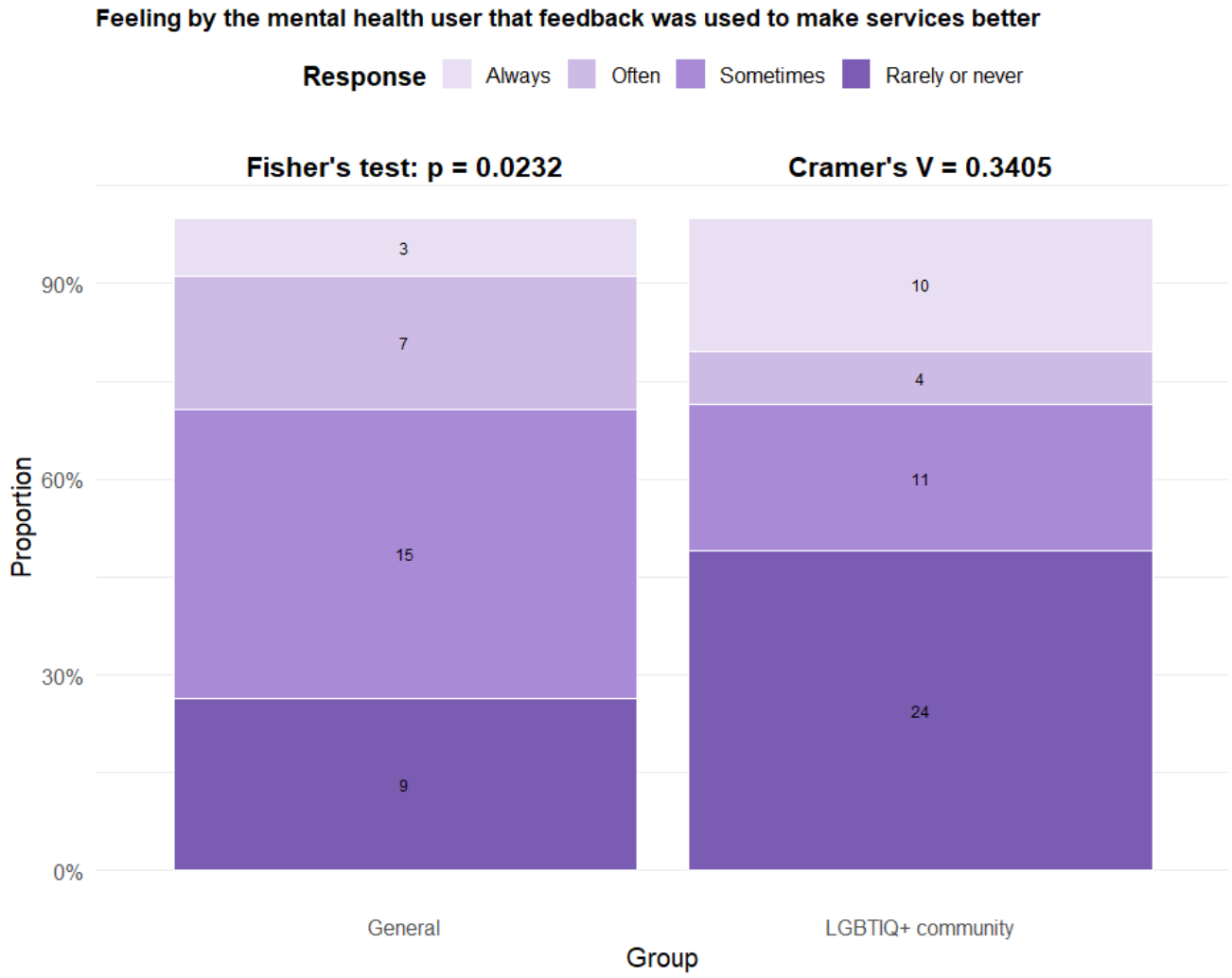


Figure 35: Fisher's exact test of the feeling by the mental health user that feedback was used to make services better item in Ireland

Finally, statistically significant differences were identified regarding whether support was offered to caregivers or family members (Figure 38; p = 0.00696, Cramer's V = 0.273). This result indicates variation in the availability of supportive resources beyond the individual service user. The corresponding effect size indicates a small to moderate association, suggesting meaningful differences between groups in perceived support availability.

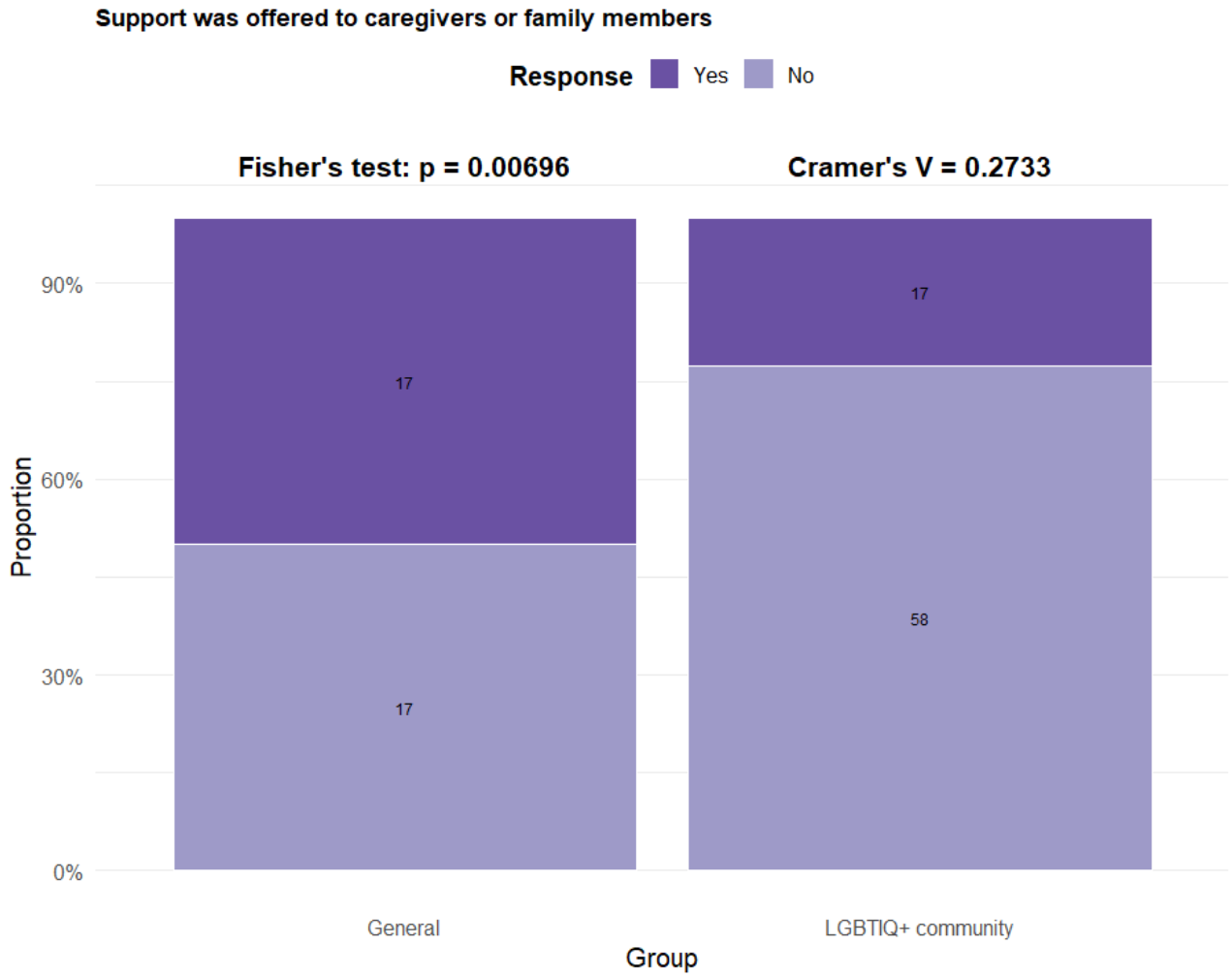


Figure 36: Fisher's exact test of the support was offered to caregivers or family members item in Ireland

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, showed moderate utility values across population groups. The overall mean utility score in the present dataset was 0.646 (SD = 0.365). Group-specific mean scores were 0.725 (SD = 0.328) for the general population and 0.574 (SD = 0.383) for the LGBTIQ+ community. For comparison, national reference values derived from Irish population data, as reported by Kinchin, Engel, and Rencz (2025)[16], indicated a mean utility value of 0.770. When compared with this national reference, mean utility scores observed in the present dataset were descriptively lower across both groups, suggesting reduced health-related quality of life relative to the general Irish population.

Self-perceived health

Self-perceived health was assessed using items corresponding to those included in the EU Statistics on Income and Living Conditions (EU-SILC) Ireland dataset, enabling comparison with

national distributions reported through Eurostat EU-SILC Ireland data. As subgroup-specific national estimates for LGBTIQ+ populations were not available within EU-SILC Ireland, comparisons were conducted primarily at the population level.[12]. Across the study population, most respondents reported good or fair health, although differences between groups were evident. Within the general population, 53.8% reported good health and 13.4% reported very good health. In contrast, the LGBTIQ+ community reported lower proportions of very good health (0.8%) and higher proportions of fair health (30.1%) and bad health (11.4%) compared with the general population (Table 18). When compared with national estimates derived from the EU-SILC Ireland dataset, the present dataset shows lower proportions of very good health and higher proportions of fair health, particularly among LGBTIQ+ participants. These findings suggest somewhat poorer perceived health status compared with national averages (Table 19)

Table 18: Self-perceived health in the dataset of Ireland

	General group	LGBTIQ+ community
Very bad, *n (%)*	2 (1.7)	1 (0.8)
Bad, *n (%)*	6 (5.0)	14 (11.4)
Fair (neither good nor bad), *n (%)*	31 (26.1)	37 (30.1)
Good, *n (%)*	64 (53.8)	47 (38.6)
Very good, *n (%)*	16 (13.4)	1 (0.8)
Missing, *n (%)*	0 (0.0)	0.0

Table 19: Self-perceived health in the dataset of EU-SILC Ireland

	Total country
Very bad, %	0.7
Bad, %	3.0
Fair (neither good nor bad), %	12.3
Good, %	37.4
	46.6

Activity limitations

Activity limitations were assessed using indicators corresponding to those included in the EU-SILC Ireland dataset, allowing comparison with national-level estimates of functional limitation[13]. Within

the present dataset, variation between groups was observed. Among the general population, 64.7% reported no activity limitations, while 31.1% reported moderate limitations and 4.2% reported severe limitations. In contrast, the LGBTIQ+ community reported lower proportions of no limitations (56.1%) and higher proportions of moderate limitations (39.0%) compared with the general population (Table 20). Compared with national estimates from the EU-SILC Ireland dataset, where the majority of the population reports no limitations, the present dataset suggests higher levels of reported activity limitations, particularly within the general population (Table 21).

Table 20: Activity limitations in the dataset of Ireland

	General group	LGBTIQ+ community
Severely limited, *n (%)*	5 (4.2)	5 (4.1)
Limited, *n (%)*	37 (31.1)	48 (39.0)
Not limited, *n (%)*	77 (64.7)	69 (56.1)
Missing, *n*	0 (0.0)	1 (0.8)

Table 21: Activity limitations in the EU-SILC dataset of Ireland

	Total country
Severely limited, %	3.8
Limited, %	12.2
Not limited, %	84.0

Unmet need for care

Unmet need for healthcare was measured using indicators corresponding to those included in the EU-SILC Ireland dataset, enabling comparison with national-level estimates reported through Eurostat EU-SILC Ireland data.[14]. Several barriers to healthcare access were identified across both groups. Within the general population, waiting lists (16.8%) and cost-related barriers (21.0%) were among the most frequently reported challenges. In the LGBTIQ+ community, unmet need was reported more frequently across several domains, including waiting lists (45.5%), cost-related barriers (36.6%), fear of treatment (23.9%), and uncertainty about appropriate providers (13.8%). Only 24.4% of LGBTIQ+ respondents reported having no unmet healthcare needs, compared with 58.0% of the general population (Table 22) National estimates derived from the EU-SILC Ireland dataset indicate that the majority of the population reports no unmet healthcare needs. Compared with these national estimates, the present dataset indicates substantially higher levels of unmet need, particularly among LGBTIQ+ respondents (Table 23)

Table 22: Unmet need for care in the dataset of Ireland

	General group	LGBTIQ+ community
Too expensive, %	25 (21.0)	45 (36.6)
Too far to travel, %	5 (4.2)	11 (8.5)
No time, %	8 (6.7)	11 (8.5)
Didn't know any good doctor or specialist, %	1 (0.8)	17 (13.8)
Waiting list, %	20 (16.8)	56 (45.5)
Fear of doctor, hospital examination or treatment, %	13 (10.9)	29 (23.6)
Wanted to wait and see if problem got better on its own, %	10 (8.4)	26 (21.1)
Other reason, %	8 (6.7)	19 (15.4)
No unmet needs to declare, %	69 (58.0)	30 (24.4)
Missing, %	0.0	0.0

Table 23: Unmet need for care in the EU-SILC dataset of Ireland

	Total country
Too expensive, %	1.8
Too far to travel, %	0.0
No time, %	0.1
Didn't know any good doctor or specialist, %	0.0
Waiting list, %	0.9

Fear of doctor, hospital examination or treatment, %	0.1
Wanted to wait and see if problem got better on its own, %	0.5
Other reason, %	0.1
No unmet needs to declare, %	96.5

Depression severity

Depressive symptom severity was assessed using indicators corresponding to those included in the European Health Interview Survey (EHIS) Ireland dataset, enabling comparison with national mental health distributions reported through Eurostat EHIS Ireland data.[15]. Across both study groups, depressive symptoms were reported across varying severity levels. Within the general population, the largest proportion reported none or minimal symptoms (37.8%), followed by mild symptoms (29.4%). In contrast, the LGBTIQ+ community reported higher proportions of moderate (16.3 %), moderately severe (22.8%), and severe symptoms (8.0%) compared with the general population. Additionally, fewer LGBTIQ+ respondents reported minimal symptoms (13.0%) compared with the general population (Table 24). National reference values derived from the EHIS Ireland dataset indicate that the majority of individuals report none or minimal depressive symptoms, with only small proportions reporting moderate or severe symptoms. Compared with these national estimates, the present dataset suggests considerably higher levels of depressive symptoms, particularly among LGBTIQ+ participants (Table 25).

Table 24: Depression severity in the dataset of Ireland

	General group	LGBTIQ+ community
Severe, %	8 (6.7)	11 (8.9)
Moderately severe, %	15 (12.6)	28 (22.8)
Moderate, %	16 (13.4)	20 (16.3)
Mild, %	35 (29.4)	46 (37.4)
None or minimum, %	45 (37.8)	16 (13.0)
Missing, %	0 (0.0)	2 (1.6)

Table 25: Depression severity in the EHIS dataset of Ireland

	Total country
Severe, %	0.8

Moderately severe, %	1.2
Moderate, %	2.7
Mild, %	8.8
None or minimum, %	86.5

4.2.2 Qualitative results

Approachability

Information awareness

Information about LGBTQIA+ inclusive mental health services does not reach the community through any systematic or coordinated channel. Across all five interviews, awareness is found to depend almost entirely on word of mouth, social media, and community networks rather than on formal information infrastructure. The NGO respondent captures this most directly: *"At the moment it's still very word of mouth. I don't think that anyone necessarily is walking into a service and expecting to get inclusive care"* (LGBT Ireland, Civil Society/NGO). The service provider corroborates this from clinical practice, noting the complete absence of information materials or signposting within the service: *"In terms of the service that I'm in, there isn't an information booklet or a signposting kind of set. So, I think people would be struggling, really, to be about kind of googling what's out there"* (LGBT Ireland, Provider).

Digital information portals exist but fail to reach people proactively. The user representative notes that even the national mental health information website goes unnoticed: *"We have yourmentalhealth.ie, and people don't even know that it exists. It doesn't come into their consciousness, regardless of the ads or campaigns or anything like that. It doesn't land for some reason, unless you need it"* (LGBT Ireland, User Representative).

A meaningful facilitator is identified by the researcher, who points to the success of community-led narrative campaigns. The You, Me and HIV campaign, where people living with HIV tell their own stories on national television, is described as transformative not only for HIV awareness but for how the HSE approaches all future health campaigns: *"The HSE campaigns team said they will never have another health campaign the same way again — this has informed how they do health campaigns going forward"* (LGBT Ireland, Researcher). This finding positions community-led,

narrative-driven information as the most effective available model for reaching the LGBTQIA+ population.

The policymaker confirms that national mental health promotion policies, “Stronger Together” and “Pathways to Well-being" formally include sections on priority groups but acknowledges that these remain at a high strategic level with no confirmed specific actions yet in place: *“That’s a very high-level objective. What are the specific things they’re planning to address that, I don’t know”* (LGBT Ireland, Policymaker).

Barriers to recognizing or seeking help

Barriers to help-seeking are multilayered and mutually reinforcing, operating across individual, cultural, and structural levels. A foundational barrier is that people do not associate their distress with a need for professional support until they are in acute crisis. The user representative describes this as a near-universal pattern: *“If I had a penny for every time somebody says ‘I never knew that service existed’. They didn’t need to know because they didn’t want it at the time — and then it’s nearly like a panic”* (LGBT Ireland, User Representative).

For LGBTQIA+ people specifically, the GP gatekeeping pathway creates an additional barrier. The service provider notes that the primary referral route is through the GP, yet LGBTQIA+-specific services are not systematically signposted within GP practices: *“The main referral pathway is their GP. I don’t think there is that much information about healthcare services, per se”* (LGBT Ireland, Provider).

Fear of encountering an untrained or non-inclusive professional is identified across three interviews as a decisive barrier to initial help-seeking. The NGO respondent describes avoidance as widespread within the community: *“There’s a massive issue around avoidance of services within the community for fear of the fact that they’re going to have a negative experience, or because they’ve previously had a negative experience”* (LGBT Ireland, Civil Society/NGO). The researcher adds a further dimension specific to people living with HIV: fear of the GP as a site of disclosure risk actively prevents engagement with mental health referral pathways: *“We know people don’t want to go to the local GPs. If I’m in rural Kerry, I don’t want my GP, who knows my mother, to know about my HIV status”* (LGBT Ireland, Researcher). Documented breaches of patient confidentiality by healthcare professionals, highlighted in the HIV Ireland Stigma Report, make this fear evidence-based rather than merely perceived.

A critical research gap is noted by the researcher, who cannot identify Irish research specifically on mental health access for LGBTQIA+ people or people living with HIV: *"I can't think of one study that will talk about people accessing mental health services whatsoever"* (LGBTI Ireland, Researcher). While the researcher acknowledges that this expertise is primarily in global rather than Irish research, this points to at least a significant visibility problem, even within the field. Evidence on this topic is not readily accessible or well known, which itself has implications for how services are informed and developed.

Acceptability

Cultural and social fit

Cultural and social alignment is a central condition of service acceptability for LGBTQIA+ people, but all five interviews converge on a critical asymmetry: barriers to acceptability are concentrated at the point of engagement rather than in the quality of care received once inside a service. This finding has direct implications for how interventions should be designed.

The NGO respondent articulates the core challenge most precisely: cultural competence for LGBTQIA+ clients requires far more than pronoun knowledge. It demands an understanding of queer subculture, community-specific experiences, and the avoidance of a cisnormative gaze: *“It goes beyond learning the pronouns and learning what the words mean, into an understanding of there’s a whole subculture of queerness that exists, and there are experiences that happen within our community that are different to the cisgender and heterosexual community”* (LGBT Ireland, Civil Society/NGO).

The service provider illustrates this from clinical experience, noting that even skilled therapists can be “clunky” around identity issues: *“She is a bit clunky around, say, if I’ve stuff around my identity, or I can see her making assumptions. She wouldn’t necessarily be that confident or comfortable around the language linked to LGBTQI+ identities. I wondered, if I was not as experienced or in a different stage of life, would that be an issue?”* (LGBT Ireland, Provider). This observation is analytically significant because it comes from within the therapeutic relationship itself, illustrating how cultural gaps play out even in otherwise good clinical encounters.

The user representative identifies the same pattern at a systemic level: *“The worst thing that can happen is that you go into somebody and you know within five minutes that that person either is uncomfortable with this subject or doesn’t actually understand where you’re coming from, and the person won’t stay”* (LGBT Ireland, User Representative). Drop-out from services is therefore not a reflection of individual reluctance but a rational response to cultural mismatch.

A public-private divide runs through all discussions of cultural fit. Those with financial resources actively seek out LGBT+-identified or LGBT+-affirming therapists and report highly positive experiences. Those relying on the public system face inconsistent, structurally embedded cultural incompetence. The NGO respondent is direct: *"If you can pay for it, you can get a wonderful range of all sorts of affirming and inclusive services that are very much ready to meet your needs. But if you don't have those financial means, it's more hit and miss"* (LGBT Ireland, Civil Society/NGO).

Intersectionality compounds cultural barriers significantly. The NGO respondent identifies a particular exclusion experienced by LGBTQIA+ Travellers: *"Members of the traveller community don't feel as welcome or supported within LGBT spaces, but obviously also don't feel welcome or supported within traveller spaces. So it's like, well, where do they actually sit?"* (LGBT Ireland, Civil Society/NGO). Similarly, the researcher highlights that older gay men living with HIV in rural areas represent one of the most isolated and underserved groups: *"They'd never even dream of talking to the GP about HIV, let alone mental health"* (LGBT Ireland, Researcher).

Stigma

Stigma emerges across all five interviews as a barrier with particular depth and complexity for LGBTQIA+ people in Ireland. Unlike other access barriers that are primarily structural or financial, stigma for this population is simultaneously internalised, socially enforced, institutionally reproduced, and historically rooted, making it uniquely resistant to straightforward intervention.

The user representative identifies stigma as the defining problem: *"Stigma remains a serious challenge — in the small town, people are hesitant to seek mental health help due to fear of judgment"* (LGBT Ireland, User Representative). This fear is not abstract: the NGO respondent documents that 40% of LGBTQIA+ people choose not to disclose their identity to a health or social care professional, meaning they must "edit themselves" throughout every clinical encounter, preventing person-centred care from functioning effectively.

The historical dimension of stigma is particularly pronounced for older members of the Irish LGBTQIA+ community. The NGO respondent situates this historically: *"If you are a member of the community and you engaged with any kind of mental health professionals prior to 1993 or even slightly later than that, there's a good chance you will have been encouraged to try and change your identity"* (LGBT Ireland, Civil Society/NGO). This legacy of pathologisation produces a form of institutional distrust that cannot be addressed by contemporary inclusion initiatives alone.

Catholic guilt and sexual shame are identified by the researcher as deep cultural roots of stigma specific to the Irish context. The duality between Ireland's rapid social progress and its enduring religious conservatism creates a particular burden: *"We have decades of Catholic shame, Catholic guilt — 'sex is wrong, let's put everything like our mental health issues under the rug. We don't talk about that'"* (LGBT Ireland, Researcher). This cultural substrate shapes how both service users and professionals relate to LGBTQIA+ mental health in ways that formal policy cannot easily reach.

Stigma also operates within healthcare institutions. The researcher identifies professional stigma as among the most damaging experienced by the community: *"The most stigmatised that I've ever been has been by healthcare professionals in this country — they are some of the most ignorant people around HIV"* (LGBT Ireland, Researcher). This is corroborated by research on healthcare provider stigma cited in the interview, and by documented confidentiality breaches that have eroded trust in GP services.

Anti-stigma initiatives exist but are fragmented and insufficiently embedded. The Green Ribbon Campaign is identified as effective for general population stigma reduction, but the policymaker cannot confirm whether it specifically addresses LGBTQIA+ people's needs. The HSE rainbow badge initiative is described as meaningful as a signal of inclusion, but the NGO respondent argues it represents only individual-level change: *"It really needs to go a bit deeper than just that kind of individual responsibility to get the knowledge. It needs to move to more of a system-wide change"* (LGBT Ireland, Civil Society/NGO). Professional training conferences on LGBTQIA+ issues exist but reach only a fraction of practitioners: *"There were about 150 people at it from a membership of 6,500. You are kind of talking to the converted"* (LGBT Ireland, Provider).

Availability

Distribution and sufficiency of services

All five interviews converge on a diagnosis of structural under-provision, with a sharp public-private divide defining the landscape of available services. The policymaker confirms that community mental health teams formally cover every area of Ireland, providing a nominal baseline of coverage. However, the quality and resourcing of these teams vary significantly: *"Some teams might be covering a larger area, or some things are better resourced. Some teams are deemed to be more effective than others"* (LGBT Ireland, Policymaker). In practice, access becomes a postcode lottery.

The most acute dimension of under-provision is the public system's six-session limit for psychotherapy. The service provider identifies this as structurally inadequate: *"Apart from the HSE,*

which is only six sessions, the public offering for psychotherapy now is very limited, so it's a short course, which really doesn't, I think, isn't adequate for most people" (LGBT Ireland, Provider).

No LGBT-specific specialist mental health team exists within the public system. The policymaker is explicit: *"There isn't a specific LGBT specialist mental health team. There's the general team that's in your area that you get referred to"* (LGBT Ireland, Policymaker). This contrasts with the provision for Travellers, who have a national traveller counselling service, a disparity that is identified but not explained.

Staff recruitment and retention are identified by the user representative as a structural threat to service availability that cannot be resolved without systemic economic intervention: *"A young fourth-year student nurse gets 1,900 euro a month. She's living in a room in Stoney Batter for 1,800. Of course she's going to go to Australia. These are the people we need"* (LGBT Ireland, User Representative). Community mental health teams are described as "falling apart because they can't get services" which is a systemic failure driven by Ireland's housing and cost-of-living crisis.

The researcher highlights a specific availability gap for Chemsex-related mental health support, which sits uncomfortably between mental health and addiction services: *"The Department of Health doesn't really know which way to put the funding or the focus"* (LGBT Ireland, Researcher). Free Chemsex support services exist, but only in Dublin, and their existence is poorly communicated. The researcher notes that a new HSE Chemsex support group has been established, described as phenomenal, but attributes this to community advocacy rather than proactive system design.

Timing, format, and accessibility of delivery

Service hours are significantly misaligned with the needs of working people and those in precarious employment. HSE public services operate within standard working hours, creating a structural barrier for those who cannot take time off. The NGO respondent illustrates this with a direct analogy: *"If you work in a job like a white-collar nine-to-five job where your employment rights are protected, you can make an appointment for a Monday afternoon. But if you're working in a place where you're not as protected, then your ability to make appointments during the available hours can be very difficult"* (LGBT Ireland, Civil Society/NGO). This barrier disproportionately affects LGBTQIA+ people in precarious employment, who are simultaneously least able to afford private alternatives. The user representative confirms that no unified national mechanism for flexible access exists: *"You have lots of HSE services, but they don't operate outside traditional working hours. Huge gap"* (LGBT Ireland, User Representative). Crisis cafés represent a partial structural response, operating into the evening, but their rollout is phased and incomplete.

Physical inaccessibility of service premises is identified as a pervasive and underacknowledged barrier. The service provider notes that all three services, the service provider works with or is joining, occupy buildings with steps and no accessibility ramps: *"Insight Matters is a Georgian building with steps up to the front door. And the one I'm in is a building with steps up to the front door and no accessibility ramps or anything"* (LGBT Ireland, Provider). This structural barrier is identified as easily fixable: "could be easily fixed if you put an EDI lens on things" but has not been addressed.

Online delivery is identified across multiple interviews as the most promising structural solution for both geographic and physical accessibility. The researcher advocates for mental health support to be made available online, particularly for those in rural areas or unable to travel. The service provider confirms that low-cost private services offer flexible daily scheduling, described as a meaningful facilitator: *"You tend to have 10 or 12 hours per day where clients can come before work or lunchtime, or whatever. So that's good"* (LGBT Ireland, Provider). However, online options remain restricted for trainee therapists, and suitability depends on having a private safe space at home.

The HIV clinic appointment model is identified by the researcher as a structural barrier to mental health referral. Brief rushed consultations with different consultants each visit prevents the trust-building necessary for mental health disclosure: *"We know we only have 5, 10 minutes. We don't always get the same consultant. Sometimes we're passed around to different consultants. So, we don't really build that relationship"* (LGBT Ireland, Researcher).

Affordability

Direct cost and indirect costs

Financial barriers are identified across all five interviews as among the most significant structural determinants of mental health access for LGBTQIA+ people in Ireland. The NGO respondent states the defining principle of the Irish system plainly: *"If you need services, if you need something fast in Ireland, you have to pay for it"* (LGBT Ireland, Civil Society/NGO).

Even the lowest-cost private therapy options remain prohibitive for many. The service provider identifies 35 euros per session as a significant weekly burden for students and low-income individuals: *"That's a big ask for students to find 35 euros a week"* (LGBT Ireland, Provider). The user representative adds that rising costs of living are further eroding the accessibility of services nominally positioned as low cost: *"The low-cost services are less low cost. So all of those things"* (LGBT Ireland, Provider).

The financial barrier to accessing culturally competent care is particularly acute. Those who want an LGBT-affirming or LGBT-identified therapist must almost always go private, since no publicly funded LGBTQIA+-specific counselling service exists. The researcher illustrates the personal dimension of this: having accessed the LGBT-specific private service Insight Matters for seven years, the researcher notes that income-based fee scaling made this possible, but this is entirely dependent on individual provider discretion rather than systemic policy.

Indirect costs compound direct costs for vulnerable subgroups. The researcher highlights the particular burden facing women living with HIV, many of whom are single mothers: *"The cost of living in Ireland is just insane, and they're like, 'I can't even get a handle on my HIV — feeding my kids'. That's what I hear so often from women"* (LGBT Ireland, Researcher). For LGBTQIA+ people in the gig economy or on precarious contracts, particularly migrants, transport costs, lost working hours, and childcare costs add further layers of financial barrier.

Tax relief and private health insurance are theoretically available as partial compensatory mechanisms, but the user representative identifies these as structurally regressive: *"You have to be working. You have to obviously pay tax to get it back, and a medical card does not get you anything"* (LGBT Ireland, Provider). Those who most need financial support are precisely those who cannot access the existing relief mechanisms.

Financial support mechanisms

Financial support mechanisms for mental health care in Ireland are extremely limited, and none are LGBTQI+-specific. The policymaker is candid: *"Other than our social protection system that's there already, I can't think of anything that we would provide within the agency"* (LGBT Ireland, Policymaker). The only public provision is the HSE's six-session counselling offering, which carries an unknown but potentially significant waiting list. Beyond this, people fall back on free helplines and peer support groups, Samaritans, Aware, and Jigsaw, which are not clinical services and cannot substitute for personalised therapeutic support: *"It mightn't be clinical, like some of the peer support groups. You wouldn't have the personalised support"* (LGBT Ireland, Provider).

Free counselling services exist through some sexual health NGOs, such as: GOSHH in Limerick, Sexual Health West in Galway, and Sexual Health Centre Cork are cited by the researcher. However, these are geographically concentrated and heavily relied upon: *"If you're in Mayo, for example, you're not going to have that, or you're going to have to travel. It's just based around the big cities here in Ireland"* (LGBT Ireland, Researcher).

Employment Assistance Programme sessions, where employers fund a number of counselling sessions, are identified by the service provider as the most effective entry-point mechanism, providing direct access rather than retrospective reimbursement. However, these are only available to those in formal employment, excluding the most financially vulnerable.

The policymaker's position is that HSE services should suffice for all groups including LGBTQIA+ people, with the expectation that they improve their cultural competence rather than resources being directed toward private providers. This assumption is contested by evidence from across the other four interviews, which consistently demonstrate that the public system's cultural competence remains insufficient for LGBTQIA+ needs.

Appropriateness

Fit and usefulness of care

A distinctive and analytically important finding across all five interviews is the asymmetry between the barriers at entry and the quality of care experienced once inside a service. When LGBTQIA+ people do access culturally competent care, feedback is predominantly positive. This suggests that the appropriateness problem is primarily one of structural access rather than clinical inadequacy in itself. The NGO respondent is most explicit: those who can pay for affirming private care speak very positively about how important it is to have someone who really understands their world. By contrast, those relying on the public system describe a chaotic, inconsistent experience: *"You might meet one person one day who is terrifically informed and really affirming, and then the next day you're talking to someone who has a completely different way of doing things. So it's much more scattershot"* (LGBT Ireland, Civil Society/NGO).

The researcher illustrates the gap between what frameworks and research recommend and what is actually delivered. Six free HIV counselling sessions are formally available, but: *"there could be a two-month waiting list, and it's only midweek during working hours, so it doesn't suit everyone"* (LGBT Ireland, Researcher). Peer support, while theoretically appropriate, failed to meet the researcher's needs because existing networks were not representative: *"peer support was horrendous, because all of the people back then were just focused on HIV from the 80s and 90s, and they couldn't see what HIV was like today"* (LGBT Ireland, Researcher).

The user representative argues that the dominant biomedical model of mental health care remains a structural barrier to appropriate care: *"The biomedical model is alive and kicking. It's about always seeing a person as an individual — not seeing a person as a set of symptoms"* (LGBT Ireland, User Representative). Person-centred, recovery-oriented care which the national policy formally endorses,

is in practice difficult to deliver within overstretched public services where high patient loads and limited staff constrain individualised approaches.

The policymaker acknowledges that monitoring of appropriate care delivery remains at an early stage: *"I think we're just at the start of that journey. We don't really do that in the agency to a huge extent already with the general population"* (LGBT Ireland, Policymaker). The absence of patient-reported outcome measures (PROMs) in HIV and mental health clinical settings is identified by the researcher as a critical structural gap that prevents both clinical and system-level improvement. The researcher advocates strongly for PROMs as a mechanism to open clinical conversations about mental health that would otherwise not occur: *"I think community needs input on what happens here, and then this opens the door for the consultants to ask the patient about their mental health a little bit more"* (LGBT Ireland, Researcher). This represents not only a quality improvement tool but a structural facilitator for mental health referral pathways.

Quality of interaction and respect

The quality of provider-patient interactions is identified across all five interviews as a central determinant of whether LGBTQIA+ people remain engaged with mental health services. A consistent pattern emerges: positive interactions are driven by individual professional commitment rather than systemic design, making them fragile, inconsistent, and unscalable.

The service provider identifies core psychotherapy training as providing a strong baseline of non-judgmental, client-led practice: *"The core training does give you the skills to be led by the client and to be non-judgmental and empathetic and active listening. I think that is a good safety net"* (LGBT Ireland, Provider). However, this safety net does not extend to LGBTQI+-specific competency. Curriculum reform has not occurred and LGBTQIA+ content remains peripheral to core training: *"EDI, this inclusion, is seen as an add-on until it's mainstreamed into the curriculum. Until there's a real equality lens on curricula, it won't change"* (LGBT Ireland, Provider).

The NGO respondent documents a self-reinforcing dynamic in which professionals' discomfort creates clinical silence that is read by clients as stigma: *"That fear creates a vacuum where nothing gets said, which then broadcasts to an individual that this isn't something we talk about. It maybe reinstates that shame or stigma, or becomes a negative experience that they then carry forward with them and share with their friends"* (LGBT Ireland, Civil Society/NGO). This finding has significant implications: poor interaction quality does not stay within the consulting room but actively damages community-level trust in services.

The researcher identifies trans people as facing the most severe quality-of-interaction failures within the mental health system: *"Trans people just don't have trust in the healthcare system. When it comes to mental health care, they have a psychiatrist asking them what kind of porn they watch — it's just so invalidating, so dehumanising"* (LGBT Ireland, Researcher). This represents one of the most acute appropriateness failures identified across the entire interview set.

Institutional arrangements are identified as structural drivers of poor interaction quality. The policymaker notes that regulation of mental health service quality currently applies only to inpatient settings, with extension to community teams planned but not yet implemented. The user representative calls for an independent patient advocacy mechanism: *"We don't have an independent external organisation that people can access around what they're experiencing when they are interfacing with services"* (LGBT Ireland, User Representative).

Inclusive intake forms and flexible naming policies are identified by the service provider as meaningful institutional facilitators. The ability to use any name and be addressed in whatever way the client chooses, combined with inclusively framed intake documents, are described as signalling respect before the clinical encounter has even begun. Conversely, the researcher argues that structural arrangements such as standardised PROMs incorporating questions about sexual satisfaction and quality of life alongside clinical indicators are necessary to equip all clinicians to ask the right questions in a culturally competent way, regardless of their prior training or personal competence.

4.3 Spain

4.3.1 Quantitative results

Descriptive results

A total of 222 respondents participated (General group: N = 85; Roma community: N = 76; Latin American migrants: N = 61), exceeding the KPI of 200 (Table 26).

Table 26: Distribution of participants across the included groups in Spain

General group	Roma community	Latin American migrants
N = 85	N = 76	N = 61

The overall mean age was 40.0 years (SD = 12.8); group means were 43.0 (SD = 12.0) in the General group, 36.3 (SD = 13.0) in the Roma community, and 40.3 (SD = 12.5) among Latin American migrants. Questionnaires were self-completed by 179 respondents (80.6%) and completed with help by 36 (16.2%); seven were completed by someone else (3.2%). By group, self-completion proportions were 91.8% (General), 56.6% (Roma), and 95.1% (Latin American). Sex at birth was reported as female by 154 respondents (69.4%) and male by 66 (29.7%); one respondent selected non-binary (0.5%) and one preferred not to say (0.5%). Gender was the same as assigned at birth for 221 respondents (99.5%). Sexual orientation was reported as heterosexual by 197 respondents (88.7%); other categories are shown in
Country of residence was Spain for 216 respondents (97.3%). Birthplace was the country of residence for 158 respondents (71.2%), another EU country for three (1.4%), and a country outside the EU for 61 (27.5%). Citizenship of the country of residence was reported by 172 respondents (77.5%), citizenship of another EU member state by two (0.9%), and citizenship of a country outside the EU by 48 (21.6%). Legal status categories were: regular (valid stay/permit) for 71 respondents (32.0%), in process of regularisation or renewal for 17 (7.7%), no valid residence authorisation for 10 (4.5%), prefer not to respond for 10 (4.5%), and not applicable for 111 (50.0%); missing responses were 3 (1.4%). Group-specific distributions are provided in Table xx.
The mean duration of stay in the country of residence was 30.6 years (SD = 20.2); group means were 42.3 (SD = 13.0) in the General group, 36.2 (SD = 13.0) in the Roma community, and 7.18 (SD = 16.4) among Latin American migrants. Educational attainment distributions across ISCED 0–8 are presented in Table 27 doctoral-level qualifications were reported in the General group. Use of mental health care in the previous 12 months was reported by 90 respondents (40.5%), while 132 (59.5%) reported no use. Missing data were minimal and are indicated in Table 27.

Table 27: Descriptive statistics of the different included groups in Spain

Demographic variable	General group	Roma community	Latin American migrants	Overall
Age, *mean (sd)*	43.0 (12.0)	36.3 (13.0)	40.3 (12.5)	40.0 (12.8)
Questionnaire completed by, *n (%)*				
Respondent alone	78 (91.8%)	43 (56.6%)	58 (95.1%)	179 (80.6%)
Respondent with help	7 (8.2%)	26 (34.2%)	3 (4.9%)	36 (16.2%)
Someone else	0 (0%)	7 (9.2%)	0 (0%)	7 (3.2%)
Sex at birth, *n (%)*				
Female	42 (49.4%)	64 (84.2%)	48 (78.7%)	154 (69.4%)
Male	41 (48.2%)	12 (15.8%)	13 (21.3%)	66 (29.7%)
Non-binary	1 (1.2%)	0 (0%)	0 (0%)	1 (0.5%)
Prefer not to say	1 (1.2%)	0 (0%)	0 (0%)	1 (0.5%)
Gender the same as assigned at birth, *n (%)*				
Yes	84 (98.8%)	76 (100%)	61 (100%)	221 (99.5%)
No	1 (1.2%)	0 (0%)	0 (0%)	1 (0.5%)
Prefer not to say	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Sexual orientation, *n (%)*				
Heterosexual	71 (83.5%)	73 (96.1%)	53 (86.9%)	197 (88.7%)
Gay	5 (5.9%)	0 (0%)	3 (4.9%)	8 (3.6%)
Lesbian	1 (1.2%)	1 (1.3%)	1 (1.6%)	3 (1.4%)
Bisexual	1 (1.2%)	2 (2.6%)	1 (1.6%)	4 (1.8%)
Other	2 (2.4%)	0 (0%)	2 (3.3%)	3 (1.4%)
Prefer not to say	5 (5.9%)	0 (0%)		7 (3.2%)
Country of residence, *n (%)*				
Greece	85 (100%)	76 (100%)	55 (90.2%)	216 (97.3%)
Other	0 (0%)	0 (0%)	6 (9.8%)	6 (2.7%)
Country of birth, *n (%)*				
Born in the country of residence	82 (96.5%)	76 (100%)	0 (0%)	158 (71.2%)
In another country in the EU	3 (3.5%)	0 (0%)	0 (%)	3 (1.4%)

Born in another country outside the EU	0 (0%)	0 (0%)	61 (100%)	61 (27.5%)
Citizen of country, *n (%)*				
Citizen of the country of residence	83 (97.6%)	76 (100%)	13 (21.3%)	172 (77.5%)
No citizenship of the country of residence but that of another EU member state	1 (1.2%)	0 (0%)	1 (1.6%)	2 (0.9%)
No citizenship of the country of residence but that of a country outside the EU	1 (1.2%)	0 (0%)	47 (77.0%)	48 (21.6%)
Immigration or legal status, *n (%)*				
Regular (valid stay, residence, and/or work permit)	22 (25.9%)	19 (25.0%)	30 (49.2%)	71 (32.0%)
In process / undergoing regularization or renewal	1 (1.2%)	0 (0%)	16 (26.2%)	17 (7.7%)
No valid residence authorization (irregular status)	0 (0%)	0 (0%)	10 (16.4%)	10 (4.5%)
Prefer not to response	3 (3.5%)	4 (5.3%)	3 (4.9%)	10 (4.5%)
Not applicable	58 (68.2%)	52 (68.4%)	1 (1.6%)	111 (50.0%)
Missing	1 (1.2%)	1 (1.3%)	1 (1.6%)	3 (1.4%)
Duration of stay in the country of	42.3 (13.0)	36.2 (13.0)	7.18 (16.4)	30.6 (20.2)

residence, *mean years (SD)*				
Highest level of education completed (ISCED), *n (%)*				
Early childhood education (ages 3 and above), including pre-primary education and early childhood educational development (under 3). (ISCED 0)	1 (1.2%)	2 (2.6%)	2 (3.3%)	5 (2.3%)
Primary education (also known as elementary or basic education). (ISCED 1)	6 (7.1%)	30 (39.5%)	1 (1.6%)	37 (16.7%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	6 (7.1%)	10 (13.2%)	6 (9.8%)	22 (9.9%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	16 (18.8%)	8 (10.5%)	26 (42.6%)	50 (22.5%)
Post-secondary non-third level education (education between secondary and	11 (12.9%)	10 (13.2%)	7 (11.5%)	28 (12.6%)

tertiary levels). (ISCED 4)				
Short-cycle third level education (programs typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)	11 (12.9%)	5 (6.6%)	3 (4.9%)	19 (8.6%)
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	9 (10.6%)	7 (9.2%)	8 (13.1%)	24 (10.8%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	14 (16.5%)	3 (3.9%)	7 (11.5%)	24 (10.8%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	11 (12.9%)	0 (0%)	0 (0%)	11 (5.0%)
Missing	0 (0%)	1 (1.3%)	1 (1.6%)	2 (0.9%)
Use of mental health care in the previous 12 months, *n (%)*				
Yes	40 (47.1%)	34 (44.7%)	16 (26.2%)	90 (40.5%)
No	45 (52.9%)	42 (55.3%)	45 (73.8%)	132 (59.5%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Within the Availability and Accommodation dimension, most items showed statistically significant differences between population groups. The only item that did not differ significantly between groups was the availability of a private space for receiving care and talking openly, indicating comparable experiences across the general population, Latin American migrants, and Roma community for this aspect of service provision (Figure 39; all p-values > 0.05).

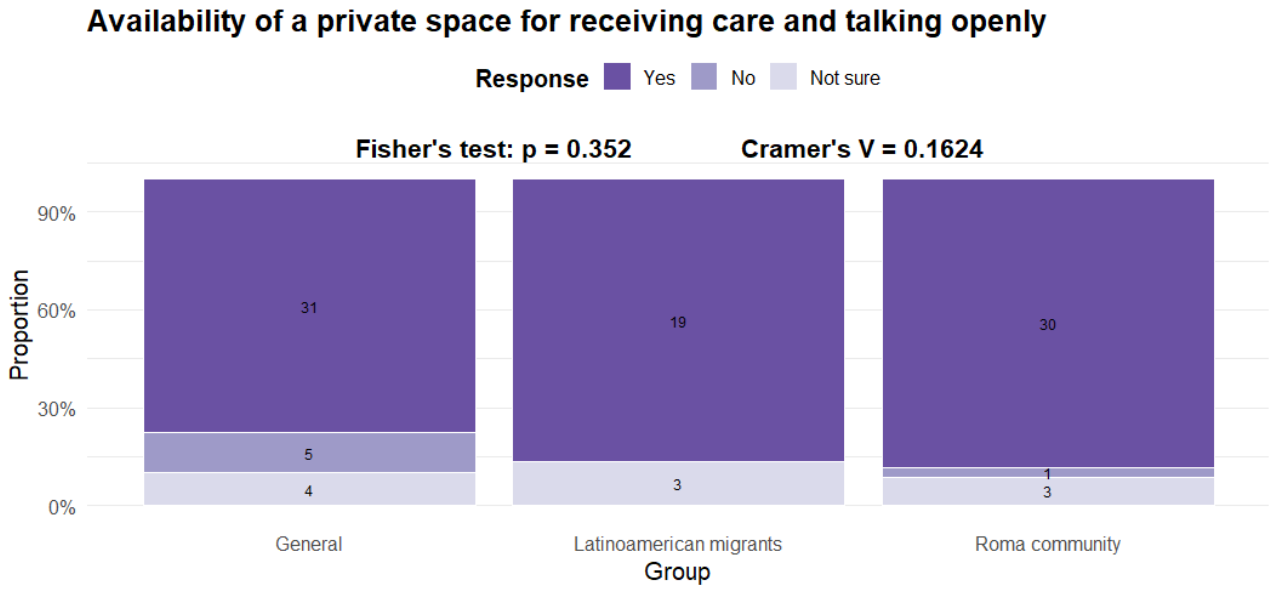


Figure 37: Fisher's test of the availability of a private space for receiving care and talking openly item in Spain

In contrast, awareness of mental health services in the local area differed significantly between groups (Figure 40). Pairwise comparisons (Table 28) indicated statistically significant differences between the general population and Latin American migrants (p = 0.0005, Cramer's V = 0.471), as well as between Latin American migrants and the Roma community (p = 0.0005, Cramer's V = 0.443). No significant difference was observed between the general population and the Roma community (p = 0.169, Cramer's V = 0.153). Descriptive findings indicated that Latin American migrants reported substantially lower awareness of available mental health services compared to the other groups. The corresponding effect sizes indicate moderate to large associations, suggesting meaningful differences between groups.

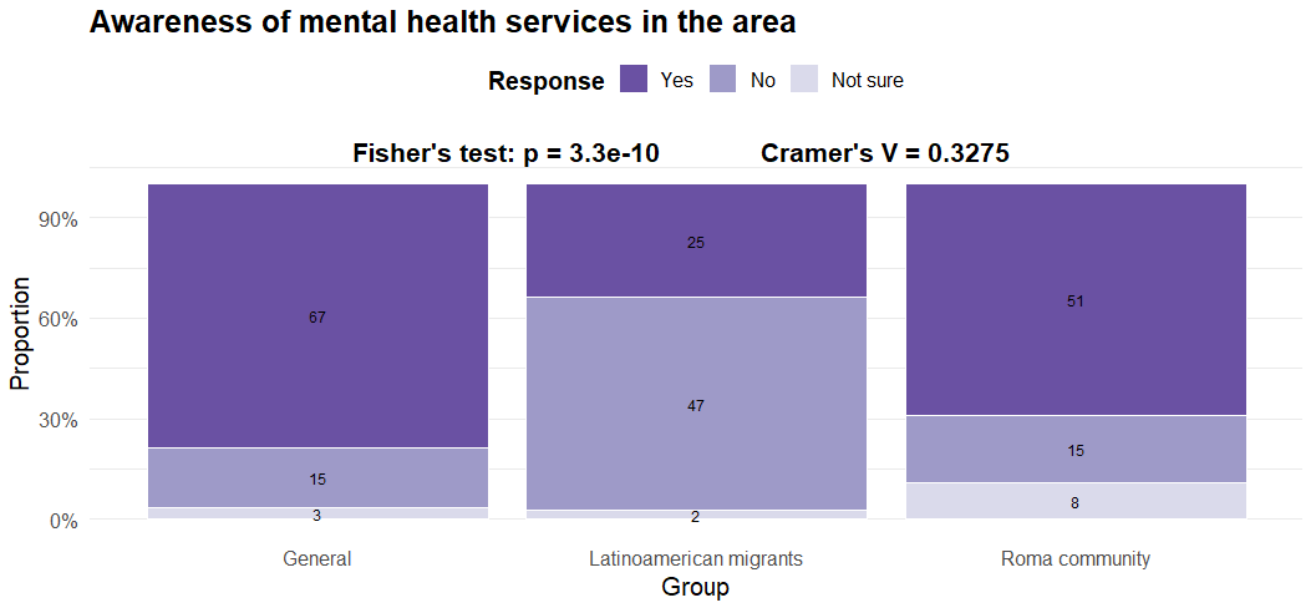


Figure 38: Fisher's test of the awareness of mental health services in the area item in Spain

Table 28: Pairwise comparison test of the awareness of mental health services in the area item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.0005	0.471
General group : Roma community	0.169	0.153
Latin American migrants: Roma community	0.0005	0.443

Significant differences were also observed for travel time to mental health service locations (Table 29; Figure 41). Pairwise analysis showed a statistically significant difference between the general population and the Roma community (p = 0.006, Cramer's V = 0.373), while no significant differences were identified between the general population and Latin American migrants (p = 0.257, Cramer's V = 0.269), or between Latin American migrants and the Roma community (p = 0.257, Cramer's V = 0.266). Descriptive results indicated that respondents from the general population reported shorter travel times to service locations compared to respondents from the Roma community. The effect size suggests a moderate association, indicating a meaningful difference in geographic accessibility between these groups.

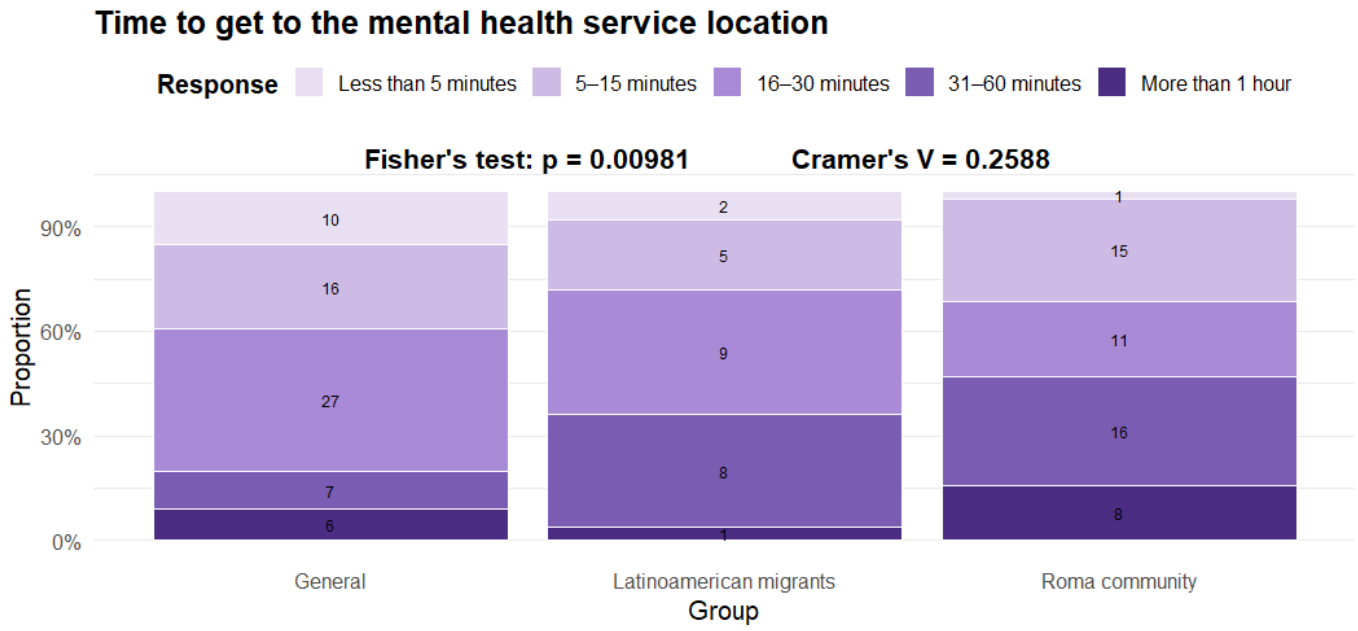
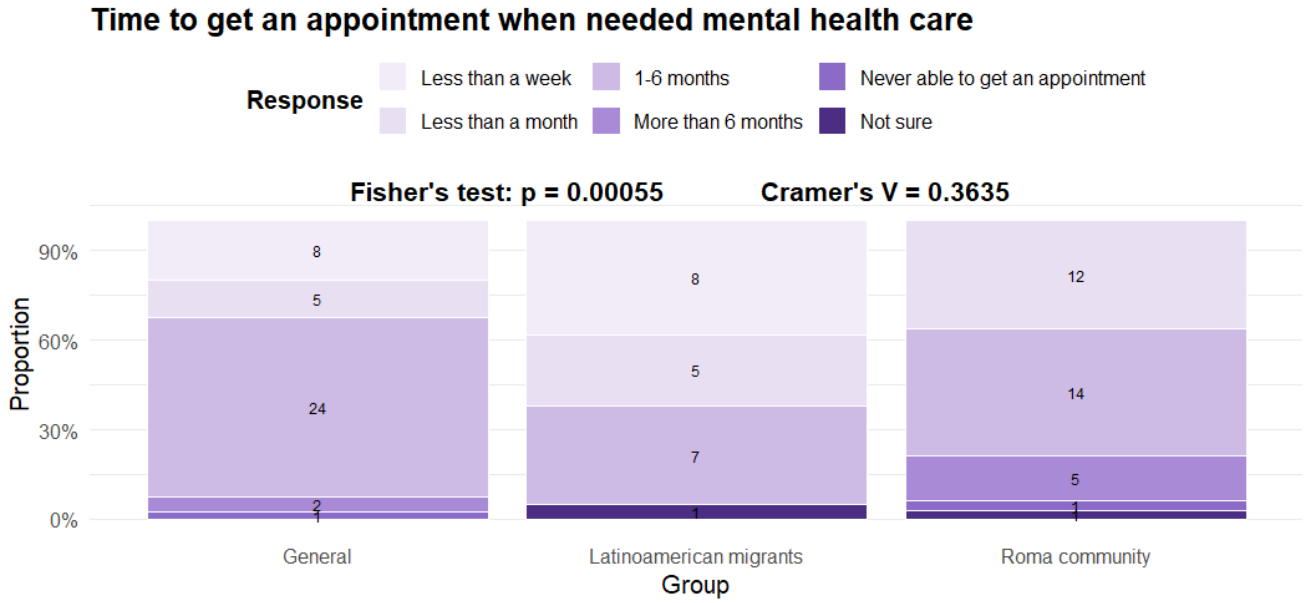


Figure 39: Fisher's test of time to get to the mental health service location item in Spain

Table 29: Pairwise comparison test of time to get to the mental health service location item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.257	0.269
General group : Roma community	0.006	0.373
Latin American migrants: Roma community	0.257	0.266

Furthermore, statistically significant differences were found regarding time required to obtain an appointment when mental health care was needed (Table 30, Figure 42). Differences were observed between the general population and the Roma community (p = 0.0075, Cramer's V = 0.457), as well as between Latin American migrants and the Roma community (p = 0.0045, Cramer's V = 0.568). No statistically significant difference was observed between the general population and Latin American migrants (p = 0.102, Cramer's V = 0.367). Descriptive findings suggested that respondents from the Roma community could not get appointments in less than a week. The effect sizes for this item



ranged from moderate to large, indicating notable differences between groups.

Figure 40: Fisher's test of the time to get an appointment when needed mental health care item in Spain

Table 30: Pairwise comparison test of the time to get an appointment when needed mental health care item in Spain

Comparison	P Value adjusted Fisher test	Cramer's V
General group: Latin American migrants	0.108	0.367
General group : Roma community	0.005	0.457
Latin American migrants: Roma community	0.005	0.568

Finally, knowledge of where to seek immediate help during a mental health crisis also differed significantly between groups (Figure 43; Table 31). Significant differences were observed between the general population and Latin American migrants (p = 0.005, Cramer's V = 0.365), as well as between Latin American migrants and the Roma community (p = 0.005, Cramer's V = 0.349). No significant difference was identified between the general population and the Roma community (p = 0.108, Cramer's V = 0.153). Descriptive results indicated that Latin American migrants reported substantially lower knowledge of crisis support services compared to the other groups. The effect sizes indicate moderate associations, suggesting meaningful disparities in crisis-related service

awareness.

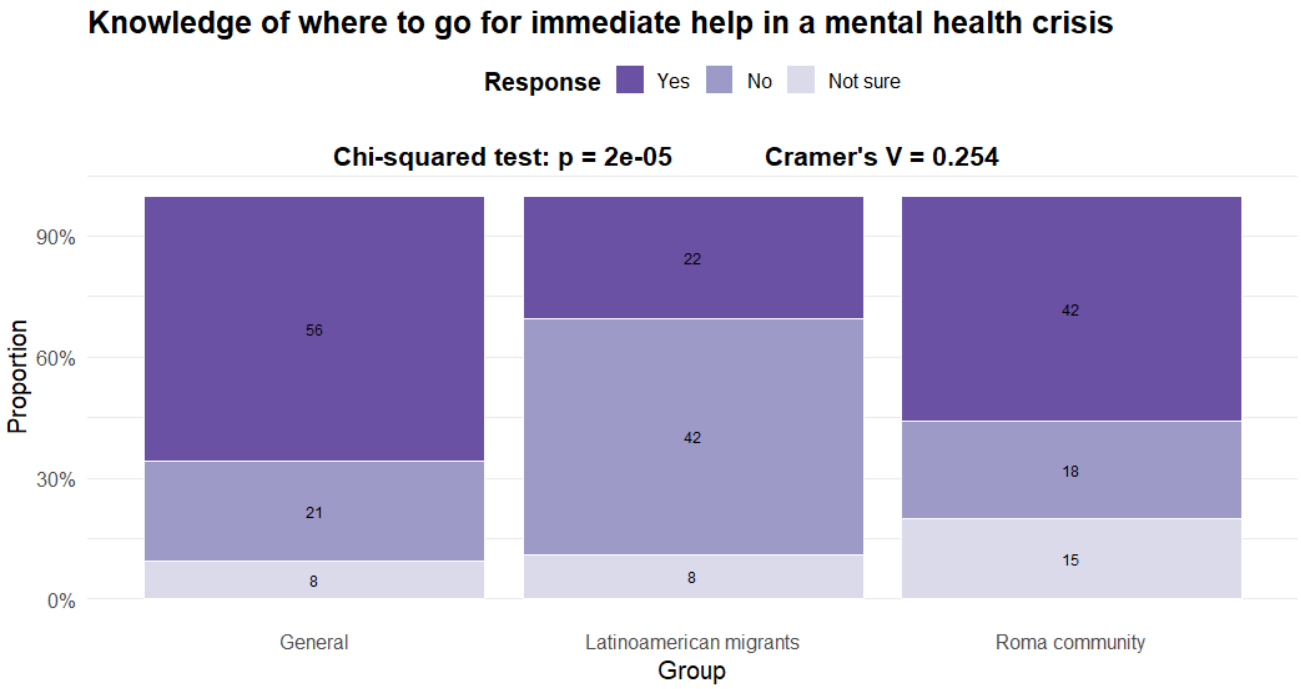


Figure 41: Chi-squared test of the knowledge of where to go for immediate help in a mental health crisis item in Spain

Table 31: Pairwise comparison test of the knowledge of where to go for immediate help in a mental health crisis item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.0015	0.365
General group : Roma community	0.159	0.153
Latin American migrants: Roma community	0.0015	0.349

Approachability

Within the Approachability dimension, two items did not show statistically significant differences between population groups. Specifically, no group differences were observed regarding whether participants had encountered information about accessing mental health support, nor regarding the ease of understanding spoken or written information about mental health services (Figure 44; all p-values > 0.05).

Figure 42: Non-significant differences across groups for the Approachability dimension in Spain

In contrast, several other indicators within this dimension demonstrated statistically significant variation between groups. One such difference was observed in relation to the ease of finding reliable information about mental health services (Figure 45; Table 32). Significant differences were identified between the general population and Latin American migrants ($p = 0.040$, Cramer's $V = 0.263$), as well as between Latin American migrants and the Roma community ($p = 0.015$, Cramer's $V = 0.313$). No significant difference was found between the general population and the Roma community ($p = 0.688$, Cramer's $V = 0.123$). Descriptive findings indicated that Latin American migrants more frequently selected neutral response options regarding the ease of finding reliable

information, suggesting potential uncertainty or variability in their experiences. The effect sizes for these comparisons indicate small to moderate associations.

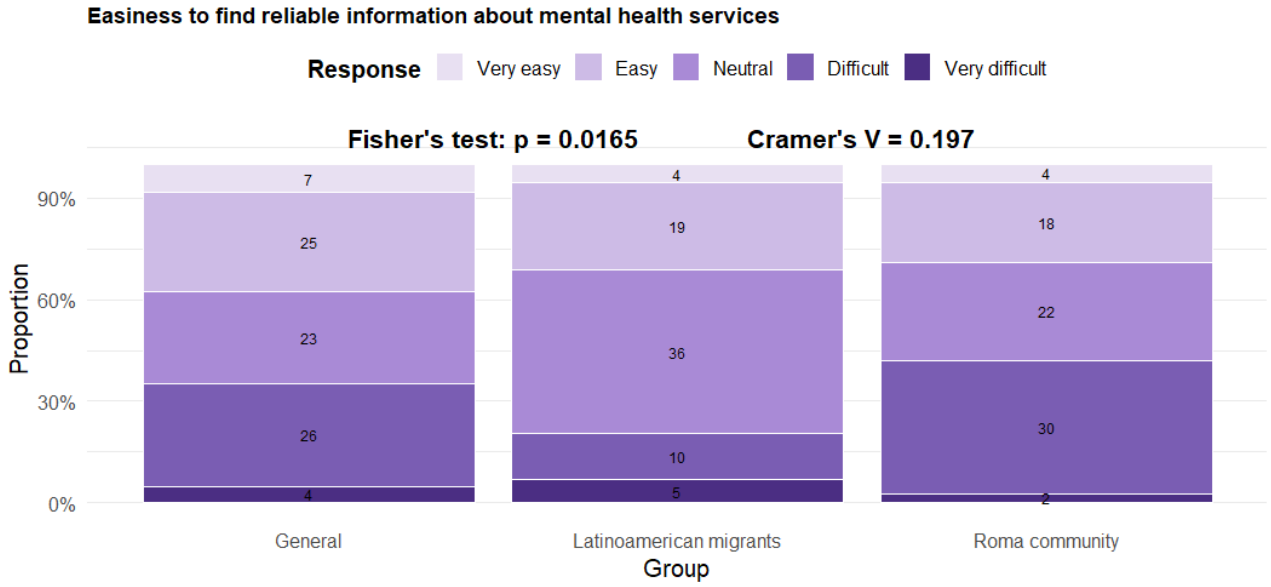


Figure 43: Fisher's test of the easiness to find reliable information about mental health services item in Spain

Table 32: Pairwise comparison test of the easiness to find reliable information about mental health services item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.040	0.263
General group : Roma community	0.668	0.123
Latin American migrants: Roma community	0.015	0.313

Differences were also identified in relation to whether respondents were asked about their mental wellbeing during encounters with a family doctor, school counsellor, or social worker. Significant differences (Figure 46; Table 33). were observed between the general population and the Roma community (p = 0.016, Cramer's V = 0.244), as well as between Latin American migrants and the Roma community (p = 0.009, Cramer's V = 0.282). No significant difference was found between the general population and Latin American migrants (p = 0.732, Cramer's V = 0.065). Descriptive results indicated that respondents from the Roma community more frequently selected "not sure" responses compared to the other groups, suggesting possible uncertainty or reduced engagement

in routine wellbeing discussions. The observed effect sizes indicate small associations.

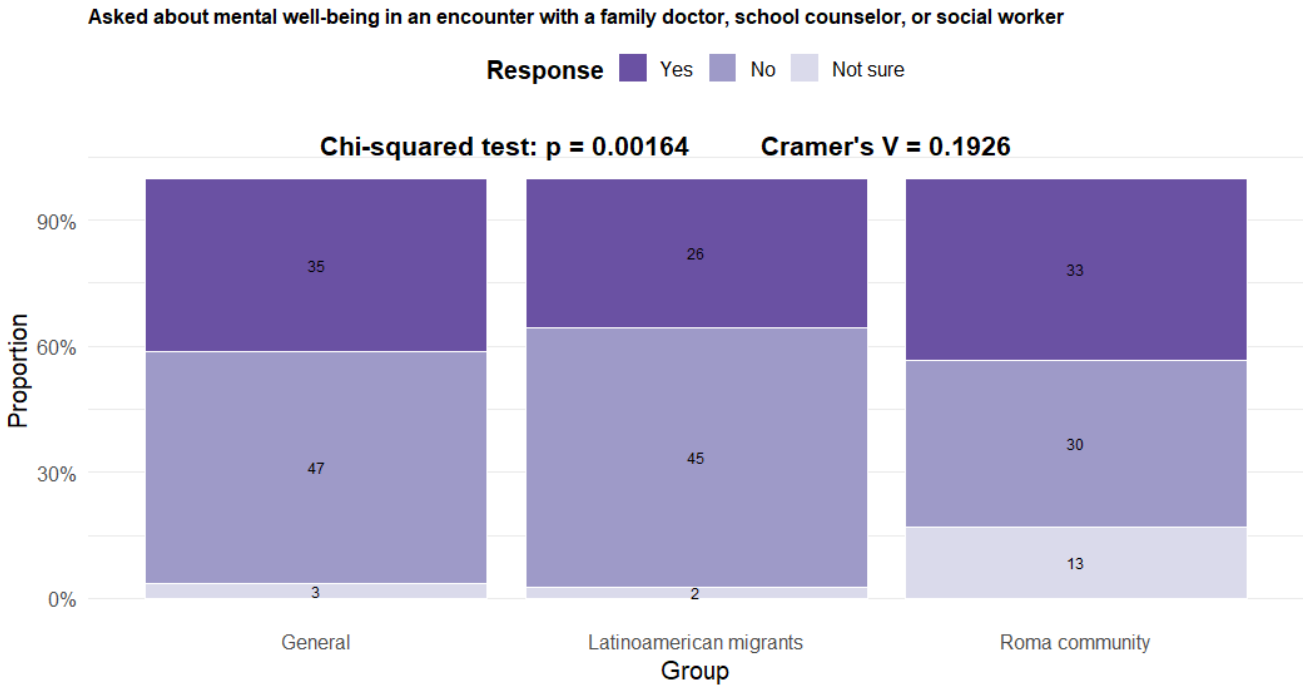


Figure 44: Chi-squared test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Spain

Table 33: Pairwise comparison test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.732	0.065
General group : Roma community	0.016	0.244
Latin American migrants: Roma community	0.009	0.282

Furthermore, significant differences were found regarding whether respondents had come across outreach programs related to mental health services (Figure 47; Table 34). All pairwise comparisons between groups were statistically significant, including differences between the general population and Latin American migrants (p = 0.0005, Cramer's V = 0.458), between the general population and the Roma community (p = 0.0110, Cramer's V = 0.228), and between Latin American migrants and the Roma community (p = 0.0010, Cramer's V = 0.364). Descriptive findings indicated that exposure to outreach programs was most frequently reported in the general population, followed by the Roma

community, and least frequently among Latin American migrants. The corresponding effect sizes ranged from small to moderate, with some approaching larger effects.

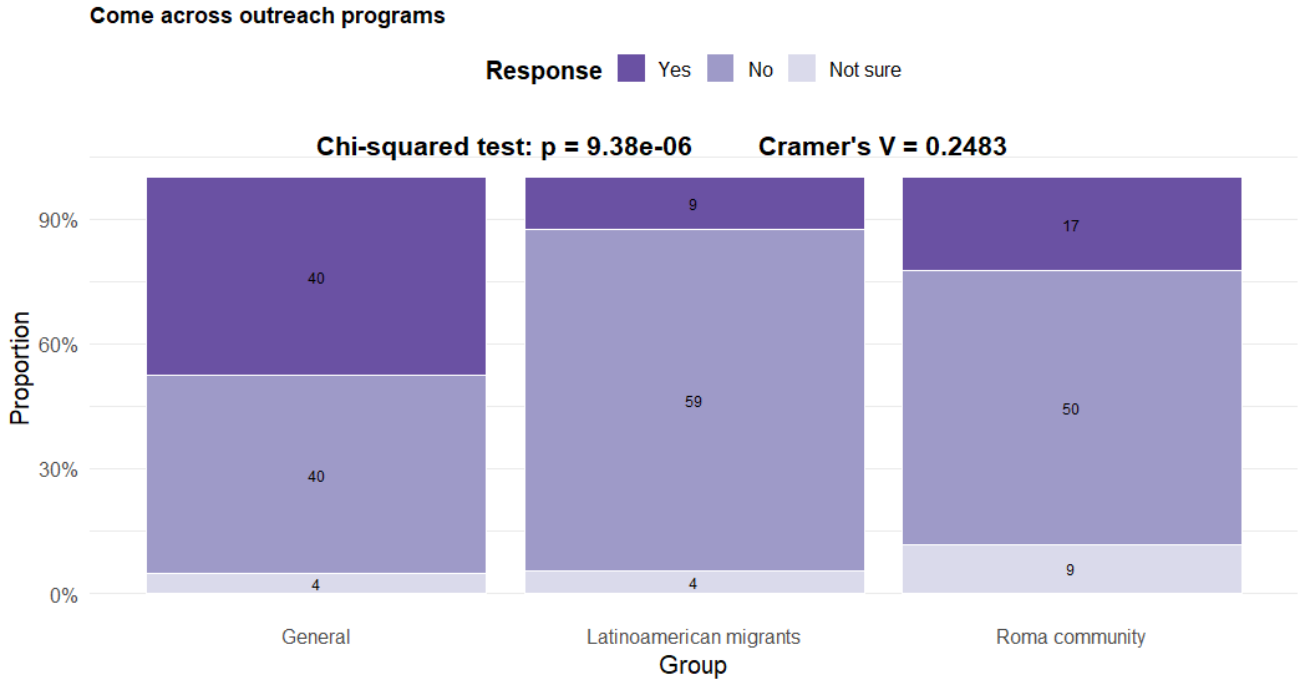


Figure 45: Fisher's test of the come across outreach programs item in Spain

Table 34: Pairwise comparison test of the come across outreach programs item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.0005	0.458
General group : Roma community	0.0110	0.228
Latin American migrants: Roma community	0.0010	0.364

Finally, statistically significant differences were observed regarding whether respondents had been invited to participate in mental health-related activities or research (Figure 48; Table 35). This difference was primarily observed between the general population and Latin American migrants (p = 0.003, Cramer's V = 0.279), with respondents in the general population more frequently reporting invitations compared to Latin American migrants. No significant differences were identified between the general population and the Roma community (p = 0.166, Cramer's V = 0.154), or between Latin American migrants and the Roma community (p = 0.166, Cramer's V = 0.150).

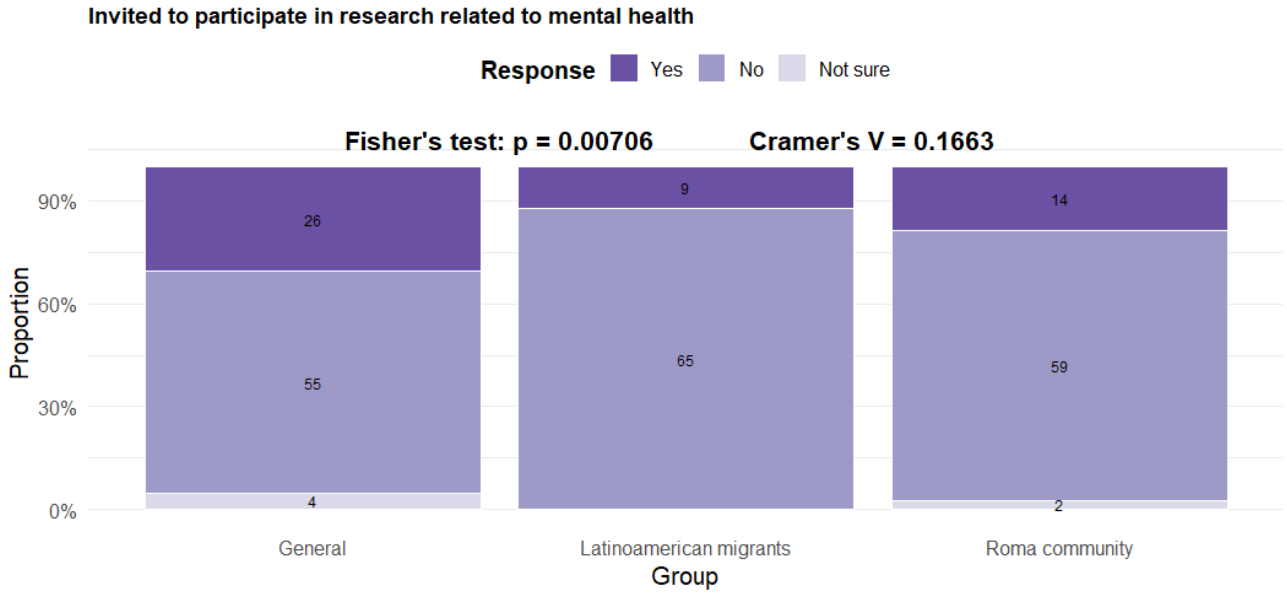


Figure 46: Fisher's test of the invited to participate in research related to mental health item in Spain

Table 35: Pairwise comparison test of the invited to participate in research related to mental health item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.003	0.279
General group : Roma community	0.166	0.154
Latin American migrants: Roma community	0.166	0.150

Acceptability

Within the Acceptability dimension, most items did not demonstrate statistically significant differences between the population groups. Specifically, no significant variation was observed regarding the option to communicate with a mental health provider in a preferred language, the possibility to choose one's own doctor or therapist, perceptions that mental health professionals communicate respectfully, whether patient rights were protected against mistreatment or abuse, or whether mental health services were considered trustworthy (Figure 49 & Figure 50; all p-values > 0.05). These findings suggest that perceptions of communication, choice of provider, respectful treatment, and overall trust in services were broadly comparable across the general population, Latin American migrants, and Roma community.

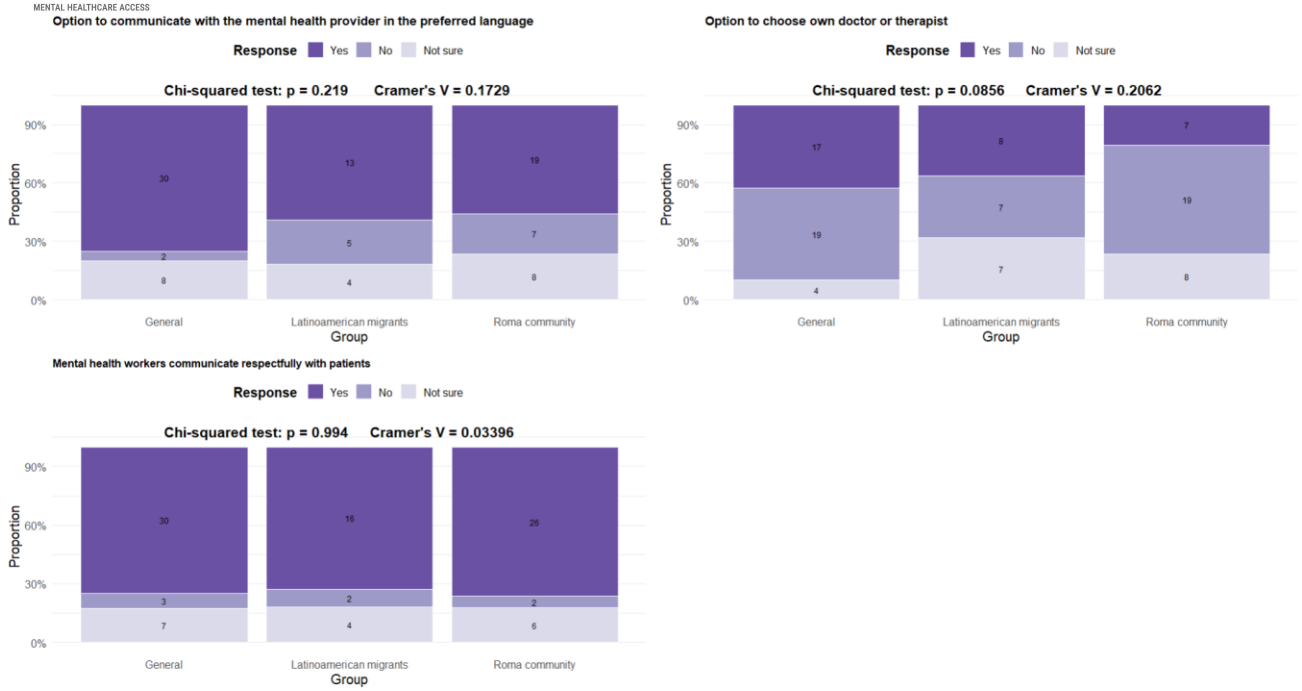


Figure 47: Non-significant differences across groups for the Acceptability dimension in Spain (1)

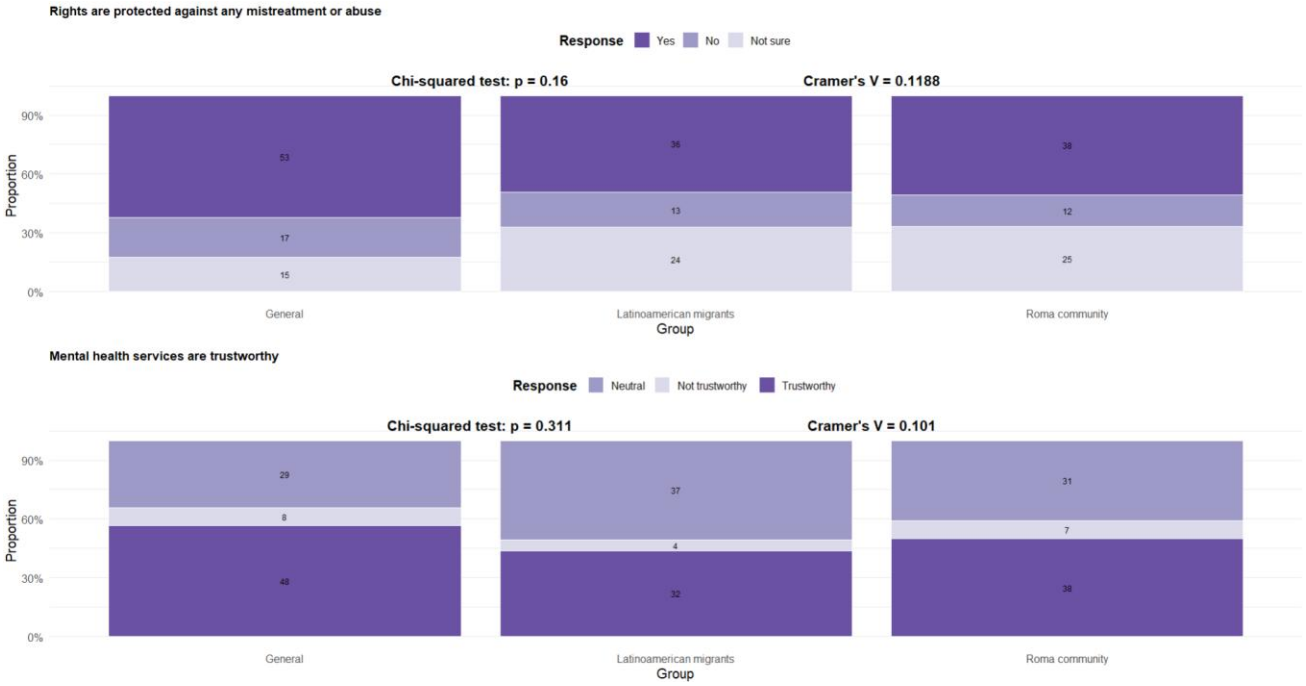


Figure 48: Non-significant differences across groups for the Acceptability dimension in Spain (2)

In contrast, a statistically significant difference was observed for perceptions that mental health services are sensitive to cultural beliefs and practices (Figure 51; Table 36). Pairwise comparisons indicated significant differences between the general population and Latin American migrants (p = 0.002, Cramer's V = 0.304), as well as between the general population and the Roma community (p = 0.002, Cramer's V = 0.293). No statistically significant difference was identified between Latin

American migrants and the Roma community (p = 0.374, Cramer's V = 0.116). Descriptive results indicated that respondents from the general population more frequently reported that cultural beliefs and practices were taken into account during mental health care, while both migrant groups reported lower levels of perceived cultural sensitivity. The corresponding effect sizes indicate moderate associations, suggesting meaningful differences between the general population and migrant groups.

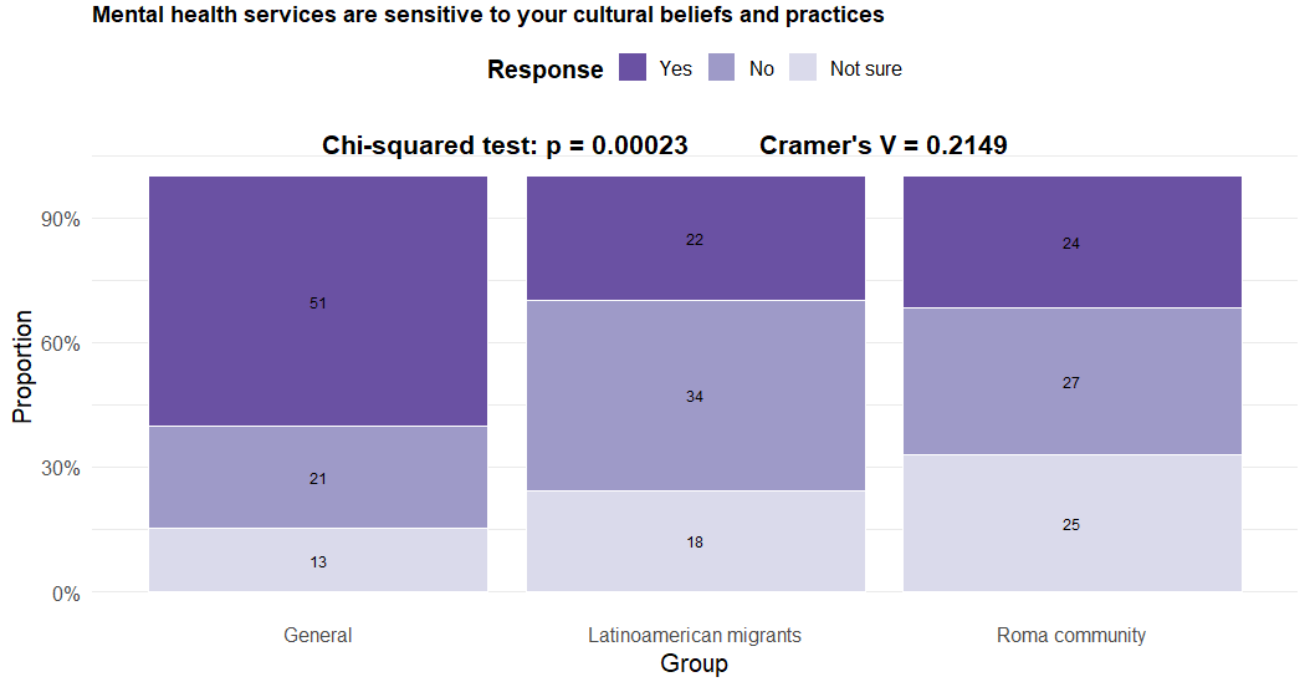


Figure 49: Chi-squared test of the mental health services are sensitive to your cultural beliefs and practices item in Spain

Table 36: Pairwise comparison test of the mental health services are sensitive to your cultural beliefs and practices item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.002	0.304
General group : Roma community	0.002	0.293
Latin American migrants: Roma community	0.374	0.116

Affordability

Within the Affordability dimension, several indicators did not demonstrate statistically significant differences between population groups (Figure 52). These included the possibility of obtaining mental health services through public programs or services free of charge or at low cost, receiving financial support or discounts to reduce the costs of care, receiving assistance from services with payment options or insurance-related questions, and having health insurance that covers mental

health services (all p-values > 0.05). These findings suggest that structural financial support mechanisms and insurance-related assistance were reported similarly across the general population, Latin American migrants, and Roma community.

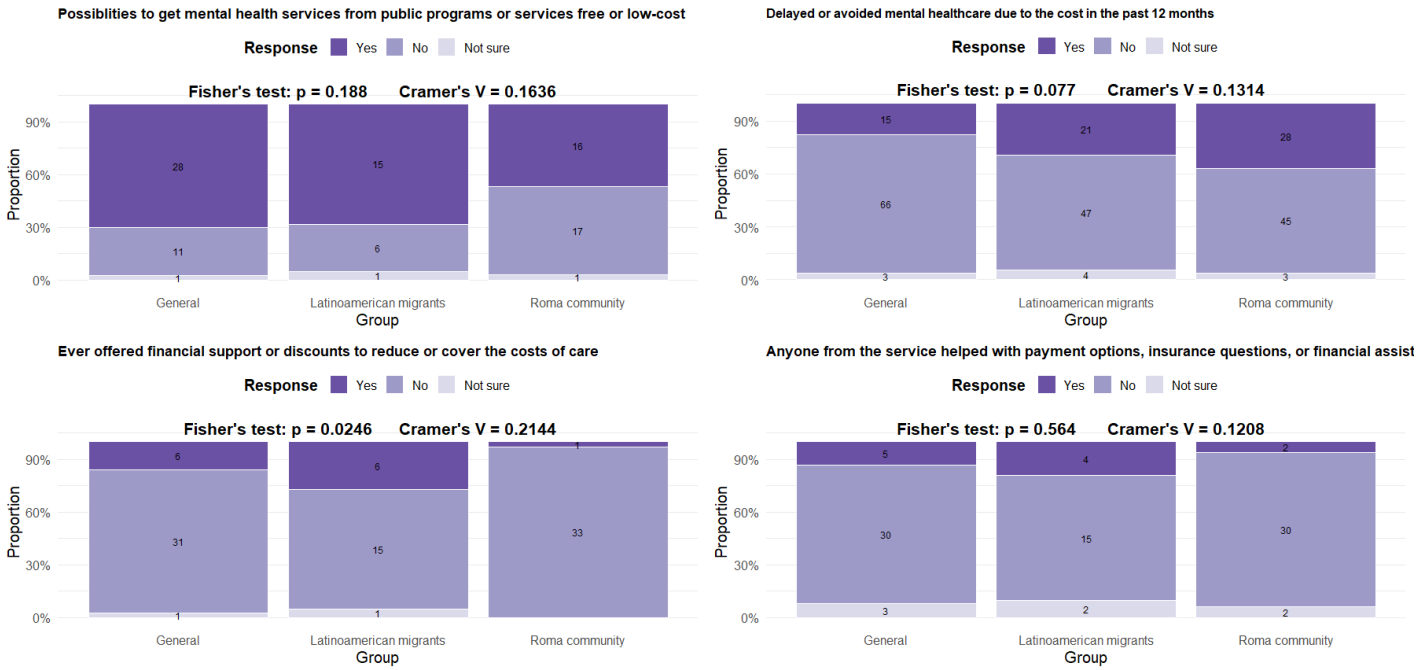


Figure 50: Non-significant differences across groups for the Affordability dimension in Spain

A significant difference was identified for delayed or avoided mental health care due to financial constraints in the past 12 months (Figure 53; Table 37). Pairwise comparisons showed significant differences between the general population and Latin American migrants (p = 0.017, Cramer's V = 0.255), between the general population and the Roma community (p = 0.002, Cramer's V = 0.391), and between Latin American migrants and the Roma community (p = 0.017, Cramer's V = 0.258). Descriptive findings indicated that respondents from the Roma community more frequently reported delaying or avoiding care due to costs compared to the other groups. The corresponding effect sizes indicate small to moderate associations, with the largest difference observed between the general population and the Roma community.

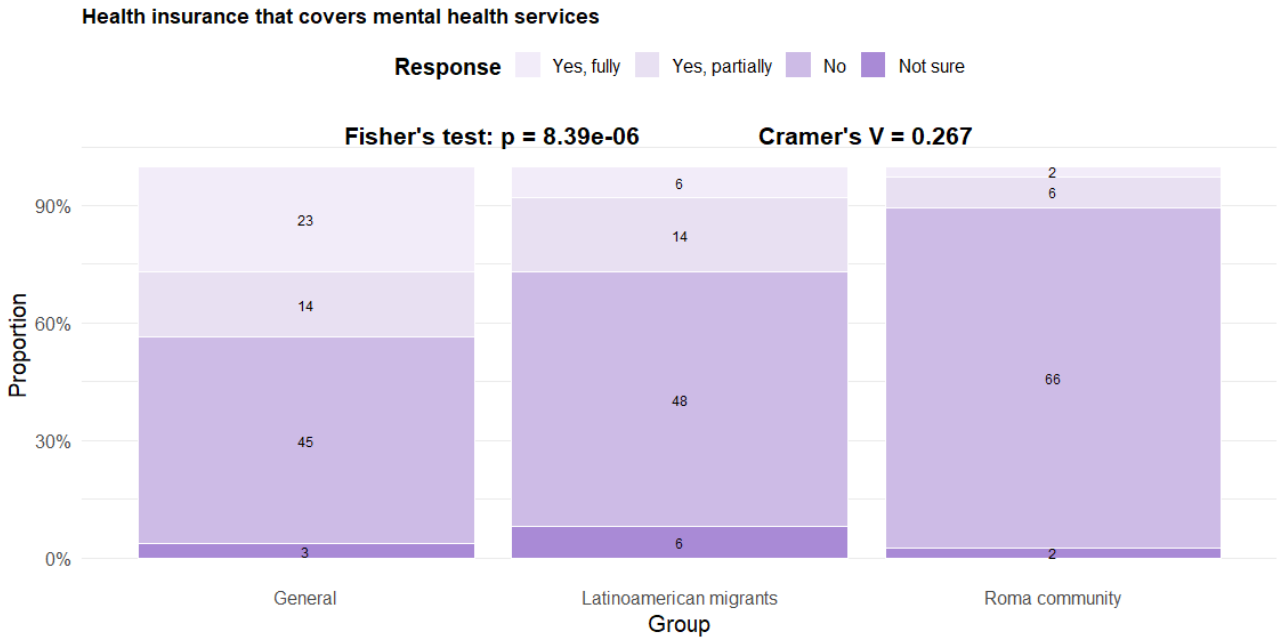


Figure 51: Fisher's test of the health insurance that covers mental health services item in Spain

Table 37: Pairwise comparison test of the health insurance that covers mental health services item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.017	0.255
General group : Roma community	0.002	0.391
Latin American migrants: Roma community	0.017	0.258

Differences were also observed in relation to not taking prescribed medication due to financial constraints (Figure 54; Table 38). Statistically significant differences were identified between the general population and the Roma community (p = 0.0005, Cramer's V = 0.407), as well as between Latin American migrants and the Roma community (p = 0.018, Cramer's V = 0.282). No statistically significant difference was observed between the general population and Latin American migrants (p = 0.145, Cramer's V = 0.199). Descriptive results indicated that respondents from the Roma community more frequently reported not taking prescribed medication due to cost-related barriers.

The observed effect sizes ranged from small to moderate, with the strongest difference occurring between the general population and the Roma community.

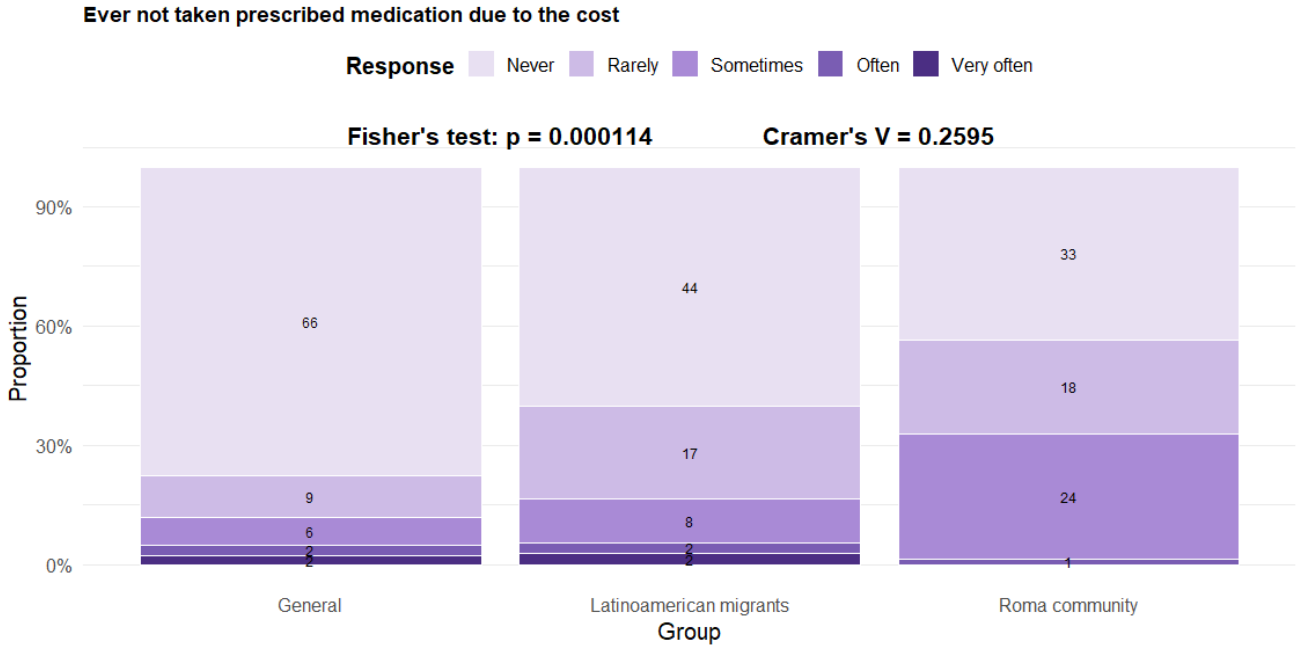


Figure 52: Fisher's test of the ever not taken prescribed medication due to the cost item in Spain

Table 38: Pairwise comparison test of the ever not taken prescribed medication due to the cost item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.145	0.199
General group : Roma community	0.0005	0.407
Latin American migrants: Roma community	0.018	0.282

Furthermore, significant differences were found for difficulty accessing mental health services due to loss of income (Figure 55; Table 39). Differences were identified between the general population and the Roma community (p = 0.005, Cramer's V = 0.329), as well as between Latin American migrants and the Roma community (p = 0.013, Cramer's V = 0.289). No statistically significant difference was observed between the general population and Latin American migrants (p = 0.854, Cramer's V = 0.094). Descriptive findings indicated that respondents from the Roma community

more frequently reported experiencing financial barriers related to income loss. The corresponding effect sizes indicate small to moderate associations.

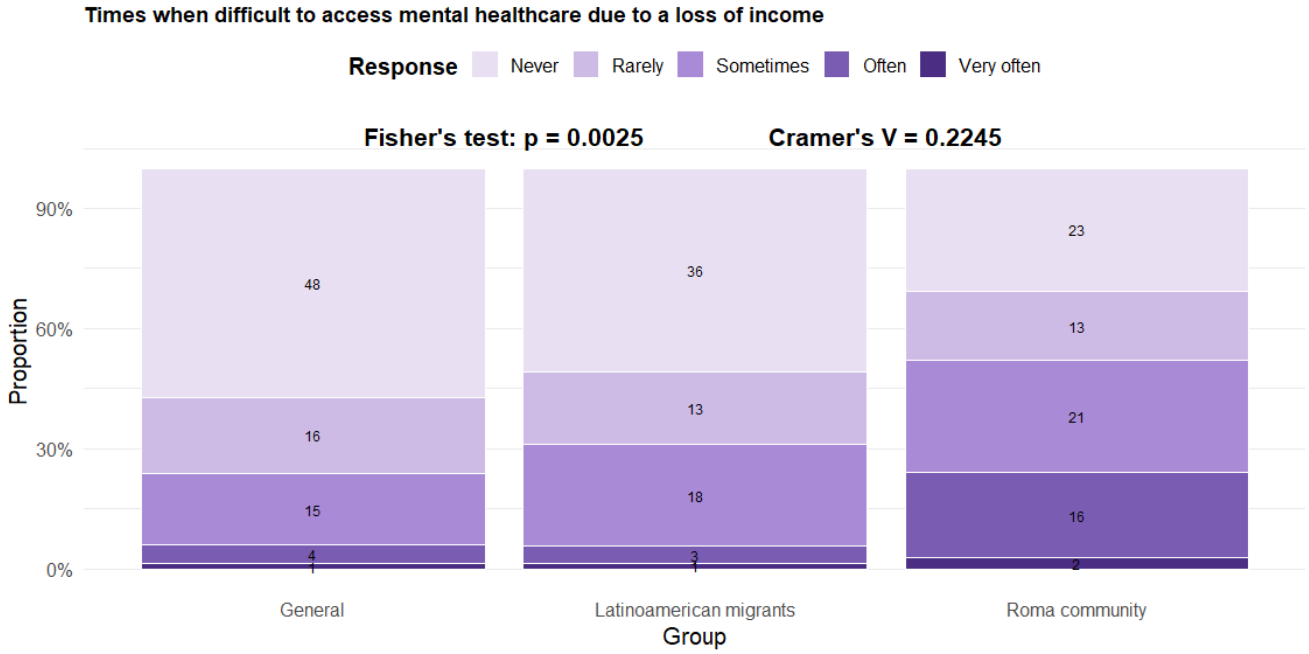


Figure 53: Fisher's test of the times when difficult to access mental healthcare due to a loss of income item in Spain

Table 39: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.854	0.094
General group : Roma community	0.005	0.329
Latin American migrants: Roma community	0.013	0.289

Similarly, statistically significant differences were observed for difficulty accessing mental health services due to additional costs (Figure 56; Table 40). These differences were identified between the general population and the Roma community (p = 0.002, Cramer's V = 0.428), as well as between Latin American migrants and the Roma community (p = 0.004, Cramer's V = 0.326). No significant difference was found between the general population and Latin American migrants (p = 0.219, Cramer's V = 0.190). Descriptive results indicated that respondents from the Roma community more frequently experienced difficulties accessing services due to additional costs. The effect sizes indicate moderate associations, particularly for comparisons involving the Roma community.

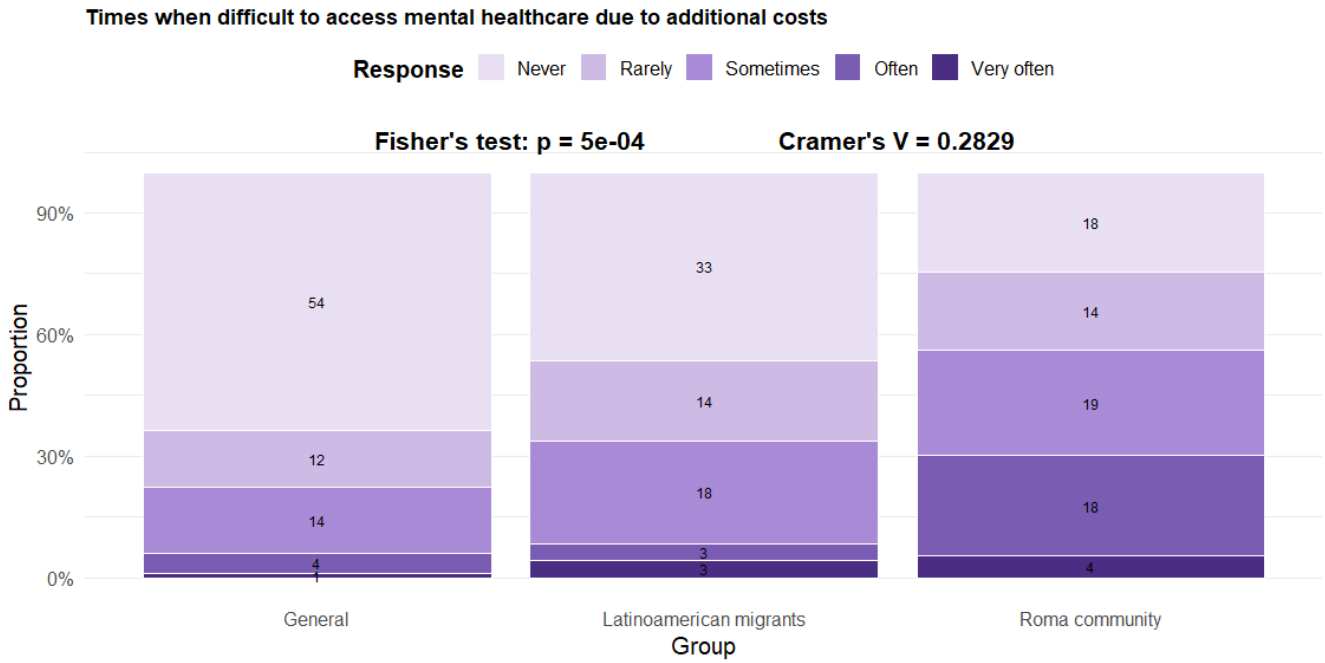


Figure 54: Chi-squared test of the times when difficult to access mental healthcare item due to additional costs in Spain

Table 40: Chi-squared test of the times when difficult to access mental healthcare item due to additional costs in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.219	0.190
General group : Roma community	0.002	0.428
Latin American migrants: Roma community	0.004	0.326

Appropriateness

Within the Appropriateness dimension, several items did not show statistically significant differences between population groups (Figure 57 & Figure 58). These included whether providers explained information in an understandable way, involvement in setting treatment goals, ease of arranging follow-up appointments, continuity of care with the same provider, support offered to caregivers or family members, and whether users received invitations to provide feedback regarding their mental health treatment (all p-values > 0.05). These findings indicate that core aspects of care continuity,

participation, and communication clarity were generally reported similarly across the general population, Latin American migrants, and Roma community.

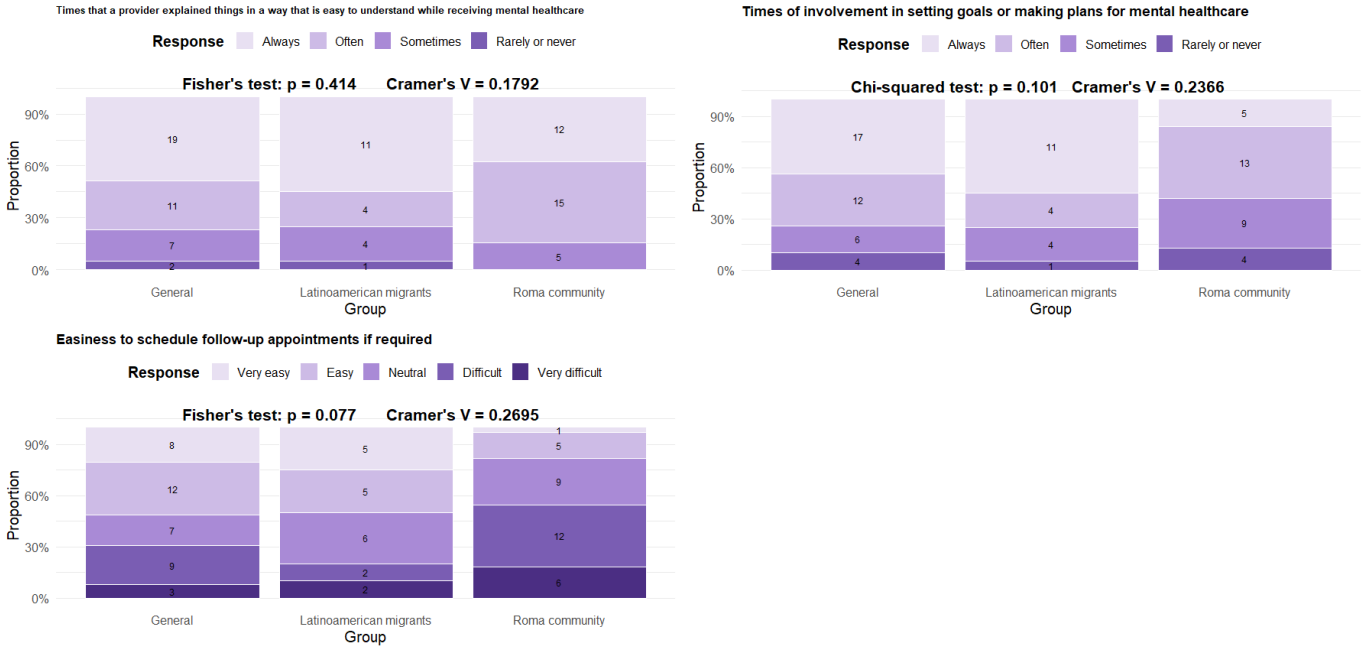


Figure 55: Non-significant differences across groups for the Appropriateness dimension in Spain (1)

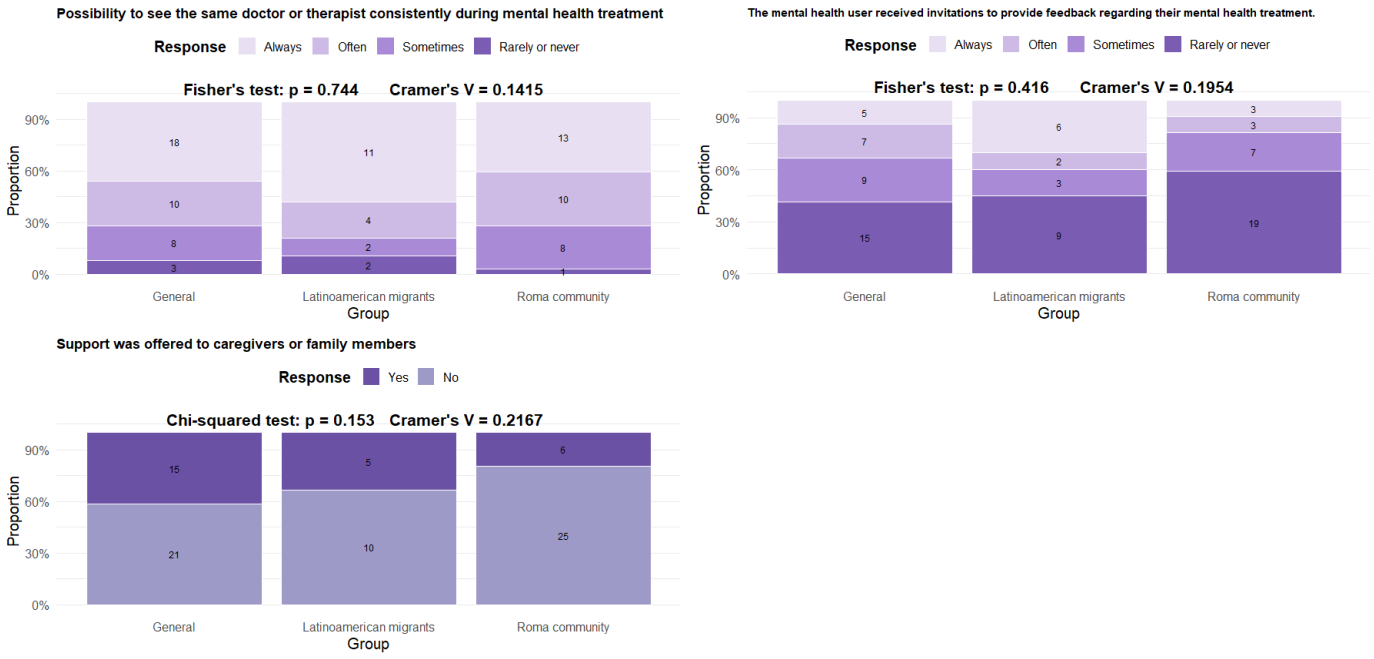


Figure 56: Non-significant differences across groups for the Appropriateness dimension in Spain (2)

Despite these similarities, a number of other indicators within this dimension revealed statistically significant differences between groups.

A significant difference was observed for whether mental health professionals treated clients with courtesy and respect (Figure 59; Table 41). This difference was primarily identified between the general population and Latin American migrants (p = 0.008, Cramer's V = 0.428), with Latin American migrants more frequently reporting respectful treatment. No statistically significant differences were found between the general population and the Roma community (p = 0.214, Cramer's V = 0.264), or between Latin American migrants and the Roma community (p = 0.341, Cramer's V = 0.275). The corresponding effect size indicates a moderate association, suggesting a meaningful difference in perceived respectful treatment.

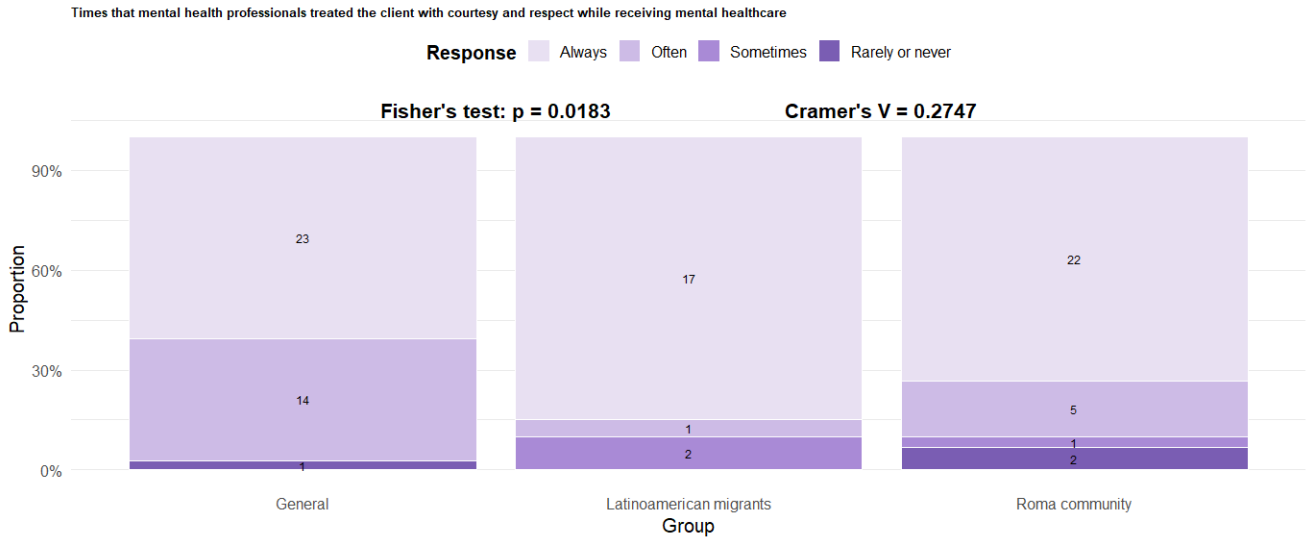


Figure 57: Fisher's test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare item in Spain

Table 41: Pairwise comparison test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.008	0.428
General group : Roma community	0.214	0.264
Latin American migrants: Roma community	0.341	0.275

Perceptions of whether mental health services were helpful or relevant also differed between groups (Figure 60; Table 42). Significant differences were identified between the general population and the

Roma community (p = 0.020, Cramer's V = 0.357), as well as between Latin American migrants and the Roma community (p = 0.003, Cramer's V = 0.554). No significant difference was found between the general population and Latin American migrants (p = 0.347, Cramer's V = 0.236). Descriptive results indicated that respondents from the Roma community reported lower levels of perceived helpfulness of services compared to the other groups. The effect sizes ranged from moderate to large, indicating substantial differences.

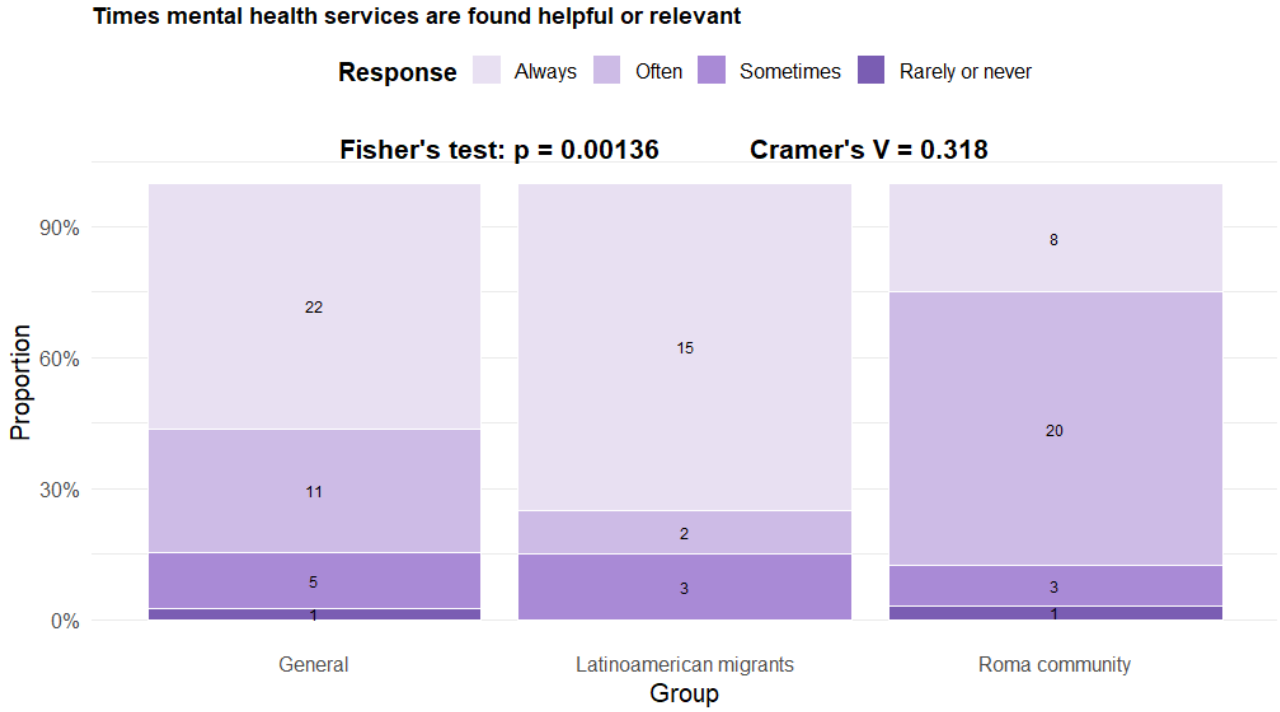


Figure 58: Fisher's test of the times mental health services are found helpful or relevant item in Spain

Table 42: Pairwise comparison test of the times mental health services are found helpful or relevant item in Spain

Comparison	P Value adjusted Fisher's test	Cramer's V
General group: Latin American migrants	0.347	0.236
General group : Roma community	0.020	0.357
Latin American migrants: Roma community	0.003	0.554

Differences were also observed regarding whether cultural beliefs and practices were taken into account during mental health care. Statistically significant differences were found across all group between Latin American migrants and the Roma community (p = 0.002, Cramer's V = 0.595). Descriptive findings indicated that Latin American migrants most frequently reported that cultural

beliefs were considered, followed by the general population, while respondents from the Roma community reported this least frequently. The observed effect sizes indicate moderate to large associations, suggesting meaningful disparities across groups (Figure 61; Table 43).

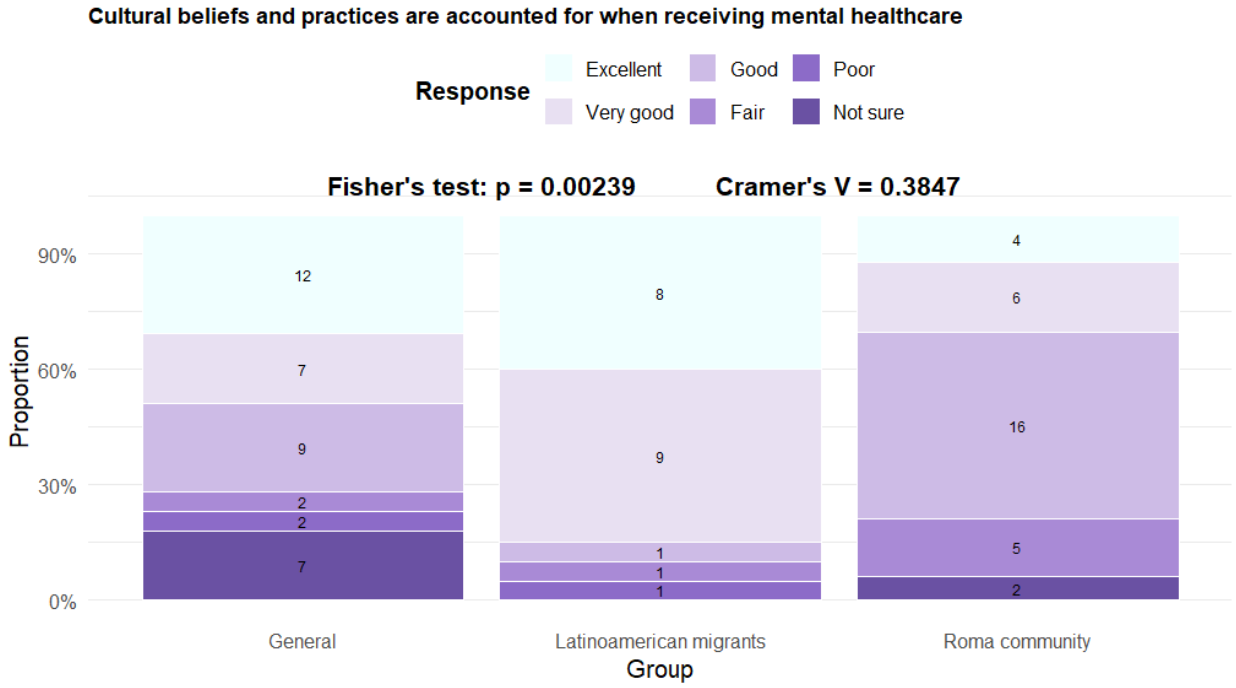


Figure 59: Fisher's test of the cultural beliefs and practices are accounted for when receiving mental healthcare item in Spain

Table 43: Pairwise comparison test of the cultural beliefs and practices are accounted for when receiving mental healthcare item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.064	0.412
General group : Roma community	0.058	0.403
Latin American migrants: Roma community	0.002	0.595

Furthermore, significant differences were found for the item assessing whether mental health providers considered broader life experiences (Figure 62; Table 44). These differences were observed between the general population and the Roma community (p = 0.020) and between Latin American migrants and the Roma community (p = 0.002, Cramer's V = 0.594). Descriptive patterns indicated that respondents from the Roma community reported lower levels of perceived

consideration of life circumstances compared to the other groups. The effect sizes suggest moderate to large associations, indicating notable group-level variation.

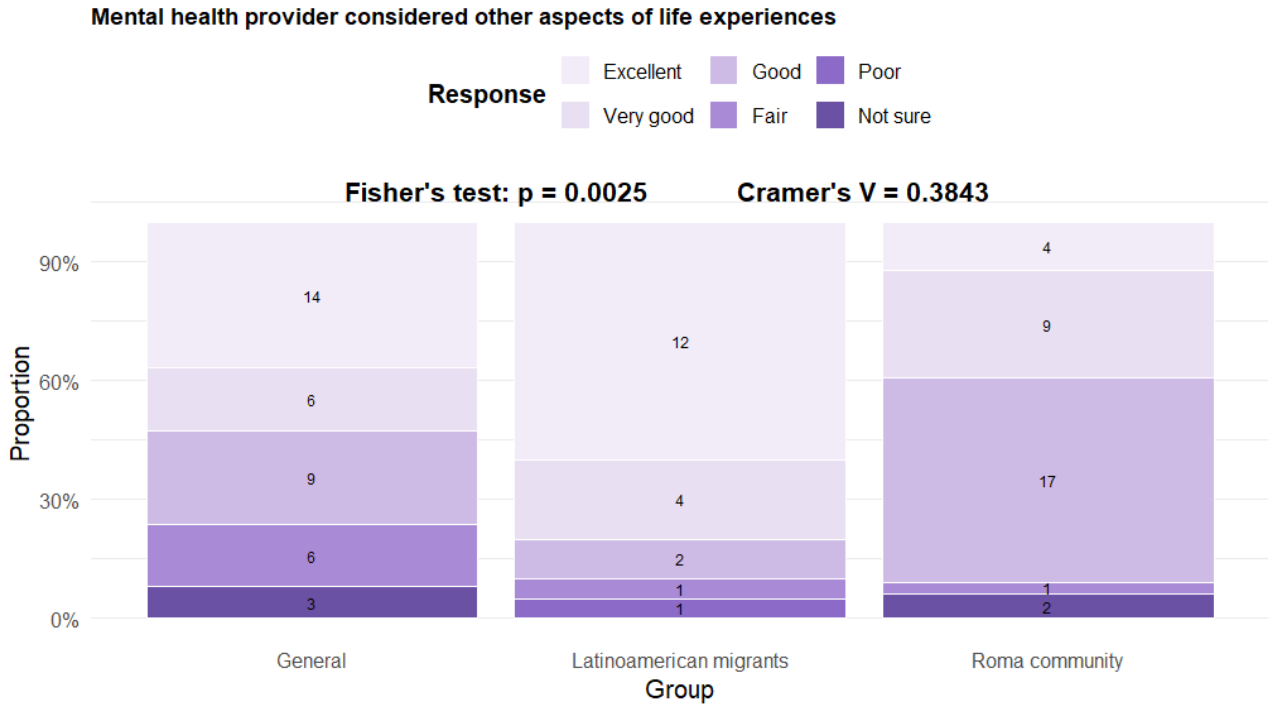


Figure 60: Fisher's test of the mental health provider considered other aspects of life experiences item in Spain

Table 44: Pairwise comparison test of the mental health provider considered other aspects of life experiences item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.207	0.365
General group : Roma community	0.020	NC
Latin American migrants: Roma community	0.002	0.594

In addition, experiences related to smooth referral between services, without requiring users to repeatedly explain their situation, differed significantly between groups (Figure 63 & Table 45). A statistically significant difference was observed between the general population and the Roma community (p = 0.006, Cramer's V = 0.446), with respondents from the Roma community reporting less favorable referral experiences. No significant differences were found between the general population and Latin American migrants (p = 0.285, Cramer's V = 0.267), or between Latin

American migrants and the Roma community (p = 0.285, Cramer's V = 0.291). The corresponding effect size indicates a moderate association, suggesting meaningful differences in coordination of care.

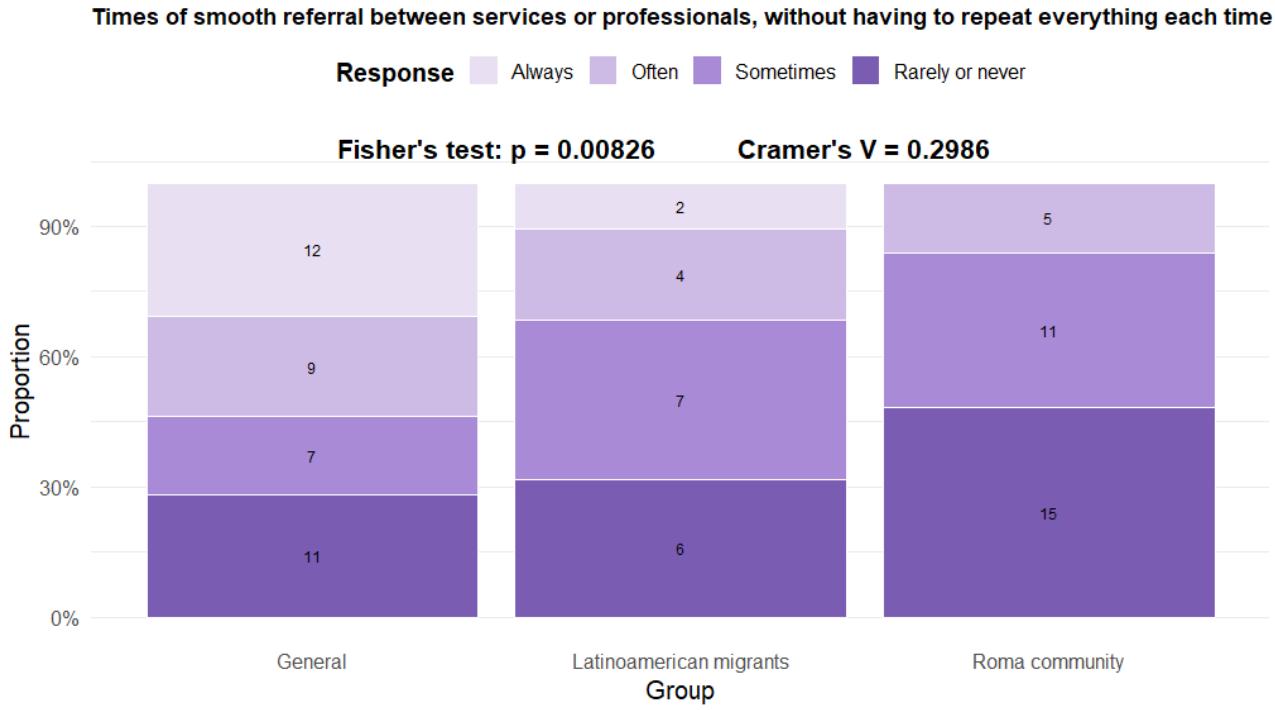


Figure 61: Fisher's test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Spain

Table 45: Pairwise comparison test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.285	0.267
General group : Roma community	0.006	0.446
Latin American migrants: Roma community	0.285	0.291

Finally, perceptions that user feedback was used to improve services also differed significantly between groups (Figure 64; Table 46). Differences were observed between the general population and the Roma community (p = 0.014, Cramer's V = 0.430), as well as between Latin American migrants and the Roma community (p = 0.008, Cramer's V = 0.551). No significant difference was identified between the general population and Latin American migrants (p = 0.714, Cramer's V =

0.172). Descriptive findings indicated that respondents from the Roma community were less likely to report that their feedback contributed to service improvement. The corresponding effect sizes indicate moderate to large associations.

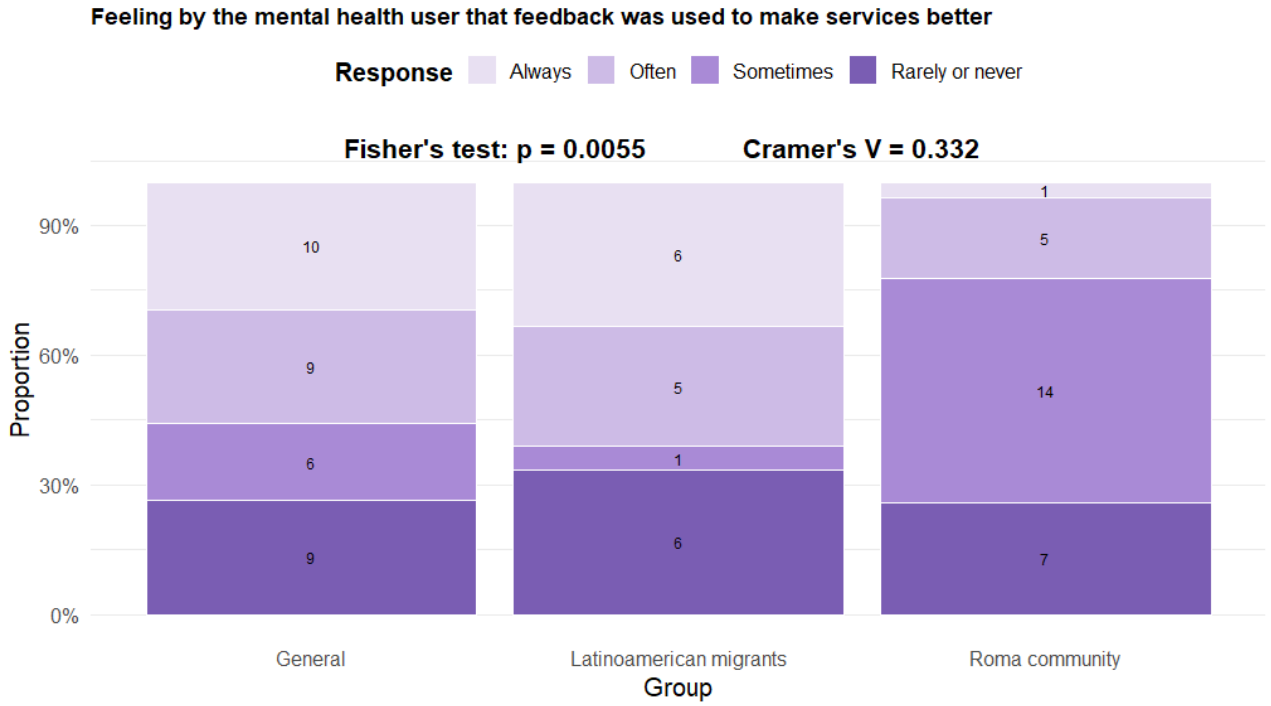


Figure 62: Chi-squared test of the feeling by the mental health user that feedback was used to make services better item in Spain

Table 46: Pairwise comparison test of the feeling by the mental health user that feedback was used to make services better item in Spain

Comparison	P Value adjusted Chi-squared test	Cramer's V
General group: Latin American migrants	0.714	0.172
General group : Roma community	0.014	0.430
Latin American migrants: Roma community	0.008	0.551

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, showed relatively high utility values across all population groups. The overall mean utility score in the present dataset was 0.788 (SD = 0.190). Group-specific means were 0.787 (SD = 0.185) for the general group, 0.762 (SD = 0.172) for the Roma community, and 0.814 (SD = 0.211) for Latin American migrants. For comparison, national reference values derived from the Spanish population data, as reported by Garcia-Gordillo, Adsuar & Olivares (2020)[17] indicated a mean utility value of 0.897. When compared with this

national reference, utility scores observed in the present dataset were descriptively lower across all study groups, suggesting somewhat reduced health-related quality of life relative to the general Spanish population.

Self-perceived health

Self-perceived health was assessed using items corresponding to those included in the EU Statistics on Income and Living Conditions (EU-SILC) Spain dataset, allowing comparison with national distributions reported through Eurostat EU-SILC Spain data. As subgroup-specific national estimates for Roma and Latin American migrant populations were not available, comparisons were conducted primarily at the overall population level.[12]. Across the study population, the majority of respondents reported good or very good health, particularly within the general group and the Latin American migrant group. In the general population, 54.1% reported good health and 18.8% reported very good health. Among Latin American migrants, similar patterns were observed, with 52.5% reporting good health and 27.9% reporting very good health. In contrast, the Roma community showed a higher proportion of respondents reporting fair health (32.9%) and a smaller proportion reporting very good health (6.6%) compared with other groups (Table 47) When compared with national estimates derived from the EU-SILC Spain dataset, overall distributions were broadly comparable, with the majority of individuals reporting good health. However, the Roma community in the present dataset demonstrated relatively higher proportions of fair health and lower proportions of very good health compared with national patterns (Table 48).

Table 47: Self-perceived health in the dataset of Spain

	General group	Latin American migrants	Roma community
Very bad, *n (%)*	1 (1.2)	0 (0.0)	1 (1.3)
Bad, *n (%)*	2 (2.4)	2 (3.3)	0 (0.0)
Fair (neither good nor bad), *n (%)*	20 (23.5)	10 (16.4)	25 (32.9)
Good, *n (%)*	46 (54.1)	32 (52.5)	45 (59.2)
Very good, *n (%)*	16 (18.8)	17 (27.9)	5 (6.6)
Missing, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0

Table 48: Self-perceived health in the dataset of EU-SILC dataset of Spain

	Total country
Very bad, %	1.2
Bad, %	3.6
Fair (neither good nor bad), %	16.8
Good, %	57.8
Very good, %	20.6

Activity limitations

Activity limitations were evaluated using indicators aligned with those included in the EU-SILC Spain dataset, enabling comparison with national-level estimates of functional limitation[13]. Within the present dataset, the majority of respondents reported no activity limitations, although notable differences between groups were observed. Among Latin American migrants, 82.0% reported no limitations, representing the highest proportion across groups. In the general population, 52.9% reported no limitations, while 31.8% reported moderate limitations. The Roma community reported similar levels of no limitations (55.3%), although a higher proportion reported moderate limitations (36.8%) compared with migrants (Table 49). Compared with national reference values from EU-SILC Spain, where the majority of the population reports no limitations, the present dataset suggests higher levels of reported limitations, particularly within the general and Roma groups (Table 50).

Table 49: Activity limitations in the dataset of Spain

	General group	Latin American migrants	Roma community
Severely limited , *n (%)*	12 (14.1)	3 (4.9)	6 (7.9)
Limited, *n (%)*	27 (31.8)	8 (13.1)	28 (36.8)
Not limited, *n (%)*	45 (52.9)	50 (82.0)	42 (55.3)
Missing, *n (%)*	1 (1.2)	0 (0.0)	0 (0.0)

Table 50: Activity limitations in the EU-SILC dataset of Spain

	Total country
Severely limited, %	2.6

Limited, %	12.1
Not limited, %	85.3

Unmet need for care

Unmet need for healthcare was assessed using indicators corresponding to those included in the EU-SILC Spain dataset, allowing comparison with national-level estimates reported through Eurostat EU-SILC Spain data.[14]. Several barriers to accessing care were identified across groups. Among the general population, waiting lists were the most frequently reported barrier (35.3%), followed by cost-related barriers (10.6%). Within the Latin American migrant group, waiting lists (14.8%) and cost-related barriers (11.5%) were also reported, although a relatively higher proportion reported no unmet needs (52.5%). In contrast, the Roma community reported substantially higher levels of unmet need across several categories. Specifically, waiting lists (46.1%), cost-related barriers (35.5%), travel distance (19.7%), and fear of treatment (21.1%) were frequently reported. Only 18.4% of Roma respondents reported no unmet needs (Table 51). National reference values derived from the EU-SILC Spain dataset indicate that the vast majority of the population reports no unmet healthcare needs. Compared with these national estimates, the present dataset suggests considerably higher levels of unmet need, particularly within the Roma community (Table 52).

Table 51: Unmet need for care in the dataset of Spain

	General group	Latin American migrants	Roma community
Too expensive, *n (%)*	9 (10.6)	7 (11.5)	27 (35.5)
Too far to travel, *n (%)*	1 (1.2)	0 (0.0)	15 (19.7)
No time, *n (%)*	3 (4.7)	3 (4.9)	10 (13.2)
Didn't know any good doctor or specialist, *n (%)*	7 (8.2)	4 (6.6)	5 (6.6)
Waiting list, *n (%)*	30 (35.3)	9 (14.8)	35 (46.1)
Fear of doctor, hospital examination or treatment, *n (%)*	6 (7.1)	3 (4.9)	16 (21.1)

Wanted to wait and see if problem got better on its own, *n (%)*	12 (14.1)	6 (9.8)	15 (19.7)
Other reason, *n (%)*	6 (7.1)	4 (6.6)	0 (0.0)
No unmet needs to declare, *n (%)*	35 (41.2)	32 (52.5)	14 (18.4)
Missing, *n (%)*	0 (0.0)	0 (0.0)	1 (1.3)

Table 52: Unmet need for care in the EU-SILC dataset of Spain

	Total country
Too expensive, %	0.1
Too far to travel, %	0.0
No time, %	0.3
Didn't know any good doctor or specialist, %	0.0
Waiting list, %	0.3
Fear of doctor, hospital examination or treatment, %	0.0
Wanted to wait and see if problem got better on its own, %	0.5
Other reason, %	0.1
No unmet needs to declare, %	98.6

Depression severity

Depressive symptom severity was assessed using indicators corresponding to those included in the European Health Interview Survey (EHIS) Spain dataset, enabling comparison with national mental health distributions reported through Eurostat EHIS Spain data.[15]. Across the study population, most respondents reported mild or minimal depressive symptoms, although group differences were observed. Within the general population, mild symptoms were most common (44.7%), followed by none or minimal symptoms (34.1%). Among Latin American migrants, a slightly higher proportion reported none or minimal symptoms (45.9%). In contrast, the Roma community reported higher proportions of moderate and moderately severe symptoms compared with other groups, alongside

lower proportions of minimal symptoms (Table 53). National estimates from the EHIS Spain dataset indicate that the majority of the population reports none or minimal depressive symptoms, with only small proportions reporting moderate or severe symptoms. Compared with these national estimates, the present dataset suggests higher levels of depressive symptom severity, particularly among Roma participants (Table 54).

Table 53: Depression severity in the dataset of Spain

	General group	Latin American migrants	Roma community
Severe, *n (%)*	0 (0.0)	2 (3.3)	0 (0.0)
Moderately severe, *n (%)*	6 (7.1)	2 (3.3)	7 (9.2)
Moderate, *n (%)*	11 (12.9)	8 (13.1)	11 (14.5)
Mild, *n (%)*	38 (44.7)	20 (32.8)	37 (48.7)
None or minimum, *n (%)*	29 (34.1)	28 (45.9)	20 (26.3)
Missing, *n (%)*	1 (1.2)	1 (1.6)	1 (1.3

Table 54: Depression severity in the EHIS dataset of Spain

	Total country
Severe, %	0.4
Moderately severe, %	1.0
Moderate, %	2.4
Mild, %	8.2
None or minimum, %	88.0

4.3.2 Qualitative results

Approachability

Information awareness

All five interviews converge on the finding that mental health information is present but unevenly distributed and highly mediated, rather than systematically accessible. Stakeholders consistently indicate that awareness depends on intermediaries such as NGOs, primary care, or community actors, rather than on a coherent system-wide strategy.

The academic highlights that *"vulnerable populations are not receptive to external interventions that arrive in a 'parachuted' manner"* and *"the current strategy consists of approaching these populations through internal interlocutors, such as associations or community leaders"* (FISEVI, Academic). Thus, the academic emphasizes that information must come from within communities, stressing that top-down communication is insufficient when trust is lacking. Similarly, the NGO explains that awareness is actively created through community talks and neighbourhood engagement rather than formal channels (FISEVI, Community Representative NGO).

The academic and the civil society respondent are unambiguous: only community-mediated, trusted-figure-based information provision is effective for these populations. External information campaigns directed at marginalized communities are dismissed as "parachuted" interventions with no genuine penetration. The civil society respondent reinforces this by describing psychoeducation as something that must be introduced gradually, often from the first contact with users who do not initially recognise their distress as mental health-related (FISEVI, Civil Society).

The health provider presents a more system-based perspective, noting that information is mainly transmitted through primary care, suggesting a reliance on GP-mediated entry points rather than proactive outreach (FISEVI, Health Provider). In contrast, the service provider highlights a major structural gap, stating that there are many people "not in the network," indicating that awareness does not reach those most excluded (FISEVI, Service Provider).

Barriers to recognizing or seeking help

Barriers to help-seeking are multilayered and mutually reinforcing across individual, cultural, and structural levels. At the individual level, low health literacy and normalization of distress are universal findings. The civil society respondent's observation that Roma and migrant women "*do not identify emotional distress*" as a mental health issue is corroborated by the academic's broader framing of symptoms normalized within cultural frameworks (FISEVI, Civil Society & Academic).

An important analytical distinction emerges between pre-stigmatic non-recognition (not identifying distress as illness) and stigma-based avoidance (recognizing but concealing or avoiding care). The community representative and the civil society respondent both describe stigma-based avoidance, while the community representative describes a deeper prior barrier of non-recognition. The service provider identifies the system itself as the structural producer of barriers, characterised as expulsive toward those who do not meet administrative and behavioural profiles. Administrative precariousness, such as undocumented status, and irregular employment, creates absolute access barriers for those

in the most vulnerable situations. Taken together, these barriers form a cascade in which each level compounds the others, making help-seeking systematically harder for exactly those who need it most.

Acceptability

Cultural and Social fit

All five interviews highlight that mental health care must align with the social realities, cultural expectations, and individual readiness of service users. However, the interviews differ meaningfully in how they conceptualise what this fit requires in practice.

The academic makes the most analytically important argument: vulnerable populations cannot be treated as homogeneous groups, and cultural factors alone do not explain access barriers. Socioeconomic context is the more powerful explanatory variable. A South American person living in a deprived neighbourhood in Seville faces different barriers from a Latin American professional in a stable job, not primarily because of cultural difference but because of structural position. Similarly, within the Roma community, differences in access and acceptability are found according to socioeconomic status rather than cultural identity per se: "C*ulture is a factor, but it is not isolated from context. Even within Roma populations, differences are found according to socioeconomic status. Therefore, barriers are not exclusively cultural; they are deeply intertwined with socioeconomic factors"* (FISEVI, Academic)

The health provider corroborates this at the clinical level, describing how the health provider has adapted practice through direct experience rather than training, and noting that symptom expression differs across populations, migrant women tend to dissociate and somatize more, with trauma as the underlying explanation, and that care cannot be imposed in the same way across groups: "Y*ou must guide them slowly and subtly. You cannot impose our system directly"* (FISEVI, Health Provider)

The civil society respondent identifies the most consequential institutional failure on this dimension: the systematic over-application of the "adjustment disorder" diagnosis to migrant patients in the public system, which treats migration as the explanatory event and obscures pre-existing traumatic histories. This does not occur within NGO settings, where more time and a comprehensive assessment approach allow for a fuller clinical picture. NGO professionals generally have higher intercultural competence than public system professionals, and no homogeneous mandatory training in cultural competence exists in the public sector.

The service provider emphasises a temporal dimension of fit that is often overlooked: different individuals need different rhythms of engagement. Some people are not yet ready for formal care and

require patient, consistent relational presence over time before any intervention is possible: "*there are people who don't want to, or who need another rhythm, and then we have to adapt*" (FISEVI, Service Provider). The civil society respondent echoes this directly, noting that drop-out and disengagement often reflect readiness rather than rejection: "*others drop out or do not want support because they are not ready at that moment to begin a process or receive therapeutic care"* (FISEVI, Civil Society)

The Roma community representative shifts the frame from professional adaptation to community expectation, offering a perspective that is largely absent from the other four interviews. What the Roma community asks for is not special treatment or cultural exceptionalism, but ordinary professional equality: "*we always say we do not want special treatment — only professional, respectful treatment*" (FISEVI, Community Representative NGO)

Across the five interviews, acceptability is therefore not only about cultural adaptation in the conventional sense. It is equally about whether services can adjust to different life situations, different expressions of distress, different temporalities of readiness, and different expectations of what a service relationship should feel like.

Stigma

Stigma is identified across all five interviews as a significant barrier, but its mechanisms differ across populations and contexts. For Roma communities, stigma operates primarily through the social exposure risk inherent in close-knit community networks. Knowledge of someone seeking psychological help can circulate quickly, and the fear of others finding out is described as one of the most powerful deterrents to help-seeking. The Roma community representative describes a pattern in which women privately recognise their need but remain unable to act on it: *"Many women say: "I want to see a psychologist because I have problems with my husband or children," but then they remain silent and never actually seek help. There is shame and fear that the family will find out"* (FISEVI, Community Representative NGO).

For migrant populations, the civil society respondent describes a similar pattern of family concealment, with psychological problems hidden within the household and help rejected because it is associated with "being crazy." In rural settings, stigma is described as greater still, compounded by isolation, limited anonymity, and historically embedded patterns of concealment.

A distinct form of stigma is identified by the service provider: professional stigma directed at people with severe mental disorder within the somatic care system. People with psychiatric histories encounter additional gatekeeping when seeking care for physical complaints, with psychiatric

assessment sometimes required before treatment for unrelated conditions. This form of stigma does not discourage initial help-seeking but degrades the quality and equity of care once someone is within the system: "Y*ou can go to the emergency room for appendicitis and "the psychiatrist has to see it first". Why?*" (FISEVI, Service Provider)

Anti-stigma efforts exist but remain fragmented. The service provider's organisation positions stigma reduction as a core strategic line, including through community integration of residential facilities. FAKALI delivers training sessions for future nursing and psychology students. The community representative, however, points to a structural driver of stigma that these initiatives cannot easily address: the absence of Roma history and culture from school curricula, alongside the active role of social media in spreading racist content and its direct impact on Roma mental health.
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Availability

Distribution and sufficiency of services

All stakeholders converge on a diagnosis of structural under-provision in the public mental health system in Seville, though all illuminate a different dimension of this problem. The NGO representative describes severe shortages: approximately one to two psychologists serve roughly 21,000 inhabitants in public primary care, with waiting times of three to five months. Additionally, the representative notes personally accessing private services when needed, an option explicitly acknowledged as unavailable to the Roma families the organisation represents. The civil society respondent identifies the systemic consequence of this scarcity most directly. NGOs like ACCEM have become the de facto first line of psychological care for vulnerable populations, absorbing clinical demand that belongs to the public system: *"Currently, we are covering a need that the public health system cannot reach. We act as a first line of care and accompaniment, covering needs that are not met by the public network*" (FISEVI, Civil Society)

The service provider adds the critical dimension of the population entirely outside the network: a large number of people with severe mental disorder who have never been assessed, who do not attend appointments, and who would never enter care through conventional pathways without active outreach. The community representative confirms from within the public system that no specific

programs for Roma or migrant populations exist, and that undocumented individuals are directed to NGOs as a matter of course, creating a hard documentation-based exclusion boundary.

The academic reframes the availability problem qualitatively: the issue is not only how many services exist but whether the services that exist are designed to respond to what these populations need. In highly marginalised environments, unmet social needs generate expectations that differ from what the healthcare system is equipped to provide, producing a mismatch that makes available services functionally inaccessible even when physically present.

Timing, format, and accessibility of delivery

Even when services exist, their format and delivery models are misaligned with the daily realities of the most vulnerable populations. Morning-only appointment schedules conflict with precarious employment and childcare responsibilities. The academic documents persistent absenteeism rates of 20-25% despite SMS and phone reminders, framing this not as individual failure but as a structural mismatch between service design and community life: *"Lifestyle patterns significantly influence attendance. If there is no structured organization of time within the family environment, it becomes difficult to maintain scheduled appointments"* (FISEVI, Academic)

The civil society respondent adds geographic inequality: in rural areas, people may live in villages of 3,000 inhabitants with no local mental health resources, requiring travel to a neighbouring town for care. NGOs in areas with concentrated agricultural migrant populations have partially filled this gap, but as local community responses to structural failures rather than systemic solutions. "*This is mitigated in areas with concentrated migrant populations where NGOs have been working for a long time and where more resources are available. For example, rural areas where Moroccan women work in agriculture and where NGOs traditionally operate and assume mental health support among other responsibilities."* (FISEVI, Civil society)

The consistent alternative proposed across all five interviews is outreach and proactive, community-embedded service delivery. The service provider is most direct about this: *"We have to get out of the offices. Because that vulnerable population does not arrive in any other way"* (FISEVI, Service Provider).

Community Intensive Treatment Teams (CITTs) are cited as a promising model for this approach, providing home care and street care to individuals who cannot be reached through standard appointment pathways. However, the service provider cautions that CITTs only fulfil this function when

they genuinely operate as outreach units, a CITT that reverts to office-based appointments provides no structural advantage over any other service.

Affordability

Direct and indirect costs

Direct healthcare costs within the Spanish public system are not consistently identified as the primary financial barrier for regularised patients. The more significant barriers are indirect: the economic cost of attending morning appointments in lost working hours, transport costs, and the structural exclusion of undocumented individuals from the public system entirely. For people working in informal or precarious employment, the decision to attend a mental health appointment involves a concrete financial sacrifice that many cannot absorb.

The civil society respondent identifies administrative precariousness as often the determining factor, more powerful than any direct cost: "L*ack of regularized documentation and precariousness are influential and often determining factors. People in irregular administrative situations or precarious employment often cannot afford to lose working hours to attend appointments. They also cannot afford private care"* (FISEVI, Civil Society)

The community representative is most direct about the cumulative burden of costs on Roma families, noting that every additional cost creates another barrier for families already managing on the margin of economic survival. Private care, which functions as the effective exit valve for the public system's inadequacies, is entirely out of reach: *"Enormously. Every cost is another barrier distancing people from mental health care"* (FISEVI, Community Representative NGO)

The community representative confirms that the relevant patient population consists entirely of regularised individuals, undocumented patients are channelled to NGOs by default. This documentation threshold functions identically to a financial barrier: those formally excluded from the public system must rely on civil society organisations that are profile-restricted, insufficiently funded, and structurally fragile.

Support mechanisms

Formal support mechanisms exist but are practically inaccessible for many of the people who most need them. The Dependency Law provides structured access to residential, day program, and employment services for those with recognised severe mental disorder, and the service provider describes several pragmatic adaptations that extend this access beyond what strict documentary

requirements would permit, including accepting individuals before their dependency resolution is finalised, and working with undocumented individuals who lack any identification: "I*f [the organisation] required to have all the documentation in order from the beginning, it would be impossible to work"* (FISEVI, Service Provider)

Ministry-funded international protection programs provide over 100 psychologists across Spain for refugee populations, giving the ACCEM respondent a relatively more developed support infrastructure than exists for other groups. However, even this is described as insufficient: funding is time-limited, restricted to specific profiles, and does not cover all needs. The community representative gives the clearest assessment of the position for the Roma population, confirming that no targeted financial supports exist at all. The practical consequence is that civil society organisations, ACCEM for migrants, FAKALI for Roma, and the anonymised foundation for people with severe mental disorder, collectively function as the de facto support mechanism for populations that the formal system does not adequately reach.

Appropriateness

Fit and usefulness of care

Across the five interviews, appropriate care is consistently described as integral, person-centred, and contextually responsive. The civil society respondent stresses that psychological support must be embedded within a broader interdisciplinary response that addresses social stabilisation, employment, housing, and legal needs simultaneously, because these domains directly condition psychological wellbeing: "A*ddressing mental health in these populations only makes sense from an integral and community-based approach. Social, employment, and administrative stabilization directly influence psychological well-being"* (FISEVI, Civil Society)

The academic identifies appropriateness problem at its most fundamental level: clinical assessment tools are calibrated to dominant cultural expressions of distress and will systematically underdiagnose or misclassify distress in communities where it is expressed differently. Depression, for instance, may present as isolation or substance use rather than visible emotional expression. If services use parameters that do not correspond to how distress is expressed in a specific community context, they will fail to detect the problems they are designed to treat.

The service provider frames appropriateness through life-history orientation and genuine relational interest in the individual, as opposed to diagnostic category management. The community nurse, from within the public system, highlights the absence of any formal outcome evaluation infrastructure as a

critical gap: "*There are no indicators to evaluate improvements in quality of life"* (FISEVI, Health Provider)

Without measurement, the appropriateness of care cannot be systematically assessed or improved. The community representative's assessment of care usefulness is primarily based on FAKALI's internal integrated model, since direct experience of public system care is limited. The civil society respondent notes that care usefulness is highly variable, many people value having been listened to and accompanied even when their problems are not resolved, but others disengage because they are not yet ready to engage with therapeutic care.

Quality of interaction and respect

The community nurse describes the mental health clinical encounter as a rare safe space in which patients disclose material they share with no one else in their lives, suggesting that when interactions are respectful and non-judgmental, they carry exceptional therapeutic value. However, this positive potential is not reliably or systematically realised across the public system. The service provider documents the inconsistency directly, recounting an experience of accompanying a user and witnessing dismissive clinical communication firsthand. The observation is particularly pointed because it occurred despite the presence of an advocate: *"It happens to us even when we accompany the user and they ask: "You sleep well, don't you? Well, same treatment." If that happens to us when we are accompanying, imagine someone who is not even accompanied, who is out of network, who goes to a first mental health appointment"* (FISEVI, Service Provider)

The community representative provides another personally resonant account of interaction quality, drawing on a family narrative that illustrates the chronic and normalised dimension of disrespect. *"My father worked in municipal Social Services from 2000 to 2020 and was still called "the little Gypsy." Even after 20 years of professional service. He would laugh about it, but at some point he would say: "I have a name.""* (FISEVI, Community Representative NGO).

The civil society respondent frames quality of interaction in terms of its holistic character: a respectful interaction does not limit itself to symptom management but attends to how the person is living and experiencing their process. The civil society respondent identifies significant variability among public system professionals, with some highly trained and sensitised and others who are not, and notes that inadequate professional responses can be actively harmful. The academic returns to the foundational condition: without trust, no interaction, however technically skilled, will be effective. Trust must be built through consistent presence, community embeddedness, and genuine engagement over time rather than through individual consultation technique alone.

4.4 Greece / Albania

4.4.1 Quantitative results

The dataset comprises 204 respondents across four groups: General (n = 74), Older adults (65+) (n = 67), Migrant community (n = 53), and Older adults (65+) in the migrant community (n = 10) (Table 55).

Table 55: Distribution of participants across the included groups in Greece / Albania

General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community
N = 74	N = 67	N = 53	N = 10

Questionnaire completion differed somewhat between groups. Most respondents completed the questionnaire themselves (72/74 in the General group, 59/67 among older adults, 32/53 in the migrant community, and 4/10 among older migrants). Assisted completion occurred in 2/74, 7/67, 18/53, and 2/10 cases, respectively, while proxy completion was rare (0/74, 1/67, 3/53, and 4/10).

Sex at birth was predominantly female in all groups: 49 females, 24 males, and one non-binary respondent in the General group; 52 females, 13 males, and two preferring not to say among older adults; 38 females and 15 males in the migrant community; and seven females and three males among older migrants. Gender identity corresponded with sex assigned at birth for most respondents (72/74 in the General group and 65/67 among older adults), and for all respondents in both migrant groups. Two older adult respondents preferred not to report their gender. Across groups, most respondents identified as heterosexual. In the General group, 65 reported heterosexual orientation, three gay, four bisexual, and two preferred not to say. Among older adults, 64 reported heterosexual orientation, one gay, and two preferred not to say. In the migrant community, 49 reported heterosexual orientation, one gay, one bisexual, one another orientation, and one preferred not to say. All older migrants reported heterosexual orientation. Residence and birthplace largely reflected the group definitions. All respondents in the General and older adult groups lived in Greece, as did 52 of 53 respondents in the migrant community and all 10 older migrants. All respondents in the General and older adult groups were also born in Greece. In the migrant community, 10 were born in Greece, 18 in another EU country, and 25 outside the EU. Among older migrants, five were born in another EU country and five outside the EU. Citizenship showed a similar pattern. All respondents in the General and older adult groups were citizens of Greece. In the migrant community, 15 held Greek citizenship, 16 citizenship of another EU member state, and 22 citizenship of a non-EU country. Among older migrants, four were citizens of Greece, two of another EU member state, and four of a non-EU country. Parental birthplace (used as an

indicator of second-generation status) was reported as follows. In the General group, 49 respondents had both parents born in Greece (25 missing). Among older adults, 61 reported both parents born in Greece (six missing). In the migrant community, two reported both parents born in Greece, one only the mother, five only the father, and 42 neither parent (three missing). Among older migrants, four reported both parents born in Greece and six neither. The mean duration of residence in the country was 36.0 years (SD 14.3) in the General group, 70.7 years (SD 5.15) among older adults, 20.5 years (SD 9.85) in the migrant community, and 52.0 years (SD 17.4) among older migrants. Educational attainment (ISCED) varied widely across groups. In the General group, most respondents reported tertiary education, including 27 with a Bachelor's degree (ISCED 6), 27 with a Master's degree (ISCED 7), and one with a Doctoral degree (ISCED 8). Among older adults, education levels ranged from primary to doctoral education, with upper secondary being the most common level. In the migrant community, educational attainment ranged from early childhood education to Master's level, with many respondents reporting Bachelor's degrees. Among older migrants, most respondents reported lower or secondary levels of education. Use of mental health services in the previous 12 months was reported by 46 of 74 respondents in the General group, 20 of 67 among older adults, 26 of 53 in the migrant community, and six of ten among older migrants (non-use: 28/74, 47/67, 27/53, and 4/10). Additional details are presented in Table 56

Table 56: Descriptive statistics of the different included groups in Greece / Albania

Demographic variable	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community	Overall
Age, *mean (sd)*	36.0 (14.3)	70.7 (5.15)	40.7 (12.5)	73.7 (6.58)	50.9 (19.3)
Questionnaire completed by, *n (%)*					
Respondent alone	72 (97.3%)	59 (88.1%)	32 (60.4%)	4 (40.0%)	167 (81.9%)
Respondent with help	2 (2.7%)	7 (10.4%)	18 (34.0%)	2 (20.0%)	29 (14.2%)
Someone else	0 (0%)	1 (1.5%)	3 (5.7%)	4 (40.0%)	8 (3.9%)
Sex at birth, *n (%)*					
Female	49 (66.2%)	52 (77.6%)	38 (71.7%)	7 (70.0%)	146 (71.6%)
Male	24 (32.4%)	13 (19.4%)	15 (28.3%)	3 (30.0%)	55 (27.0%)
Non-binary	1 (1.4%)	0 (0%)	0 (0%)	0 (0%)	1 (0.5%)
Prefer not to say	0 (0%)	2 (3.0%)	0 (0%)	0 (0%)	2 (1.0%)
Gender the same as assigned at birth, *n (%)*					

Yes	72 (97.3%)	65 (97.0%)	53 (100%)	10 (100%)	200 (98.0%)
No	2 (2.7%)	0 (0%)	0 (0%)	0 (0%)	2 (1.0%)
Prefer not to say	0 (0%)	2 (3.0%)	0 (0%)	0 (0%)	2 (1.0%)
Sexual orientation, *n (%)*					
Heterosexual	65 (87.8%)	64 (95.5%)	49 (92.5%)	10 (100%)	188 (92.2%)
Gay	3 (4.1%)	1 (1.5%)	1 (1.9%)	0 (0%)	5 (2.5%)
Lesbian	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Bisexual	4 (5.4%)	0 (0%)	1 (1.9%)	0 (0%)	5 (2.5%)
Other	0 (0%)	0 (0%)	1 (1.9%)	0 (0%)	1 (0.5%)
Prefer not to say	2 (2.7%)	2 (3.0%)	1 (1.9%)	0 (0%)	5 (2.5%)
Country of residence, *n (%)*					
Greece	74 (100%)	67 (100%)	52 (98.1%)	10 (100%)	203 (99.5%)
Other	0 (0%)	0 (0%)	1 (1.9%)	0 (0%)	1 (0.5%)
Country of birth, *n (%)*					
Born in the country of residence	74 (100%)	67 (100%)	10 (18.9%)	0 (0%)	151 (74.0%)
In another country in the EU	0 (0%)	0 (0%)	18 (34.0%)	5 (50%)	23 (11.3%)
Born in another country outside the EU	0 (0%)	0 (0%)	25 (47.2%)	5 (50%)	30 (14.7%)
Citizen of country, *n (%)*					
Citizen of the country of residence	74 (100%)	67 (100%)	15 (28.3%)	4 (40.0%)	160 (78.5%)
No citizenship of the country of residence but that of another EU member state	0 (0%)	0 (0%)	16 (30.2%)	2 (20.0%)	18 (8.8%)
No citizenship of the country of	0 (0%)	0 (0%)	22 (41.5%)	4 (40.0%)	26 (12.7%)

residence but that of a country outside the EU					
Second generation migrant, *n (%)*					
Both parents were born in the country of residence	49 (66.2%)	61 (91.0%)	2 (3.8%)	4 (40.0%)	116 (56.9%)
Only the mother is born in the country of residence	0 (0%)	0 (0%)	1 (1.9%)	0 (0%)	1 (0.5%)
Only the father is born in the country of residence	0 (0%)	0 (0%)	5 (9.4%)	0 (0%)	5 (2.5%)
Neither the father nor the mother was born in the country of residence	0 (0%)	0 (0%)	42 (79.2%)	6 (60%)	48 (23.5%)
Missing	25 (33.8%)	6 (9.0%)	3 (5.7%)	0 (0%)	34 (16.7%)
Duration of stay in the country of residence, *mean years (SD)*	36.0 (14.3)	70.7 (5.15)	20.5 (9.85)	52.0 (17.4)	44.2 (22.9)
Highest level of education completed (ISCED), *n (%)*					
Early childhood education (ages 3 and above), including pre-primary education and	0 (0%)	0 (0%)	1 (1.9%)	1 (10.0%)	2 (1.0%)

early childhood educational development (under 3). (ISCED 0)					
Primary education (also known as elementary or basic education). (ISCED 1)	0 (0%)	15 (22.4%)	1 (1.9%)	3 (30.0%)	19 (9.3%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	2 (2.7%)	9 (13.4%)	17 (32.1%)	3 (30.0%)	31 (15.2%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	15 (20.3%)	21 (31.3%)	13 (24.5%)	2 (20.0%)	51 (25.0%)
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	8 (10.8%)	5 (7.5%)	2 (3.8%)	0 (0%)	15 (7.4%)
Short-cycle third level education (programs	4 (5.4%)	2 (3.0%)	2 (3.8%)	0 (0%)	8 (3.9%)

typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)					
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	27 (36.5%)	11 (16.4%)	22 (22.6%)	1 (10.0%)	51 (25.0%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	27 (23.0%)	0 (0%)	5 (9.4%)	0 (0%)	22 (10.8%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	1 (1.4%)	3 (4.5%)	0 (0%)	0 (0%)	4 (2.0%)
Missing		1 (1.5%)	0 (0%)	0 (0%)	1 (0.5%)
Use of mental health care in the previous 12 months, *n (%)*					
Yes	46 (62.2%)	20 (29.9%)	26 (49.1%)	6 (60.0%)	98 (48.0%)
No	28 (37.8%)	47 (70.1%)	27 (50.9%)	4 (40.0%0	106 (52.0%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Within the Availability and Accommodation dimension, most indicators did not demonstrate statistically significant differences between population groups. Specifically, no group differences were identified regarding awareness of mental health services in the local area, the availability of private spaces for receiving care, the time required to obtain an appointment, or knowledge of where to seek immediate help during a mental health crisis (Figure 65; all p-values > 0.05).

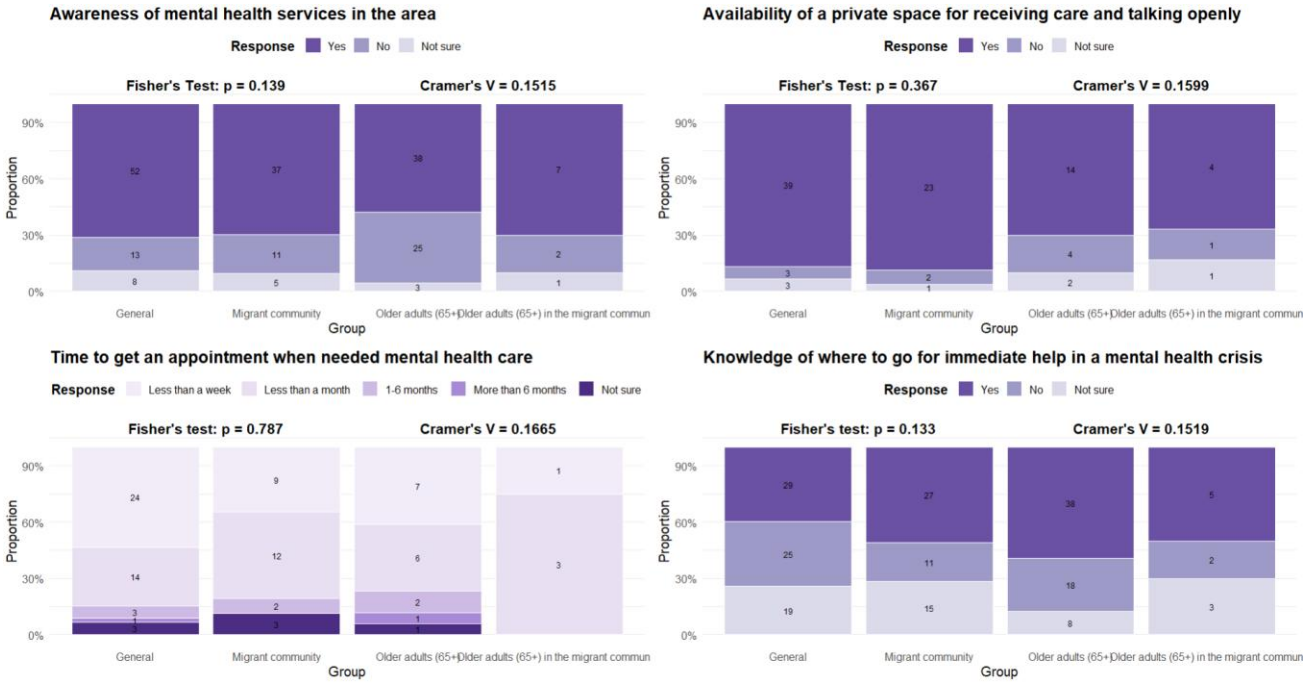

Figure 63: Non-significant differences across groups for the Availability & Accommodation dimension in Greece / Albania

In contrast, the time required to travel to mental health service locations showed a statistically significant difference between groups in the overall analysis (Figure 66). However, subsequent pairwise comparisons did not identify statistically significant differences between specific group combinations after adjustment for multiple comparisons (Table 57; all adjusted p-values > 0.05).

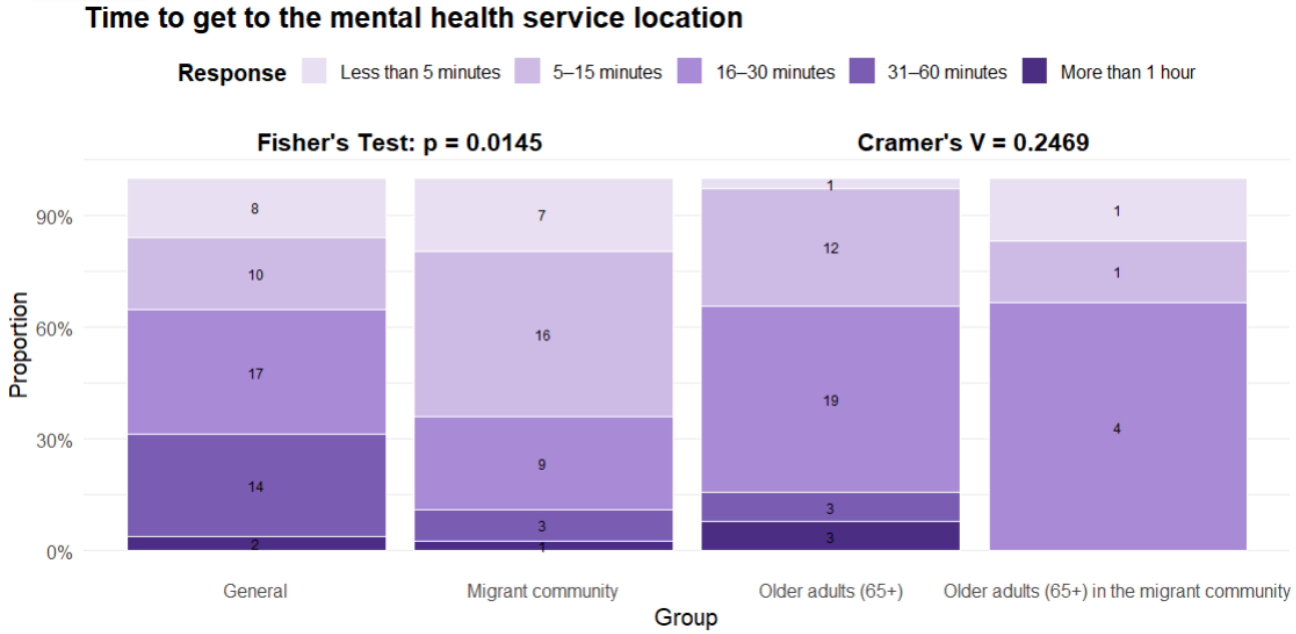

Figure 64: Fisher's exact test of the time to get to the mental health service location item in Greece / Albania

Table 57: Pairwise comparison test of the time to get to the mental health service location item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.089	0.322
General group : Older adults (65+)	0.089	0.358
General group : Older adults (65+) in the migrant community	0.507	0.249
Migrant community : Older adults (65+)	0.089	0.360
Migrant community: Older adults (65+) in the migrant community	0.507	0.329
Older adults (65+) : Older adults (65+) in the migrant community	0.507	0.296

Approachability

Within the Approachability dimension, most indicators did not demonstrate statistically significant differences between population groups. These included whether participants had encountered information on accessing mental health support, the ease of finding reliable information about mental health services, whether respondents had been asked about their mental wellbeing during encounters with healthcare or support professionals, and whether participants had come across outreach programs related to mental health services (Figure 65; all p-values > 0.05). These findings suggest that general exposure to information and routine engagement with services were broadly comparable across the general population, migrant communities, older adults, and older adults

within migrant communities.

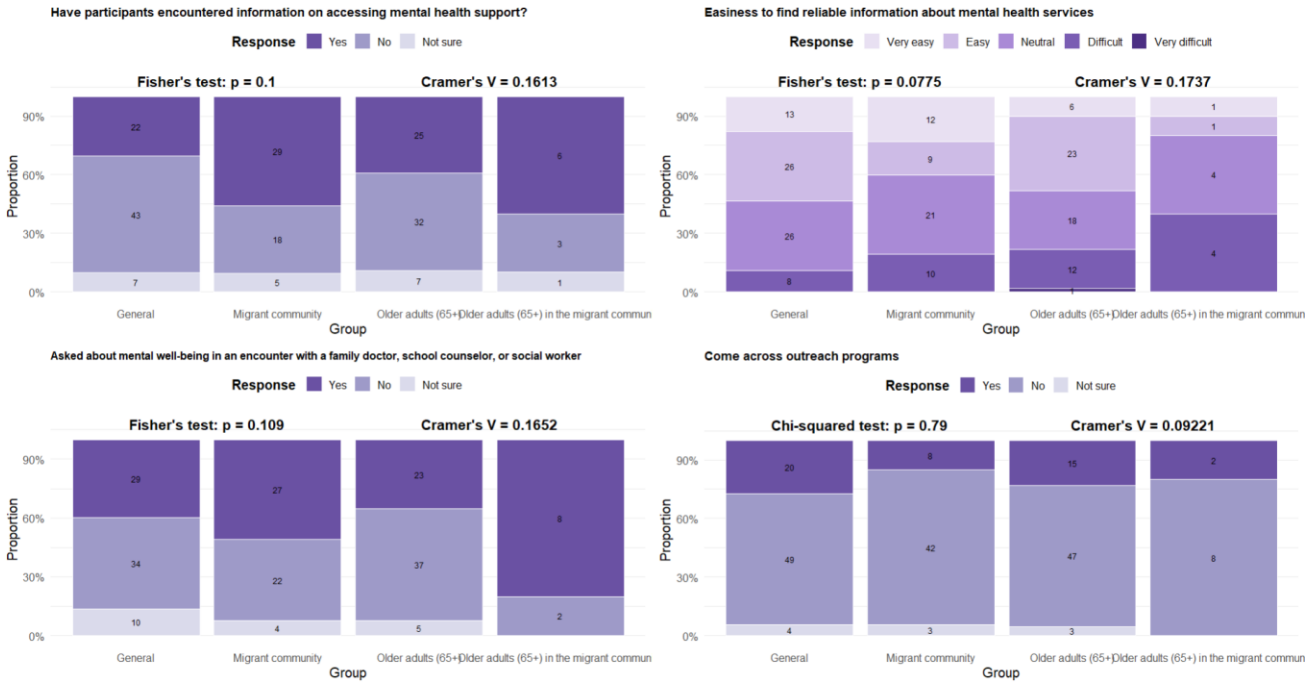

Figure 65: Non-significant differences across groups for the Approachability dimension in Greece / Albania

A statistically significant difference was identified for the ease of understanding spoken or written information about mental health services (Figure 68 and Table 57). Pairwise comparisons indicated significant differences between the general population and older adults within migrant communities ($p = 0.006$), between the migrant community and older adults within migrant communities ($p = 0.013$), and between older adults and older adults within migrant communities ($p = 0.009$). In several comparisons, Cramer's V could not be calculated due to sparse data or small subgroup

sizes, which limits the ability to estimate effect sizes reliably.

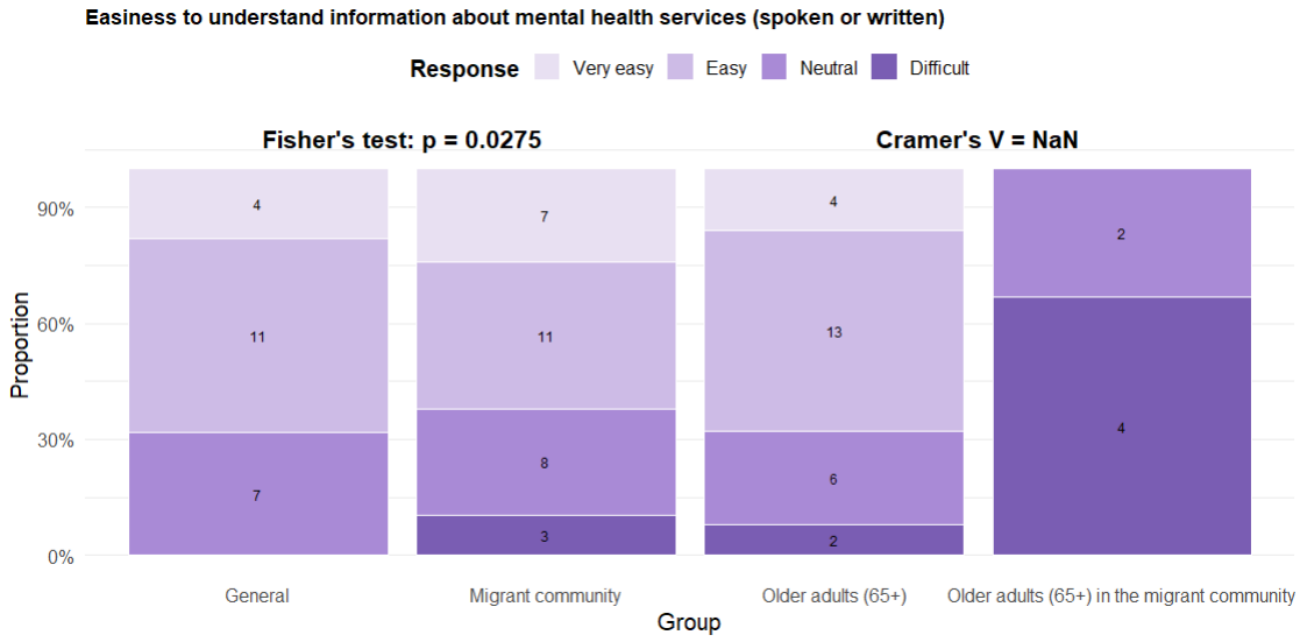

Figure 66: Fisher's exact test of the easiness to understand information about mental health services (spoken or written) item in Greece / Albania

Table 58: Pairwise comparison test of the easiness to understand information about mental health services (spoken or written) in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.706	NC
General group : Older adults (65+)	0.757	NC
General group : Older adults (65+) in the migrant community	0.006	NC
Migrant community : Older adults (65+)	0.757	NC
Migrant community: Older adults (65+) in the migrant community	0.013	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.009	NC

Differences were also observed regarding whether respondents had heard about experiences of other patients regarding mental health services (Table 59 & Figure 69). Significant differences were identified between the general population and older adults (p = 0.042, Cramer's V = 0.246), as well as between the migrant community and older adults (p = 0.012, Cramer's V = 0.325). Descriptive findings indicated that older adults reported lower awareness of peer-related experiences compared

to other groups. The corresponding effect sizes indicate small to moderate associations, suggesting meaningful differences in peer-related information exposure.

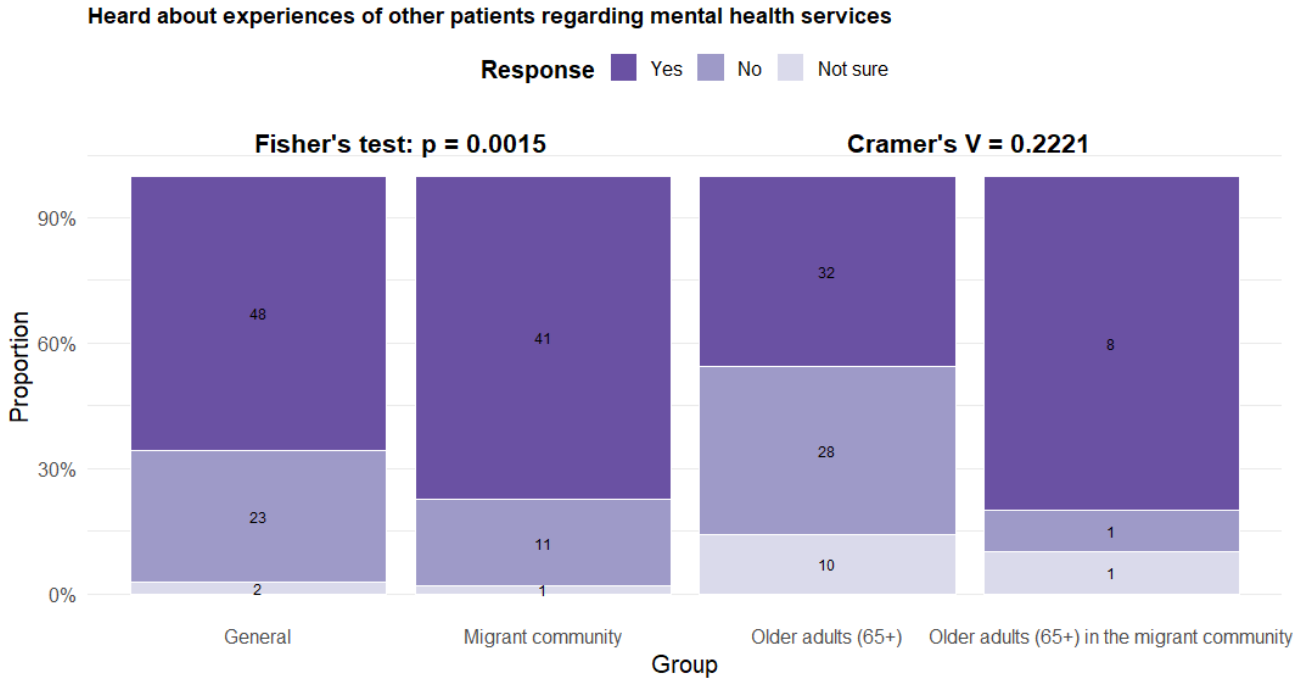

Figure 67: Fisher's exact test of the heard about experiences of other patients regarding mental health services item in Greece / Albania

Table 59: Pairwise comparison test of the heard about experiences of other patients regarding mental health services item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.444	0.127
General group : Older adults (65+)	0.042	0.246
General group : Older adults (65+) in the migrant community	0.240	0.189
Migrant community : Older adults (65+)	0.012	0.325
Migrant community: Older adults (65+) in the migrant community	0.392	0.190
Older adults (65+) : Older adults (65+) in the migrant community	0.240	0.225

Furthermore, statistically significant differences were found regarding whether respondents had been invited to participate in mental health-related research (Table 60, Figure 70). Significant differences were observed between the general population and the migrant community (p = 0.041, Cramer's V = 0.262), as well as between the general population and older adults (p = 0.027, Cramer's V = 0.283). Descriptive findings indicated that invitations to participate in research were

reported more frequently among respondents from the general population compared to the other groups. The observed effect sizes indicate small to moderate associations, suggesting modest but meaningful differences in participation opportunities

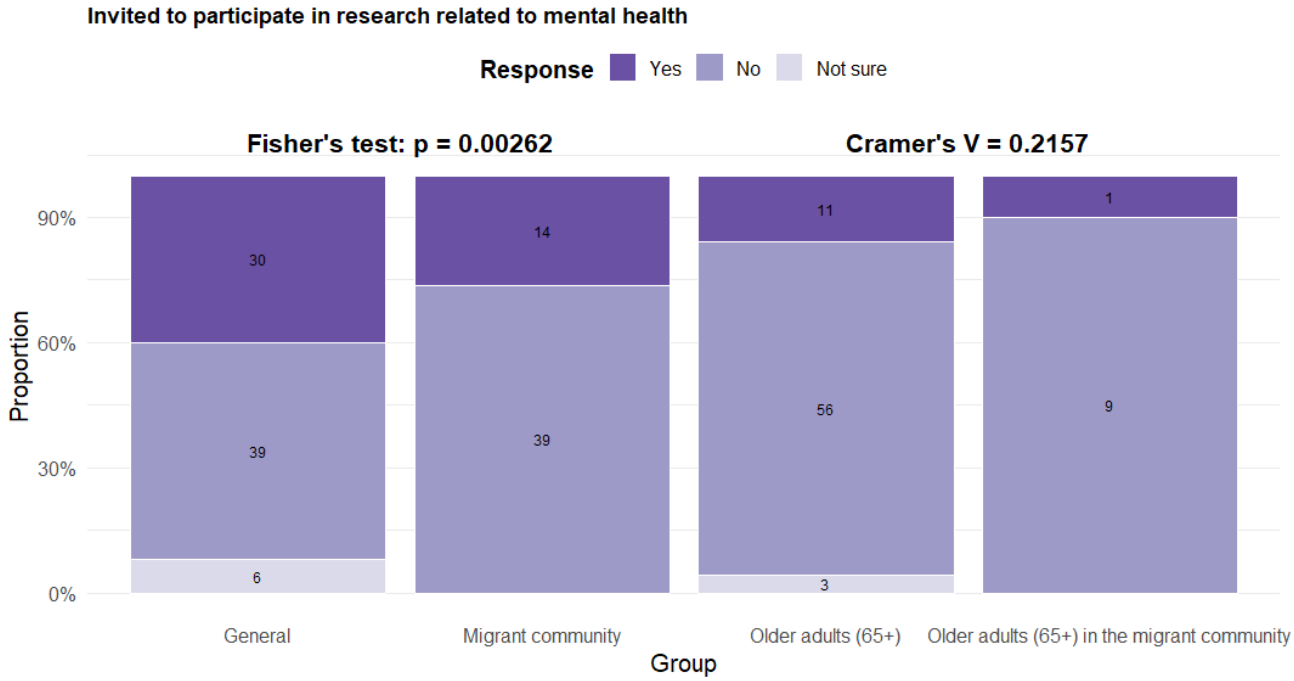

Figure 68: Fisher's exact test of the invited to participate in research related to mental health item in Greece / Albania

Table 60: Pairwise comparison test of the invited to participate in research related to mental health item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.041	0.262
General group : Older adults (65+)	0.027	0.283
General group : Older adults (65+) in the migrant community	0.188	0.256
Migrant community : Older adults (65+)	0.306	0.179
Migrant community: Older adults (65+) in the migrant community	0.518	NC
Older adults (65+) : Older adults (65+) in the migrant community	1.000	0.107

Acceptability

Within the Acceptability dimension, no statistically significant differences were observed between population groups across any of the assessed indicators. Specifically, perceptions regarding the option to communicate with mental health providers in a preferred language, the possibility to choose one's own doctor or therapist, whether mental health professionals communicated respectfully with patients, whether patients' rights were protected against mistreatment or abuse, and whether mental health services were considered trustworthy did not differ significantly between

the general population, migrant communities, older adults, and older adults within migrant communities (Figure 71 & Figure 72; all p-values > 0.05).

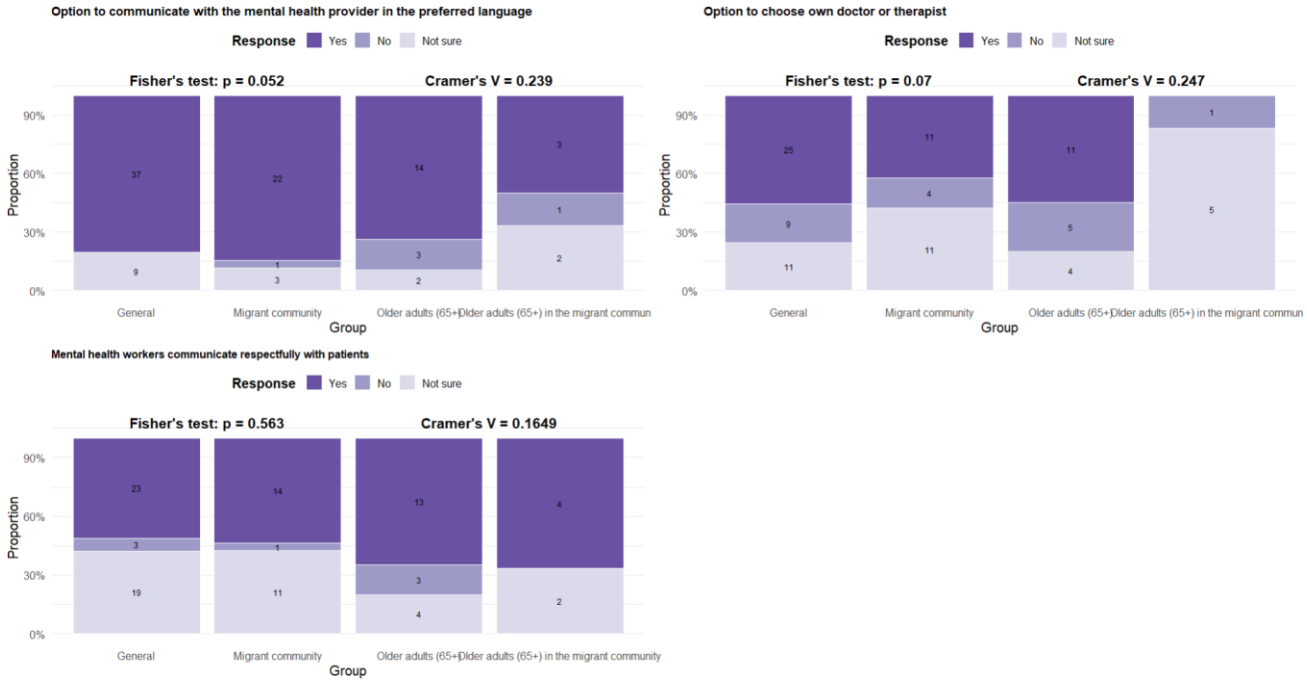

Figure 69: Non-significant differences across groups for the Acceptability dimension in Greece / Albania (1)

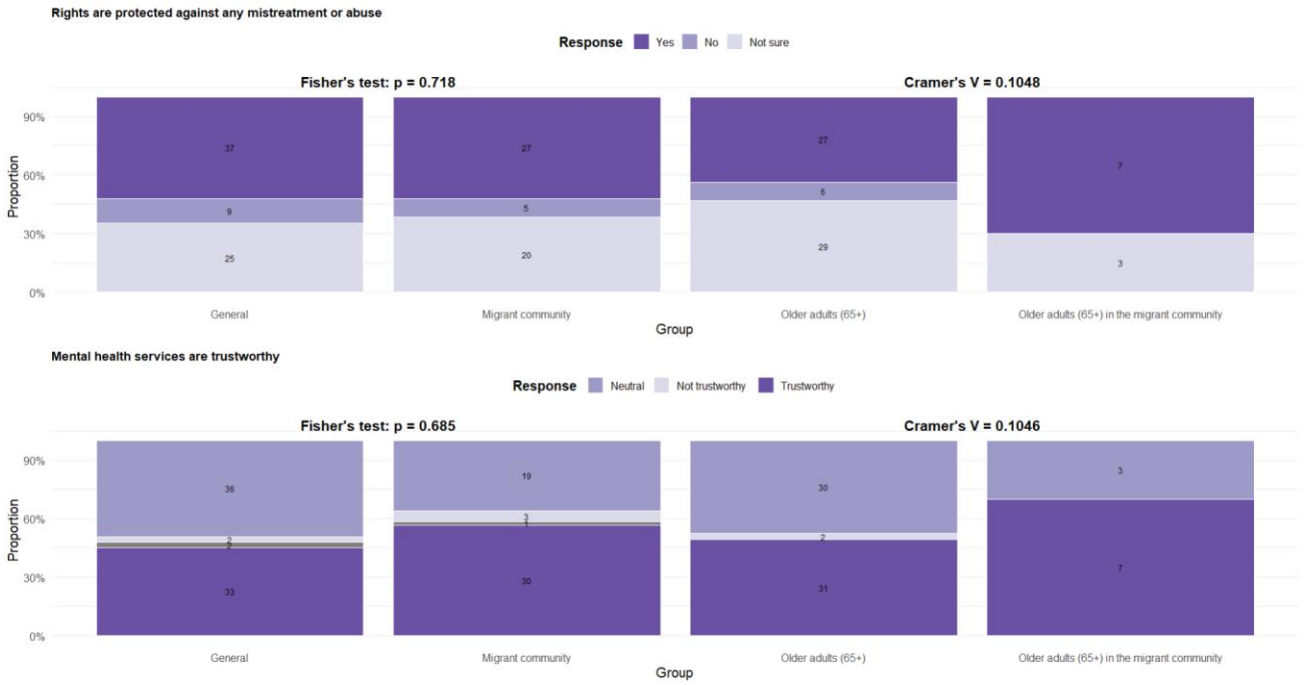

Figure 70: Non-significant differences across groups for the Acceptability dimension in Greece / Albania (2)

Affordability

Within the Affordability dimension, several indicators did not demonstrate statistically significant differences between population groups. These included the possibility of obtaining mental health services through public programs or services free of charge or at low cost, delayed or avoided mental healthcare due to costs in the past 12 months, difficulty accessing mental healthcare due to additional costs, and whether respondents received assistance from services with payment options, insurance questions, or financial support (Figures 73; all p-values > 0.05). These findings suggest that several structural aspects of financial access were broadly comparable across the general population, migrant communities, older adults, and older adults within migrant communities.

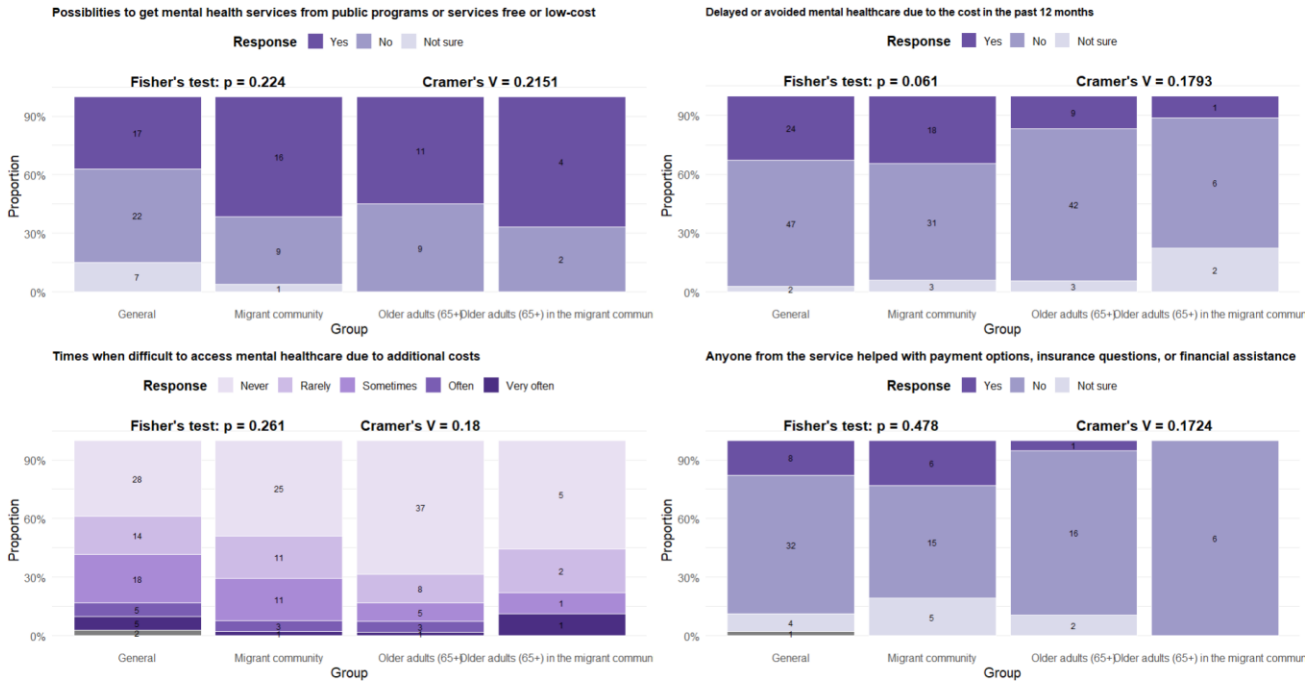

Figure 71: Non-significant differences across groups for the Affordability dimension in Greece / Albania

A statistically significant difference was observed regarding health insurance coverage for mental health services (Figure 74; Table 61). Pairwise comparisons indicated significant differences between the general population and older adults (65+) (p = 0.010, Cramer's V = 0.309), between the migrant community and older adults (65+) (p = 0.009, Cramer's V = 0.353), and between older adults (65+) and older adults (65+) within migrant communities (p = 0.009, Cramer's V = 0.427). Descriptive findings indicated that older adults, particularly those aged 65 years and above, more frequently selected "not sure" responses regarding insurance coverage. The corresponding effect sizes ranged

from small to moderate, with the strongest differences observed among older adult groups.

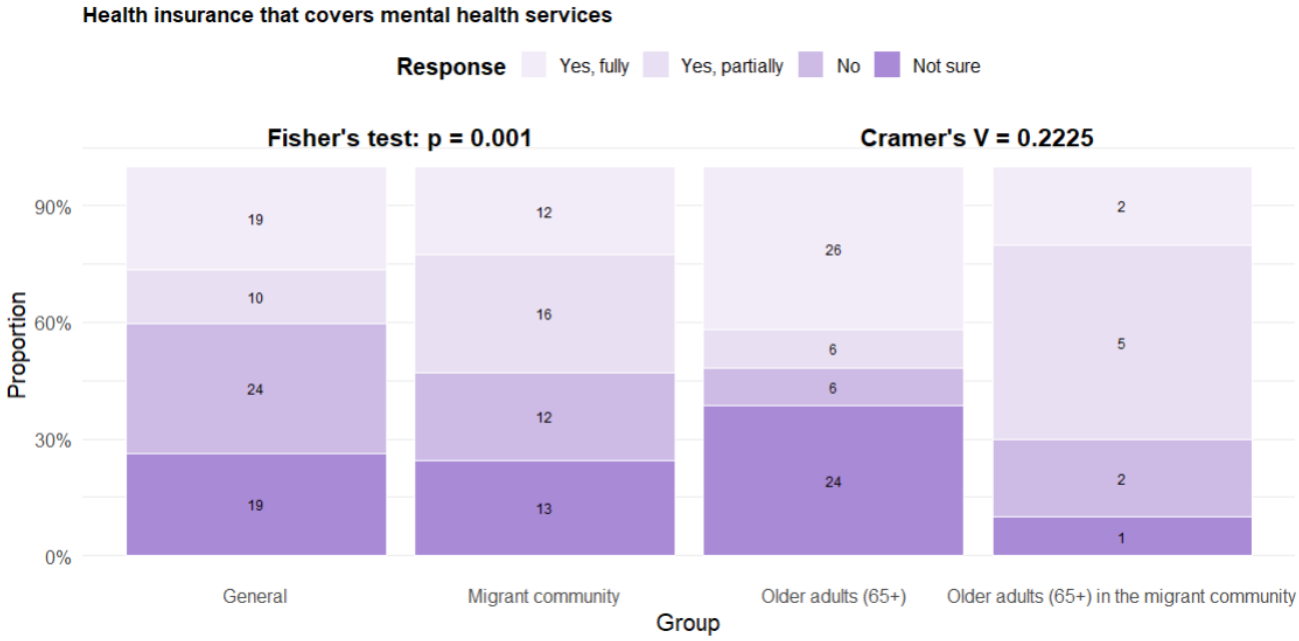

Figure 72: Fisher's exact test of the health insurance that covers mental health services item Greece / Albania

Table 61: Pairwise comparison test of the health insurance that covers mental health services item Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.192	0.206
General group : Older adults (65+)	0.010	0.309
General group : Older adults (65+) in the migrant community	0.111	0.310
Migrant community : Older adults (65+)	0.009	0.353
Migrant community: Older adults (65+) in the migrant community	0.613	0.171
Older adults (65+) : Older adults (65+) in the migrant community	0.009	0.427

Differences were also identified for not taking prescribed medication due to cost, with statistically significant differences observed between the general population and the migrant community (p = 0.027), as well as between the general population and older adults within migrant communities (p = 0.027), and between the migrant community and older adults (65+) (p = 0.027). Descriptive findings indicated that respondents from the migrant community more frequently reported not taking prescribed medication due to financial constraints. In these comparisons, Cramer's V could not be calculated due to sparse cell counts, which limits interpretation of effect size magnitude (Figure 75; Table 62).

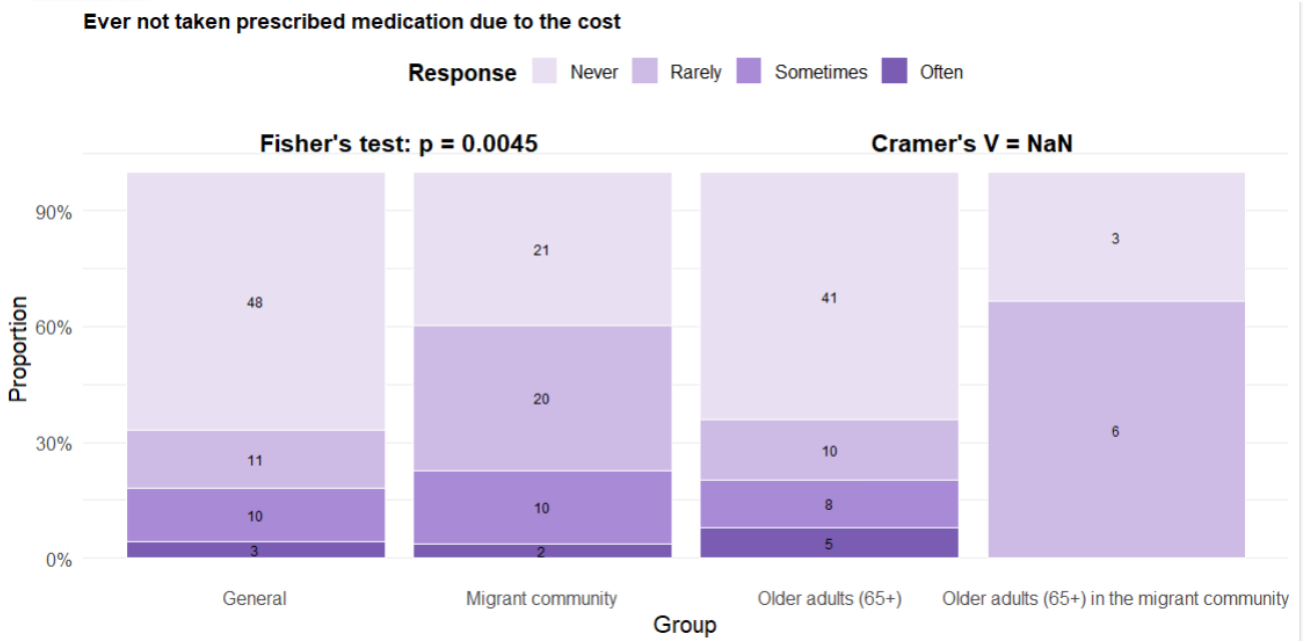

Figure 73: Fisher's exact test of the ever not taken prescribed medication due to the cost item in Greece / Albania

Table 62: Pairwise comparison test of the ever not taken prescribed medication due to the cost item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.027	NC
General group : Older adults (65+)	0.848	NC
General group : Older adults (65+) in the migrant community	0.027	NC
Migrant community : Older adults (65+)	0.027	NC
Migrant community: Older adults (65+) in the migrant community	0.420	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.027	NC

Further statistically significant differences were observed for difficulty accessing mental healthcare due to loss of income (Figure 76; Table 63). Significant differences were identified between the general population and older adults (65+) (p = 0.009, Cramer's V = 0.378), as well as between older adults (65+) and older adults within migrant communities (p = 0.027). Descriptive findings indicated that difficulties related to income loss were reported less frequently among older adults compared to

other groups. The corresponding effect sizes indicate small to moderate associations, suggesting meaningful differences in income-related financial barriers.

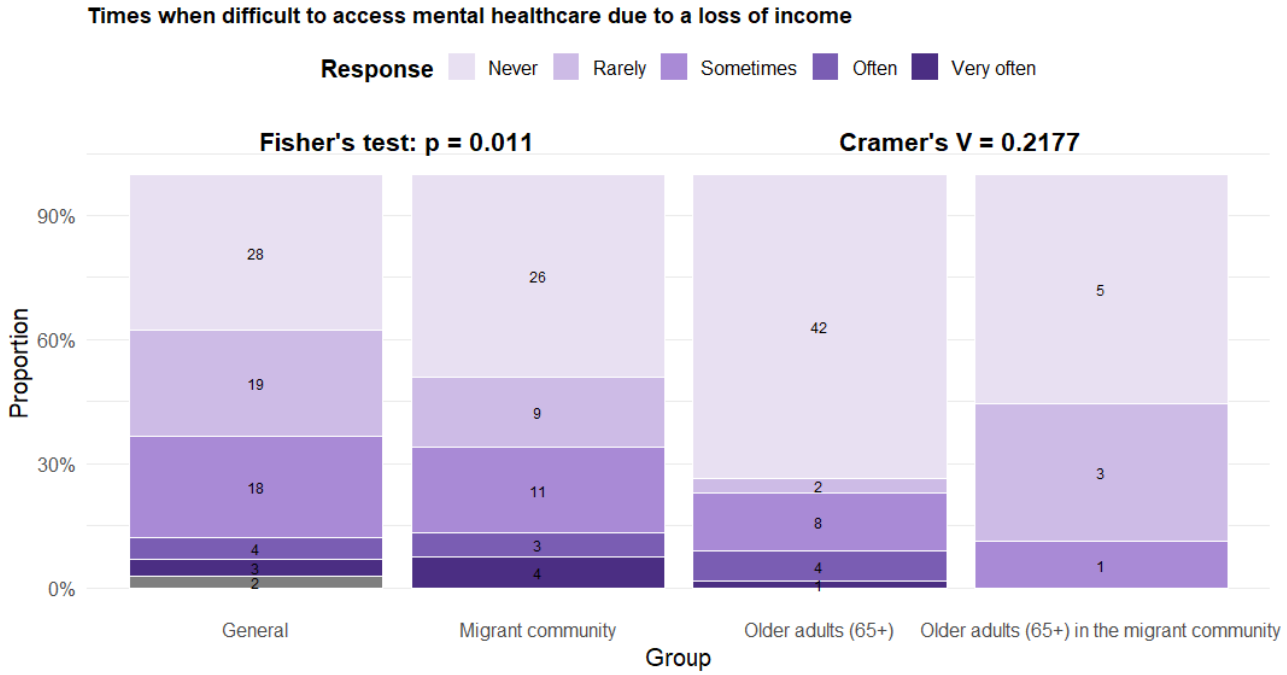

Figure 74: Fisher's exact test of the times when difficult to access mental healthcare due to a loss of income item in Greece / Albania

Table 63: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.894	0.170
General group : Older adults (65+)	0.009	0.378
General group : Older adults (65+) in the migrant community	0.894	0.177
Migrant community : Older adults (65+)	0.129	NC
Migrant community: Older adults (65+) in the migrant community	0.894	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.027	NC

Additionally, differences were observed regarding whether respondents had been offered financial support or discounts to reduce or cover the costs of care (Figure 77; Table 64). A statistically significant difference was identified between the migrant community and older adults (65+) ($p = 0.006$). Descriptive findings indicated that financial support was reported more frequently among older adults, including those within migrant communities. In several comparisons, Cramer's V could not be calculated due to limited subgroup sizes, which restricts interpretation of the strength of

these associations.

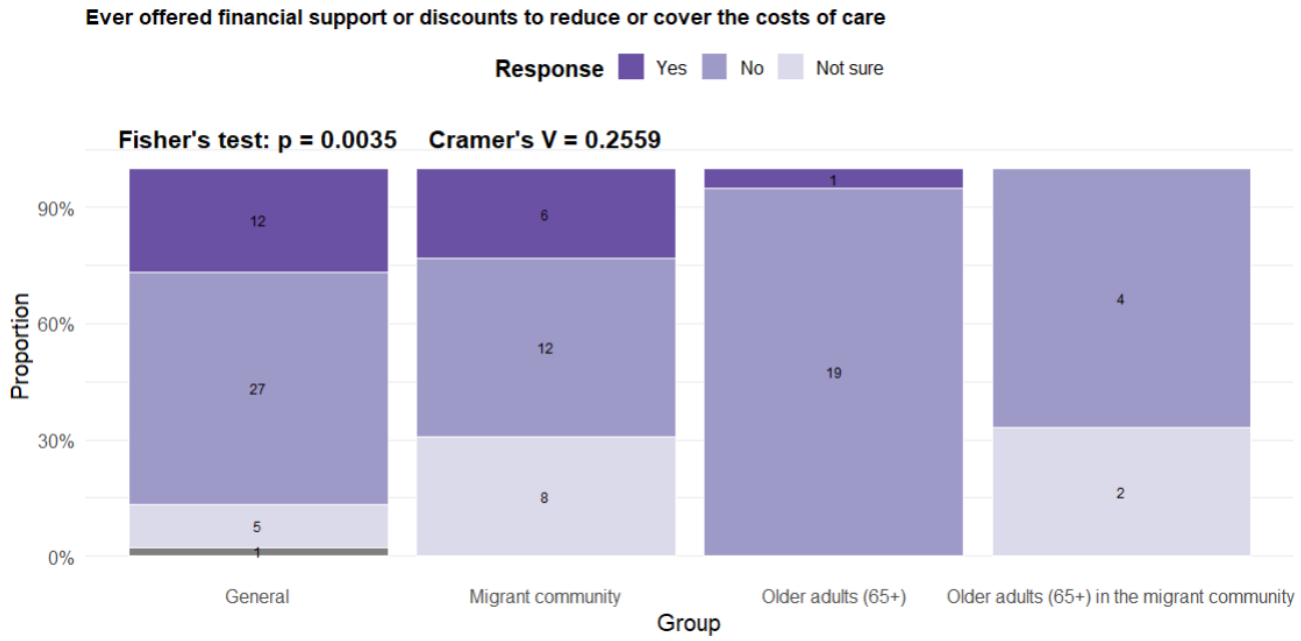

Figure 75: Fisher's exact test of the ever offered financial support or discounts to reduce or cover the costs of care item in Greece / Albania

Table 64: Pairwise comparison test of the ever offered financial support or discounts to reduce or cover the costs of care item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.246	0.258
General group : Older adults (65+)	0.075	0.358
General group : Older adults (65+) in the migrant community	0.280	0.269
Migrant community : Older adults (65+)	0.006	NC
Migrant community: Older adults (65+) in the migrant community	0.518	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.101	NC

Appropriateness

For appropriateness; times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare, times the provider spend enough time while receiving mental healthcare, times mental health services are found helpful or relevant, cultural beliefs and practices are accounted for when receiving mental healthcare, mental health provider considered other aspects of life experiences, times of involvement in setting goals or making plans for mental healthcare, times of smooth referral between services or professionals, without having to repeat

everything each time, times of involvement in setting goals or making plans for mental healthcare and easiness to schedule (Figure 78, Figure 79 & Figure 80)

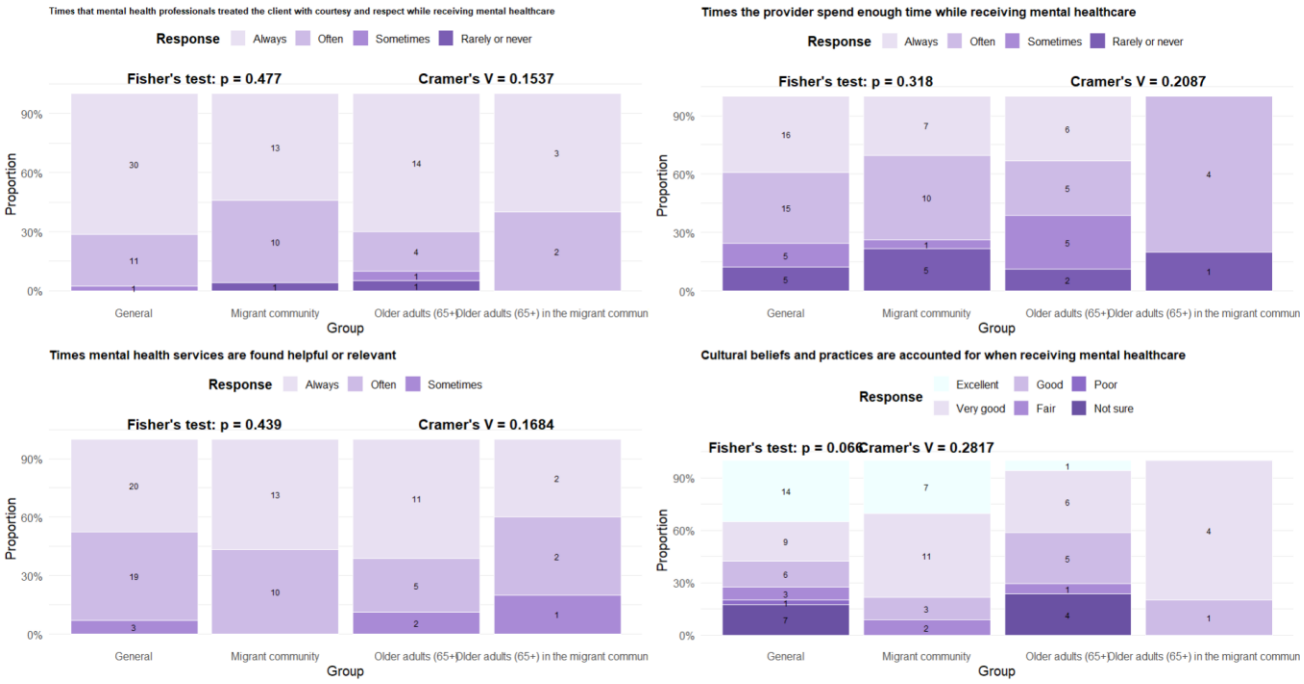

Figure 76: Non-significant differences across groups for the Appropriateness dimension in Greece / Albania (1)

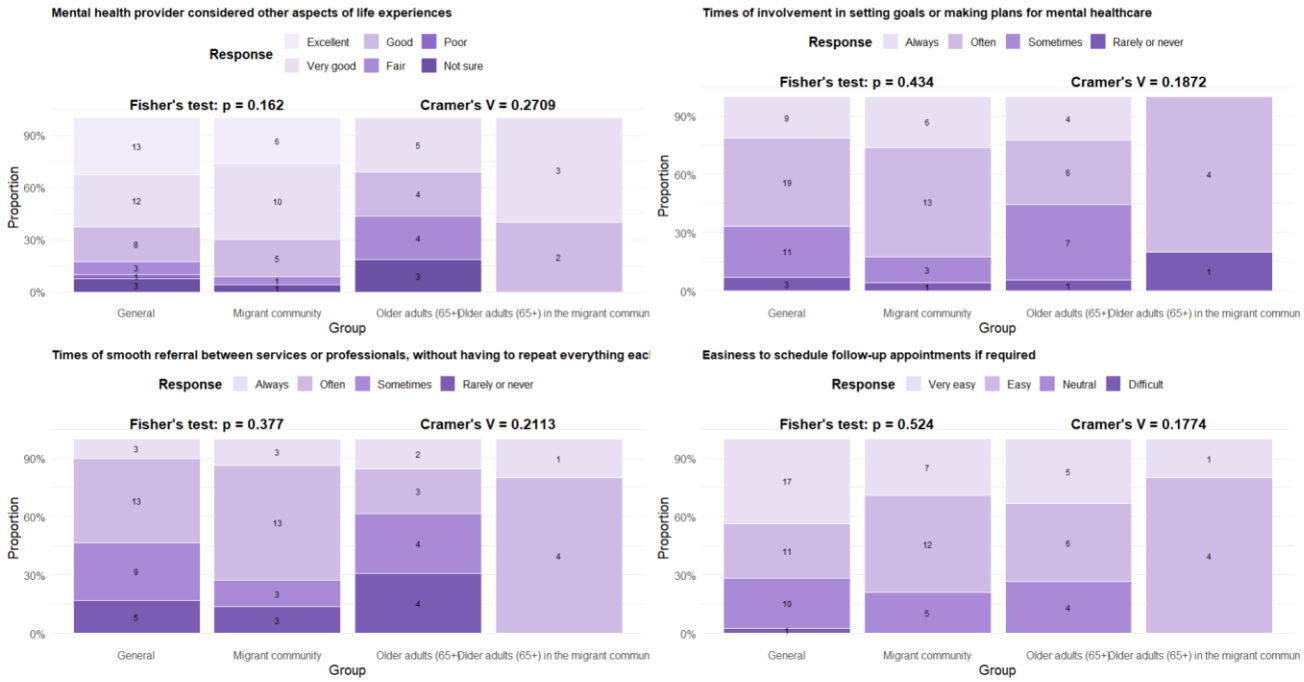

Figure 77: Non-significant differences across groups for the Appropriateness dimension in Greece / Albania (2)

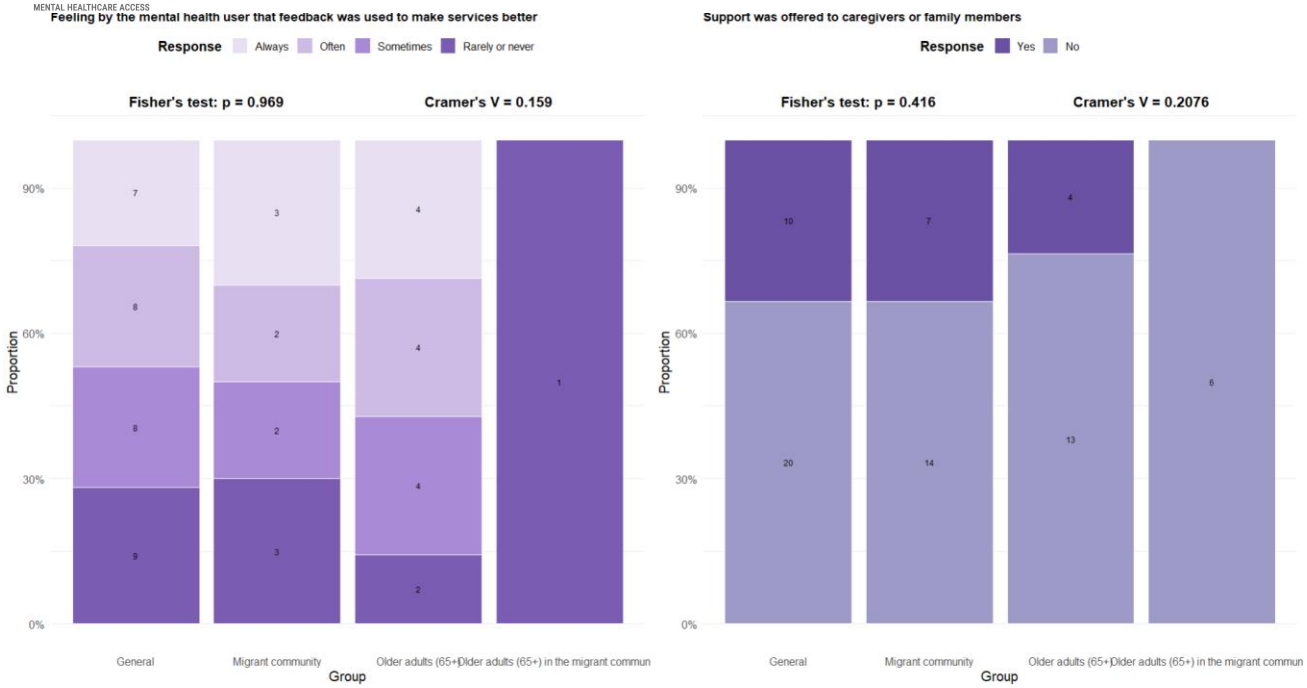

Figure 78: Non-significant differences across groups for the Appropriateness dimension in Greece / Albania (3)

However, some dimensions did show statistically significant differences between groups. Differences were observed for times that a provider explained things in a way that was easy to understand while receiving mental healthcare (Figure 81; Table 65). Pairwise comparisons showed significant differences between the migrant community and older adults (65+) ($p = 0.015$, Cramer's $V = 0.558$), as well as between older adults (65+) and older adults (65+) in the migrant community ($p = 0.048$, Cramer's $V = 0.624$).

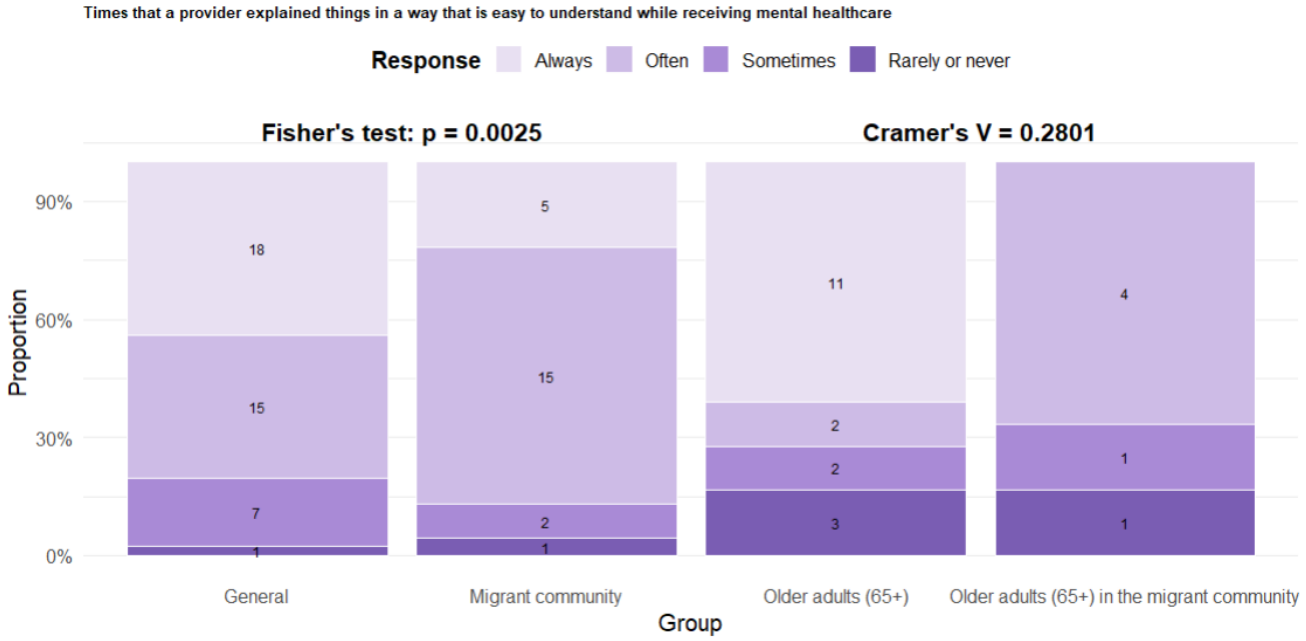

Figure 79: Fisher's exact test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Greece / Albania

Table 65: Pairwise comparison test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.130	0.293
General group : Older adults (65+)	0.097	0.359
General group : Older adults (65+) in the migrant community	0.097	0.366
Migrant community : Older adults (65+)	0.015	0.558
Migrant community: Older adults (65+) in the migrant community	0.324	0.302
Older adults (65+) : Older adults (65+) in the migrant community	0.048	0.624

Differences were also identified regarding the possibility to see the same doctor or therapist consistently during mental health treatment (Figure 82, Table 66). Pairwise comparisons indicated a significant difference between the migrant community and older adults (65+) (p = 0.045, Cramer's V

= 0.477).

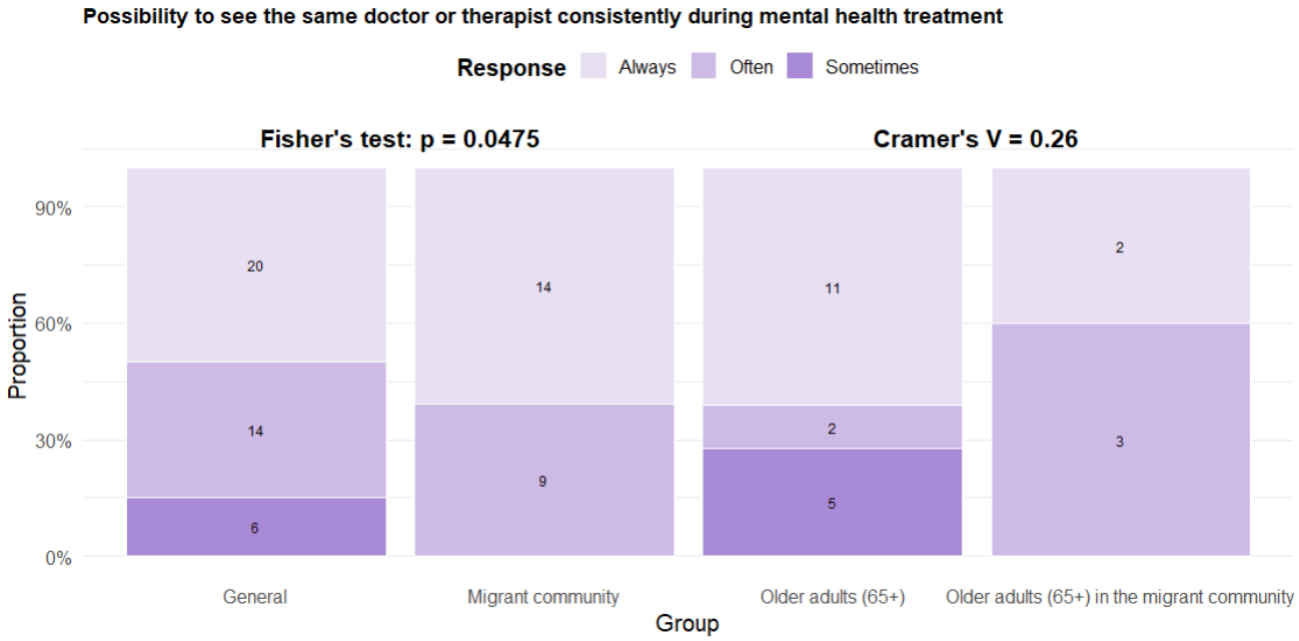

Figure 80: The Fisher's exact test of the possibility to see the same doctor or therapist consistently during mental health treatment item in Greece / Albania

Table 66: Pairwise comparison test of the possibility to see the same doctor or therapist consistently during mental health treatment item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.242	0.247
General group : Older adults (65+)	0.242	0.260
General group : Older adults (65+) in the migrant community	0.664	0.187
Migrant community : Older adults (65+)	0.045	0.477
Migrant community: Older adults (65+) in the migrant community	0.664	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.242	0.511

Lastly, the mental health user receiving invitations to provide feedback regarding their mental health treatment also differed between groups. Significant pairwise differences were found between the

migrant community and older adults (65+) (p = 0.021, Cramer's V = 0.585).

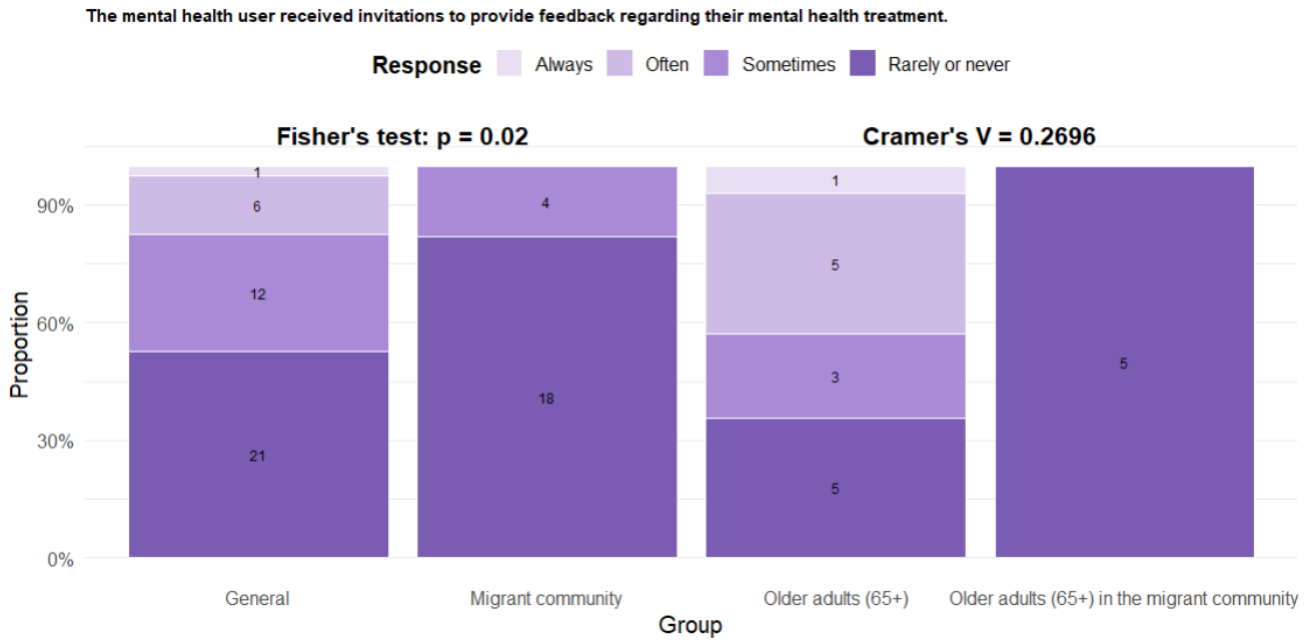

Figure 81: Fisher's exact test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Greece / Albania

Table 67: Pairwise comparison test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Greece / Albania

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Migrant community	0.190	0.325
General group : Older adults (65+)	0.382	0.261
General group : Older adults (65+) in the migrant community	0.382	0.302
Migrant community : Older adults (65+)	0.021	0.585
Migrant community: Older adults (65+) in the migrant community	0.560	NC
Older adults (65+) : Older adults (65+) in the migrant community	0.190	0.567

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, could not be directly compared with national reference values for Greece, as no nationally validated EQ-5D-5L value set or population norm dataset specific to Greece was available at the time of analysis. Consequently, EQ-5D-5L findings are presented descriptively only, without comparison to national reference values.

Self-perceived health

Self-perceived health was assessed using items aligned with those included in the EU Statistics on Income and Living Conditions (EU-SILC) Greece dataset, enabling comparison with national distributions reported through Eurostat EU-SILC Greece data.[12]. In contrast to some other countries, subgroup-level estimates for older adults and migrant populations were available within the EU-SILC Greece dataset, allowing direct comparison across similar population categories. Within the present dataset, most respondents reported good or very good health, although some variation between groups was observed. In the general population, 58.1% reported good health and 32.4% reported very good health. Among older adults (65+), responses were more frequently distributed across fair and good health categories, with 31.3% reporting fair health and 50.7% reporting good health. Within the migrant community, 56.6% reported good health and 24.5% reported very good health. Among older adults within the migrant community, half of respondents (50.0%) reported fair health, with smaller proportions reporting good or very good health (Table 68). When compared with national estimates from the EU-SILC Greece dataset, broadly comparable patterns were observed across population groups. However, relatively higher proportions of fair health were reported among older adults and older migrants in the present dataset compared with national distributions, suggesting somewhat lower perceived health status in these subgroups (Table 69).

Table 68: Self-perceived health in the dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community
Very bad, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Bad, *n (%)*	2 (2.7)	2 (3.0)	1 (1.9)	0 (0.0)
Fair (neither good nor bad), *n (%)*	5 (6.8)	21 (31.3)	9 (17.0)	5 (50.0)
Good, *n (%)*	43 (58.1)	34 (50.7)	30 (56.6)	3 (30.0)
Very good, *n (%)*	24 (32.4)	9 (13.4)	13 (24.5)	2 (20.0)
Missing, *n (%)*	0 (0.0)	1 (1.5)	0 (0.0)	0 (0.0)

Table 69: Self-perceived health in the dataset of EU-SILC Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community

Very bad, %	0.5	4.3	0.4	4.7
Bad, %	1.9	14.9	1.2	12.7
Fair (neither good nor bad), %	5.0	39.6	5.5	38.5
Good, %	28.4	36.1	40.5	36.3
Very good, %	64.2	5.0	52.5	7.8

Activity limitations

Functional limitations were assessed using indicators corresponding to those included in the EU-SILC Greece dataset, allowing subgroup-level comparison with national activity limitation data.[13]. Across the study population, the majority of respondents reported no limitations in daily activities, particularly within the general population (73.0%) and the migrant community (77.4%). Among older adults, 79.1% reported no limitations, although moderate limitations were reported slightly more frequently compared with the general population. In the older migrant group, responses were equally distributed between limited and not limited categories (50.0% each), suggesting a higher burden of functional limitations in this subgroup (Table 70). Comparison with subgroup-specific estimates from EU-SILC Greece indicated broadly similar distributions overall, although older adults and older migrants in the present dataset showed somewhat higher levels of reported limitations compared with national averages (Table 71).

Table 70: Activity limitations in the dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community
Severely limited, *n (%)*	2 (2.7)	1 (1.5)	2 (3.8)	0 (0.0)
Limited, *n (%)*	17 (23.0)	11 (16.4)	10 (18.9)	5 (50.0)
Not limited, *n (%)*	54 (73.0)	53 (79.1)	41 (77.4)	5 (50.0)

Missing, *n (%)*	1 (1.4)	2 (3.0)	0 (0.0)	0 (0.0)

Table 71: Activity limitations in the EU-SILC dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community
Severely limited, %	2.5	25.1	1.7	27.2
Limited, %	2.7	26.4	2.6	18.5
Not limited, %	94.8	48.6	95.7	54.3

Unmet need for care

Information on unmet need for healthcare was collected using indicators aligned with those included in the EU-SILC Greece dataset, enabling triangulation with national estimates reported through Eurostat EU-SILC Greece data.[14]. Within the present dataset, several reasons for unmet need were reported across groups. Among the general population, cost-related barriers were frequently reported, with 16.2% indicating that services were too expensive, while waiting lists were reported by 14.9% of respondents. Among older adults, waiting lists (19.4%) were the most frequently reported barrier, followed by cost-related barriers (10.4%). Within the migrant community, cost-related barriers were reported more frequently (24.5%), together with waiting lists (20.8%). In the older migrant group, fewer specific barriers were reported overall, although a relatively lower proportion reported having no unmet needs compared with other groups Table 72. In comparison with national subgroup-level estimates from the EU-SILC Greece dataset, the present dataset indicates higher levels of reported unmet need, particularly among migrant populations. National data show that a large majority of individuals report no unmet healthcare needs, whereas lower proportions of respondents in the present dataset reported the absence of unmet need Table 73.

Table 72: Unmet need for care in the dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community

Too expensive, %	12 (16.2)	7 (10.4)	13 (24.5)	1 (10.0)
Too far to travel, %	0 (0.0)	1 (1.5)	1 (1.9)	0 (0.0)
No time, %	4 (5.4)	0 (0.0)	3 (5.7)	0 (0.0)
Didn't know any good doctor or specialist, %	4 (5.4)	0 (0.0)	2 (3.8)	0 (0.0)
Waiting list, %	11 (14.9)	13 (19.4)	11 (20.8)	0 (0.0)
Fear of doctor, hospital examination or treatment, %	6 (8.1)	1 (1.5)	2 (3.8)	0 (0.0)
Wanted to wait and see if problem got better on its own, %	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Other reason, %	3 (4.1)	0 (0.0)	2 (3.8)	0 (0.0)
No unmet needs to declare, %	46 (62.2)	44 (65.7)	26 (49.1)	3 (30.0)
Missing, %	0 (0.0)	4 (6.0)	1 (1.9)	0 (0.0)

Table 73: Unmet need for care in the EU-SILC dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community

Too expensive, %	10.6	21.2	19.0	22.8
Too far to travel, %	0.1	1.9	0.2	0.7
No time, %	0.5	0.7	0.3	1.0
Didn't know any good doctor or specialist, %	0.0	0.0	0.0	0.0
Waiting list, %	0.6	4.8	0.2	1.8
Fear of doctor, hospital examination or treatment, %	0.2	0.8	0.1	1.0
Wanted to wait and see if problem got better on its own, %	0.7	0.2	0.2	0.0
Other reason, %	0.1	0.0	0.0	0.0
No unmet needs to declare, %	87.3	70.3	79.9	72.7

Depression severity

Depressive symptom severity was assessed using items aligned with those included in the European Health Interview Survey (EHIS) Greece dataset, enabling comparison with national mental health distributions reported through Eurostat EHIS Greece data. Unlike the EU-SILC

dataset, subgroup-specific national estimates were not available within EHIS Greece for migrant or older migrant populations. Therefore, comparisons were conducted at the overall population level only.[15]. Within the present dataset, depressive symptoms were reported at varying levels of severity across groups. Among the general population, mild symptoms were frequently reported, while a substantial proportion also reported none or minimal symptoms. Among the general population, mild symptoms were reported more frequently. Similar patterns were observed in the migrant community, while older migrants showed a more distributed pattern across symptom severity levels (Table 74). National reference values derived from the EHIS Greece dataset indicate that the majority of the general population reports none or minimal depressive symptoms, with only small proportions reporting moderate or severe symptoms. Compared with these national estimates, the present dataset suggests higher levels of depressive symptoms, particularly among older adults and migrant populations (Table 75).

Table 74: Depression severity in the dataset of Greece / Albania

	General group	Older adults (65+)	Migrant community	Older adults (65+) in the migrant community
Severe, *n (%)*	1 (1.4)	1 (1.5)	2 (3.8)	0 (0.0)
Moderately severe, *n (%)*	3 (4.1)	3 (4.5)	2 (3.8)	0 (0.0)
Moderate, *n (%)*	12 (16.2)	4 (6.0)	7 (13.2)	0 (0.0)
Mild, *n (%)*	33 (44.6)	20 (29.9)	20 (37.7)	3 (30.0)
None or minimum, *n (%)*	25 (33.8)	34 (50.7)	21 (39.6)	7 (70.0)
Missing, *n (%)*	0 (0.0%)	5 (7.5)	1 (1.9)	0 (0.0)

Table 75: Depression severity in the EHIS dataset of Greece / Albania

	Total country
Severe, %	0.2
Moderately severe, %	0.4
Moderate, %	1.3
Mild, %	4.8

None or minimum, %	93.3

4.4.2 Qualitative results

Approachability

Information awareness

Information about mental health services in Greece is consistently described as fragmented, unevenly distributed, and dependent on non-structured intermediaries rather than systematic public provision. The problem is not merely one of insufficient content but of a system that has never been organised to guide citizens toward appropriate care. The academic frames this as a fundamental design failure: the citizen should not be expected to know how to navigate the system; the system should be organised to lead the citizen into it. As the academic states: *"It is not a matter of informing every citizen. It is a matter of the organisation of the system, because the citizen should not know how to move in the system"* (SEERC, Academic).

Public mental health services are virtually invisible. Unlike NGO and private sector services, which self-advertise to attract clients, public services do not communicate proactively with the population. The academic illustrates this directly: the flagship public mental health institution in Thessaloniki cannot be navigated through its own website. *"Public services are not advertised"* (SEERC, Academic). The consequence is that those who find appropriate care do so through personal networks, education, or social connection, resources that are structurally unavailable to vulnerable populations. As the academic notes: *"People who are educated, who are connected, who know the right people, will find the right services. Populations who do not have access to knowledge and information, such as vulnerable populations, do not reach the right services"* (SEERC, Academic).

For the Albanian migrant community specifically, information about mental health services flows almost exclusively through a single trusted community intermediary rather than through any formal channel. The civil society respondent describes a decade of trust-building that has created a functional information network within the community, but one entirely dependent on this individual's personal role: *"He's going to ring me right away. And from experience I tell if I say to that person that you will go to Anna who is a doctor they will go without a second question, because I have earned their trust"* (SEERC, Civil Society). The sustainability and scalability of this model are openly questioned.

The policymaker confirms that information initiatives exist at the municipal level, such as seminars, school programs, partnerships with UNHCR, ARSIS, and Doctors of the World, but these are

fragmented across organisations and dependent on project cycles rather than embedded in stable institutional architecture: *"There are many policies and actions for information, not only from the municipality but also from civil society and NGOs, many of which also provide psychological support"* (SEERC, Policymaker). For migrants and refugees specifically, the absence of multilingual information materials until very recently represents a structural exclusion that has only partially been addressed.

Greece's absence of any national data collection infrastructure compounds the information problem at the system level. It is the only European country that does not collect data on involuntary hospitalisations, and no national evaluation framework for public mental health services exists: *"Unfortunately, we do not have any data at all. Data are not collected at national level, nor are data collected on the mental health needs of the population as well as on services and the effectiveness of services"* (SEERC, Academic). Without data, information systems cannot be designed to meet actual needs, and the cycle of structural invisibility is perpetuated.

Barriers to recognising or seeking help

Barriers to recognising and seeking mental health care in Greece operate simultaneously at individual, community, cultural, and structural levels, and are mutually reinforcing. The provider identifies three foundational barriers that precede all others: not recognising distress as a mental health problem, not knowing where to go, and stigma. *"First, they don't recognize it as a mental health problem. Second, they don't know where to go. And to some extent, there's stigma"* (SEERC, Provider). This sequence is analytically important: the barrier to help-seeking often operates before awareness of services even becomes relevant.

For migrants and refugees, these individual-level barriers are compounded by structural ones that are unique to their situation. The policymaker identifies administrative and bureaucratic procedures as a decisive barrier: insurance coverage requires employment, and migrants with mental health problems are the least likely to be employed, meaning their only route to care is through emergency services as uninsured patients: *"To be insured for healthcare, one must be employed, and migrants with mental health problems are unlikely to be employed"* (SEERC, Policymaker). Asylum seekers face an additional structural barrier: placement in isolated facilities far from cities, with no stimuli and no support network, which worsens pre-existing mental health problems before any service contact is even possible.

The academic reframes the entire information and navigation problem as a systemic organisational failure rather than an individual knowledge gap. The absence of structured referral pathways, a functioning primary care gateway that would lead citizens from their first point of contact to appropriate specialist services, means that each individual must independently navigate a fragmented and

uncoordinated landscape. In this context, social capital, knowing the right people, becomes the de facto pathway to care, producing a structural class difference in access.

The user representative provides a vivid illustration of how these barriers play out in lived experience. Decades of sole caregiving, precarious employment, and social isolation meant that even when acute physical symptoms signalled serious distress, accessing care was structurally impossible: *"Because even when I went to the hospital sometimes, I left secretly. I went to work and then returned again because I was alone with two children. The children could not stay in the hospital. There was no time"* (SEERC, User Representative). The barriers are not primarily informational or motivational but structural, produced by the intersection of economic precarity, social isolation, and service design that assumes availability of time.

Acceptability

Stigma and societal dimension

Stigma is identified across all five interviews as a prominent barrier to mental health care access in the Greek context, operating at individual, family, community, and institutional levels simultaneously. Its mechanisms differ meaningfully across the two vulnerable populations at the centre of SEERC's work, but the outcome is consistent: people who experience or suspect mental health difficulties do not seek professional help.

For the Albanian migrant community, stigma is described by the civil society respondent as the dominant barrier, more significant than language, geography, or cost: *"This is the main issue for the Albanian community"* (SEERC, Civil Society). It operates through fear of social labelling, shame within the family, and the equation of mental health care with being "crazy." The user representative confirms this from personal experience: *"Some of my friends are also ashamed. They say: 'Why should we go to a psychologist? We are not crazy.'"* (SEERC, User Representative). The user representative is aware of experiencing anxiety but actively avoids seeking help, a pattern the academic identifies as characteristic of older, less educated populations who carry the highest levels of stigma: *"Older, less educated ones have more stigma for mental disorders than older ones"* (SEERC, Academic).

Stigma within the Albanian community is compounded by decades of broader social stigmatisation in Greek society, in which Albanian identity itself was associated with criminality and unworthiness through media representation. This layered stigma, of both mental illness and ethnic origin, has shaped a generalised distrust of Greek institutions that extends directly to healthcare: *"The community was hurt and stigmatized knowing that society feel that we are only bad"* (SEERC, Civil Society). Disentangling the stigma of mental illness from the stigma of migration is therefore a prerequisite for effective stigma reduction in this population.

For the general Greek population, the academic confirms that stigma remains intense and is supported by recent research: *"Even the most recent data show that the stigma is still too intense"* (SEERC, Academic). Notably, stigma has not been addressed at the policy level in Greece, meaning that the social environment in which individuals must decide whether to seek help has not been structurally improved. The policymaker identifies silence and stigma as the primary obstacles to mental health help-seeking and notes that the first step, family acceptance of a mental health problem, is where the system currently fails.

The provider identifies a particular form of stigma that is analytically distinct: the belief that engaging with mental health support will make problems worse, as if the process of solving the problem will magnify it. This is a specific fear that prevents even motivated individuals from taking the first step toward care: *"Many people say that if they 'dig into' their problems with mental health, things will get worse. As if the process of solving the problem will magnify it"* (SEERC, Provider). Anti-stigma efforts in Greece have not yet reached the point where this fear is effectively countered.

Cultural and social fit

Cultural and social alignment of mental health services with the needs of vulnerable populations, particularly migrants and refugees, is identified across all five interviews as largely absent at the systemic level, with only isolated initiatives providing genuine cultural responsiveness. The provider, drawing on years of work in the refugee sector, describes the failure most directly: *"We are completely lacking in that area in Greece"* (SEERC, Provider).

The structural failure of cultural adaptation is not primarily a failure of individual professionals but a failure of programme design. Intervention programmes routinely include budgets for legal, social, and psychological professionals while omitting the foundational questions: in what language will services be delivered, and with what prior cultural training? *"Because of the urgency to intervene, no funds were allocated to train professionals first or to develop interpreter networks. In my opinion, it's a design problem"* (SEERC, Provider). The policymaker confirms that intercultural competence training does not exist in medical education in Greece, meaning culturally appropriate care depends entirely on individual initiative rather than institutional design.

A particularly important finding is that distrust of Greek institutions among the Albanian migrant community is grounded not in unfounded fear but in concrete experiences and culturally transferred expectations. The civil society respondent describes years of work to dismantle stereotypes about Greek healthcare: that doctors would discriminate based on nationality, charge more, or provide inferior care. These beliefs persisted regardless of the duration of residence in Greece, suggesting they are culturally reproduced rather than individually acquired: *"No. When I came here in 1997, there*

were people who came here in 1990. We still have emigration from Albania to Greece" (SEERC, Civil Society).

Community-led stigma reduction, through weekly gatherings, shared social activities, and the creation of a safe, non-judgmental space for women to discuss their problems, is identified by the civil society respondent as the most effective available approach. This peer-based model has produced measurable change in help-seeking attitudes over a decade. The provider echoes this at the system level, identifying peer and community worker models as the most promising mechanism for reaching populations that formal services cannot access: *"The model now is that you train community workers who provide mental health first aid directly, and for those who need more, they refer them to the appropriate services"* (SEERC, Academic).

Availability

Distribution and sufficiency of services

All five interviews converge on a diagnosis of severe structural under-provision of mental health services in Greece, with an extreme geographic concentration in urban centres and near-total absence of services in rural and remote areas. The academic describes the distribution as highly heterogeneous *"some areas are sufficiently covered and some areas have nothing"* (SEERC, Academic) while the policymaker is more direct: on the island of Samothrace there are no doctors during winter. For vulnerable populations living in remote areas or in isolated asylum-seeker facilities, the structural absence of services means that any discussion of access barriers is moot.

Even in major urban centres, service provision is inadequate for the volume of need. In Thessaloniki, the second largest city in Greece, no adequate public mental health services exist for common presentations such as depression and anxiety. The academic describes the impossibility of referring even connected acquaintances to appropriate free care: *"All my acquaintances and friends who say, 'where should I go and I don't have money to pay for psychotherapy?'. You know I have nowhere to send them"* (SEERC, Academic). The only systematic care available through the public system requires either a psychiatric crisis or prior connection to a specific NGO programme.

A distinctive and analytically important finding specific to Greece is the coexistence of under-provision of qualified care with over-provision of unqualified private practitioners. In areas such as Serres, public mental health centres are understaffed and unknown to the population, while the private sector is populated by practitioners working without adequate qualifications and without regulatory oversight: *"We do not find specialists as we want someone who lives in Serres. In Thessaloniki there may be many, but they do not come to work in Serres. We have 10, 15 psychologists who have offices in Serres who do not have the right qualifications"* (SEERC, Academic). People who cannot find qualified

public care are therefore funnelled toward unqualified private providers, meaning that help-seeking may not result in appropriate care.

The mobile mental health unit in Serres prefecture represents the most significant facilitator identified in the SEERC interviews for rural and elderly vulnerable populations. For the first time in the history of the prefecture, elderly farmers in remote villages have access to a psychiatrist, psychologist, social worker, and nurse visiting their local health centre weekly: *"They are the most vulnerable groups, who until now have had no mental health care. And now for the first time, they have access"* (SEERC, Academic). However, unmet demand has already produced a month-long waiting list after only two years of operation, illustrating both the scale of previously unmet need and the insufficiency of current provision.

The provider identifies the structural root of availability failures as the reliance on temporary European funding cycles rather than integration of mental health into stable state social policy: *"We should stop viewing temporary funding as the ultimate solution and integrate mental health more firmly into state social policy"* (SEERC, Provider). Without this shift, the pattern of service emergence and dissolution will continue, preventing the community structures and therapeutic relationships that effective care requires from being built.

Timing, format, and continuity of services

The format and delivery model of mental health services in Greece is structurally misaligned with the realities of the most vulnerable populations. Standard working hours in public services create a categorical barrier for working people, particularly migrant women in informal employment without protected leave rights. The user representative describes twenty years of working from 5am to 9:30pm, during which time any regular appointment was structurally impossible regardless of cost or motivation: *"Do you believe that for 20 years I didn't even know where the beach was? I didn't even take the children. I woke up at five in the morning and returned home at 21:30 at night"* (SEERC, User Representative).

The contrast between NGO and public sector scheduling flexibility is stark and consistent across interviews. The provider confirms: *"NGOs have a lot of flexibility, from what I've experienced. Public services have very little. The more public the structure, the more rigid things become"* (SEERC, Provider). For vulnerable populations who cannot make weekday appointments, the practical choice is between NGO services, where these exist and are funded, or no mental health support at all.

Continuity of care is identified by the provider as the most clinically critical and most consistently absent element of the Greek mental health system. EU-funded programmes provide meaningful access during their operational period, but their dissolution at the end of funding cycles destroys the therapeutic relationships that have been built: *"Without these programs, we'd have zero accessibility.*

They're wonderful. But after one, two, three years, everything dissolves until the next funding cycle. There's no continuity. Communities are not built" (SEERC, Provider). For a population whose needs are long-term and highly sensitive to relational discontinuity, this structural instability represents a fundamental appropriateness failure embedded within the availability dimension.

Online therapy is identified as an emerging structural facilitator that partially addresses both geographic and scheduling barriers. The explosion of online provision in the private sector has opened new possibilities, particularly for Greek-speaking migrants living abroad and for those in rural areas: *"Online sessions have opened huge possibilities. It's also easier to find providers online now than in the past"* (SEERC, Provider). However, digital access requires both hardware and digital literacy, conditions that cannot be assumed for older adults or recent migrants.

Affordability

Direct and indirect cost

Financial barriers in Greece operate through a mechanism distinct from many other European contexts. Because public mental health services are formally free of charge, direct costs are not the primary barrier for those who can access the public system. Instead, financial barriers manifest through the two-tier system: those who can afford to pay access faster private care of variable quality, while those who cannot must wait months in an under-resourced public system. The academic states this directly: *"The cost affects availability, does not affect quality"* (SEERC, Academic).

In practice, the public system's waiting times of six to seven months create a de facto financial barrier, because those who need care urgently must pay privately or go without. The policymaker identifies this as a mechanism of inequality: *"Those people who do not have the money will have to wait months before they can access it"* (SEERC, Policymaker). The provider confirms that financial hardship is near-universal among vulnerable groups, raising the question of whether any vulnerable social group is not also financially vulnerable.

For migrants in particular, the insurance system creates an additional categorical exclusion. Healthcare coverage requires formal employment, and migrants with mental health difficulties are the least likely to be employed. This structural exclusion means the free public system is not actually free for a significant portion of the most vulnerable: *"Administrative and bureaucratic procedures are a major barrier because to be insured for healthcare, one must be employed, and migrants with mental health problems are unlikely to be employed"* (SEERC, Policymaker).

Indirect costs are equally significant. The user representative describes the prohibitive costs of private hospital care, 700 euros per night at a private hospital in Athens, and the response upon hearing the price: *"When I heard that I said: 'Leave it. I will die like this. I don't want it.'"* (SEERC, User Representative). Even in the public system, indirect costs of lost working hours, transport, and

childcare arrangements represent insuperable barriers for working migrants with sole caregiving responsibilities. For this population, the cost of accessing care is not primarily monetary but temporal.

Support mechanisms

Financial support mechanisms for mental health care in Greece are limited, patchwork, and not specifically targeted at mental health for vulnerable populations. The primary access route for vulnerable groups is through EU-funded programmes implemented by NGOs and municipalities, a model that is effective while operational but structurally fragile: *"Funded programs are a huge relief and often the main access point for non-clinical cases. NGOs or local authorities implement them"* (SEERC, Provider).

The policymaker confirms that municipal initiatives include free psychological and social services for vulnerable people, but these are embedded within broader social programmes rather than constituting a dedicated mental health funding mechanism: *"Within our initiatives we have psychologists and social workers providing free services for vulnerable people"* (SEERC, Policymaker). There are no specific financial support mechanisms for mental health for migrants, elderly populations, or other vulnerable groups comparable to those available for people with recognised disability.

A structural gap identified by the provider is the absence of state reimbursement for private psychology sessions for adults, while such reimbursement exists for children. This creates a financial cliff at the age of eighteen: *"For children, insurance reimburses private sessions. For adults, nothing similar exists"* (SEERC, Provider). The provider proposes extending reimbursement to adult psychology as a systemic solution that would simultaneously address access, cost, and stigma.

The civil society respondent's community has reached the point of guiding members toward free public services, but notes that financial cost has not yet become the primary barrier, because stigma and motivation barriers have not yet been overcome sufficiently for cost to become relevant: *"We haven't reached the point where the cost is the issue yet"* (SEERC, Civil Society). This is a distinctive finding that illustrates the sequential nature of access barriers: for this population, stigma must be addressed before financial accessibility even becomes the relevant concern.

Appropriateness

Fit and usefulness of care

Across all five interviews, the appropriateness of mental health care in Greece is characterised by a fundamental asymmetry: when care is accessed, particularly through the public hospital system or well-resourced NGO programmes, it is generally described as good in quality and delivered by committed professionals. However, this positive assessment applies only to the small minority who

reach services and is therefore of limited analytical value without acknowledging the much larger population that never does.

The academic's evaluation data from mobile units and outreach services consistently shows high satisfaction among those who access care. In one evaluation of a mobile unit on Mykonos, recipients were highly reluctant to say anything critical for fear the unit would be closed: *"Their great agony was not to say anything negative and close the unit. They were very anxious about it"* (SEERC, Academic).

For migrants and refugees, care appropriateness is compromised at the most fundamental level by the absence of language support and cultural preparation among providers. The civil society respondent's initiative to train community peer workers and the academic's piloting of peer-supported self-help groups for Ukrainian refugees represent the most promising models for appropriate care delivery for this population, precisely because they embed cultural and linguistic competence within the care relationship itself: *"For most people, there is no need for anything else. For populations that are distressed in general, if you deal with their problems, psychosocial problems directly, most of them will avoid developing more serious mental problems"* (SEERC, Academic).

The user representative's experience illustrates the appropriateness problem most concretely: the user representative has never accessed mental health services despite experiencing symptoms of anxiety and panic attacks for overt wo decades. This mental health need is entirely unmet, not because of negative experiences of mental health care but because the combination of stigma, distrust, work demands, and social isolation has prevented any entry into the system. This case represents the majority experience for vulnerable populations in Greece, under-treatment driven not by service inadequacy but by access failure at every prior stage.

National evaluation infrastructure for mental health services does not exist in Greece. There are no satisfaction studies, no national registries, and no systematic quality monitoring data. This means it is structurally impossible to assess whether care is appropriate for vulnerable populations at a system level: *"No, there are no evaluations or data. In Greece, evaluations are lacking, and statistical data are missing"* (SEERC, Policymaker). The planned national framework for assessment of mental health services, announced very recently, will apply only to private entities, leaving the public system outside evaluation.

Quality of interaction and respect

The quality of provider-patient interactions in Greece is described across all five interviews as highly variable and dependent on individual professional character rather than systemic standards or training. The user representative captures this experience most directly: *"There are good ones and*

there are bad ones. Different kinds" (SEERC, User Representative). This variability is not experienced as a neutral observation but as a source of anxiety that actively deters help-seeking: if one does not know what kind of provider one will encounter, the risk of a dismissive or harmful interaction may outweigh the anticipated benefit.

Experiences of disrespectful care, a doctor looking at a phone during a consultation, an unsolicited prognosis delivered without context, a demand for 70 euros before any examination, are described by the user representative as concrete deterrents to future help-seeking. These are not marginal experiences but representative encounters that generate stories shared within communities, shaping collective expectations: *"A lot of stories that can create a reality afterwards and people decide there are not going because if I'm going to be vulnerable I don't want anything negative happening"* (SEERC, User Representative).

By contrast, the user representative's encounter with a provider who conducted a thorough examination, explained the situation clearly, respected the user representative's autonomy in decision-making, and followed up over time is described as transformative: *"He said: 'You will think about it as long as you want and then come back to me and tell me what you want to do.' That's the doctor who is good and proper and knows his job"* (SEERC, User Representative). This description captures the core elements of appropriate interaction, respect, clear communication, and person-centred decision-making, and demonstrates that the professional capacity for such interactions exists. The problem is that it is distributed unevenly and without systemic support.

The provider draws a precise analytical distinction between the quality of individual professionals and the quality of systems: *"Mental health professionals are generally sensitive, humane, respectful. Teams are strong on a personal level. The problem is duration"* (SEERC, Provider). And: *"Many times in Greece, what happens is that providers are forced to compensate for the shortcomings of the system"* (SEERC, Provider). This structural compensation, where individual professional commitment is the mechanism by which system failures are partially absorbed, is recognised across all five interviews as both a testament to the quality of professionals and an unsustainable basis for service delivery.

For migrants, the desire to be seen as a human being rather than defined by ethnicity or occupation runs through the interview as the core acceptability condition: *"I want them to see me not as a cleaner, but as a human being. That's it"* (SEERC, User Representative). This encapsulates what appropriate care means for this population: not cultural competence as a technical skill, but the basic recognition of personhood that every clinical encounter should begin from.

4.5 Greece

4.5.1 Quantitative results

The dataset included 224 respondents across three groups: General (n = 112), Unaccompanied children (n = 16), and Youth aged 18–25 (n = 96) (Table 76).

Table 76: Distribution of participants across the included groups in Greece

General group	Unaccompanied children	Youth (18 – 25)
N = 112	N = 16	N = 96

The mean age was 38.8 years (SD 11.8) in the General group, 16.3 years (SD 0.9) among Unaccompanied children, and 20.5 years (SD 2.6) in the Youth group (Table 77).
Questionnaire completion differed across groups. In the General group, most questionnaires were self-completed (109), with two completed with assistance and one by someone else. Among Unaccompanied children, none were self-completed; six (37.5%) were completed with assistance and ten (62.5%) by someone else. In the Youth group, 70 questionnaires (72.9%) were self-completed, 10 (10.4%) were completed with assistance, and 16 (16.7%) by someone else.
For sex at birth, the General group included 86 females, 24 males, and two non-binary respondents. Among Unaccompanied children, three reported female, twelve male, and one preferred not to say. In the Youth group, 61 reported female and 35 male. Gender identity aligned with sex assigned at birth for most respondents: 109/112 in the General group, all 16 Unaccompanied children, and 94/96 in the Youth group. Three respondents in the General group and two in the Youth group reported a different gender identity. Most respondents in each group identified as heterosexual. In the General group, 101 reported heterosexual orientation, four gay, six bisexual, and one another orientation. Among Unaccompanied children, 15 reported heterosexual orientation and one preferred not to say. In the Youth group, 74 reported heterosexual orientation, one gay, two lesbian, nine bisexual, and ten preferred not to say. Most participants resided in Greece: 110/112 in the General group, 14/16 Unaccompanied children, and 93/96 in the Youth group. Birthplace distributions were as follows: in the General group, 108 were born in Greece, one in another EU country, and three outside the EU; all Unaccompanied children were born outside the EU; and in the Youth group, 68 were born in Greece, two in another EU country, and 26 outside the EU.
Citizenship largely corresponded to country of residence. In the General group, 111 respondents held citizenship of the country of residence and one of another EU member state. Among Unaccompanied children, three held citizenship of the country of residence and thirteen of a non-EU country. In the Youth group, 74 were citizens of the country of residence, one of another EU member state, and 21 of a non-EU country. The mean duration of stay in the country was 36.4

years (SD 13.7) in the General group, 3.63 years (SD 4.36) among Unaccompanied children, and 16.0 years (SD 8.41) in the Youth group. Educational attainment (ISCED) reflected the groups' life stages. In the General group, most respondents reported tertiary education, including 40 with a Bachelor's degree (ISCED 6), 49 with a Master's degree (ISCED 7), and two with a Doctoral degree (ISCED 8). Smaller numbers reported lower levels of education. Among Unaccompanied children, education levels ranged from ISCED 0 to ISCED 3. In the Youth group, educational attainment was more varied, with many respondents reporting tertiary education (45 with ISCED 6 and five with ISCED 7), alongside others at earlier educational levels. Use of mental health services in the previous 12 months was reported by 54 of 112 respondents in the General group, all 16 Unaccompanied children, and 56 of 96 respondents in the Youth group.

Table 77: Descriptive statistics of the different included groups in Greece

Demographic variable	General group	Unaccompanied children	Youth (18-25)	Overall
Age, *mean (sd)*	38.8 (11.8)	16.3 (0.9)	20.5 (2.6)	29.3 (12.7)
Questionnaire completed by, *n (%)*				
Respondent alone	109 (97.3%)	0 (0%)	70 (72.9%)	179 (79.9%)
Respondent with help	2 (1.8%)	6 (37.5%)	10 (10.4%)	18 (8.0%)
Someone else	1 (0.9%)	10 (62.5%)	16 (16.7%)	27 (12.1%)
Sex at birth, *n (%)*				
Female	86 (76.8%)	3 (18.8%)	61 (63.5%)	150 (67.0%)
Male	24 (21.4%)	12 (75.0%)	35 (36.5%)	71 (31.7%)
Non-binary	2 (1.8%)	0 (0%)	0 (0%)	2 (0.9%)
Prefer not to say	0 (0%)	1 (6.3%)	0 (0%)	1 (0.4%)
Gender the same as assigned at birth, *n (%)*				
Yes	109 (97.3%)	16 (100%)	94 (97.9%)	219 (97.8%)
No	3 (2.7%)	0 (0%)	2 (2.1%)	5 (2.2%)
Prefer not to say	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Sexual orientation, *n (%)*				
Heterosexual	101 (90.2%)	15 (93.8%)	74 (77.1%)	190 (84.8%)
Gay	4 (3.6%)	0 (0%)	1 (1.0%)	5 (2.2%)
Lesbian	0 (0%)	0 (0%)	2 (2.1%)	2 (0.9%)
Bisexual	6 (5.4%)	0 (0%)	9 (9.4%)	15 (6.7%)
Other	1 (0.9%)	0 (0%)	0 (0%)	1 (0.4%)

Prefer not to say	0 (0%)	1 (6.3%)	10 (10.4%)	11 (4.9%)
Country of residence, *n (%)*				
Greece	110 (98.2%)	14 (87.5%)	93 (96.9%)	217 (96.9%)
Other	2 (1.8%)	2 (12.5%)	3 (3.1%)	7 (3.1%)
Country of birth, *n (%)*				
Born in the country of residence	108 (96.4%)	0 (0%)	68 (70.8%)	176 (78.6%)
In another country in the EU	1 (0.9%)	0 (0%)	2 (2.1%)	3 (1.3%)
Born in another country outside the EU	3 (2.7%)	16 (100%)	26 (27.1%)	45 (20.1%)
Citizen of country, *n (%)*				
Citizen of the country of residence	111 (99.1%)	3 (18.8%)	74 (77.1%)	188 (83.9%)
No citizenship of the country of residence but that of another EU member state	1 (0.9%)	0 (0%)	1 (1.0%)	2 (0.9%)
No citizenship of the country of residence but that of a country outside the EU	0 (0%)	13 (81.3%)	21 (21.9%)	34 (15.2%)
Duration of stay in the country of residence, *mean years (SD)*	36.4 (13.7)	3.63 (4.36)	16.0 (8.41)	25.3 (16.0)
Highest level of education completed (ISCED), *n (%)*				
Early childhood education (ages 3 and above),	0 (0%)	3 (18.8%)	5 (5.2%)	8 (3.6%)

including pre-primary education and early childhood educational development (under 3). (ISCED 0)				
Primary education (also known as elementary or basic education). (ISCED 1)	1 (0.9%)	5 (31.3%)	6 (6.3%)	12 (5.4%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	0 (0%)	5 (31.3%)	9 (9.4%)	14 (6.3%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	4 (3.6%)	3 (18.8%)	18 (18.8%)	25 (11.2%)
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	9 (8.0%)	0 (0%)	6 (6.3%)	15 (6.7%)
Short-cycle third level education (programs	7 (6.3%)	0 (0%)	2 (2.1%)	9 (4.0%)

typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)				
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	40 (35.7%)	0 (0%)	45 (46.9%)	85 (37.9%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	49 (43.8%)	0 (0%)	5 (5.2%)	54 (24.1%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	2 (1.8%)	0 (0%)	0 (0%)	2 (0.9%)
Missing				
Use of mental health care in the previous 12 months, *n (%)*				
Yes	54 (48.2%)	16 (100%)	56 (58.3%)	126 (56.3%)
No	58 (51.8%)	0 (0%)	40 (41.7%)	98 (43.8%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Within the Availability and Accommodation dimension, most indicators did not demonstrate statistically significant differences between population groups. Specifically, no statistically significant differences were observed regarding the time required to travel to mental health service locations, the availability of private space for receiving care and speaking openly, the time required to obtain an appointment when mental healthcare was needed, or knowledge of where to seek immediate help during a mental health crisis (Figure 84; all p-values > 0.05).

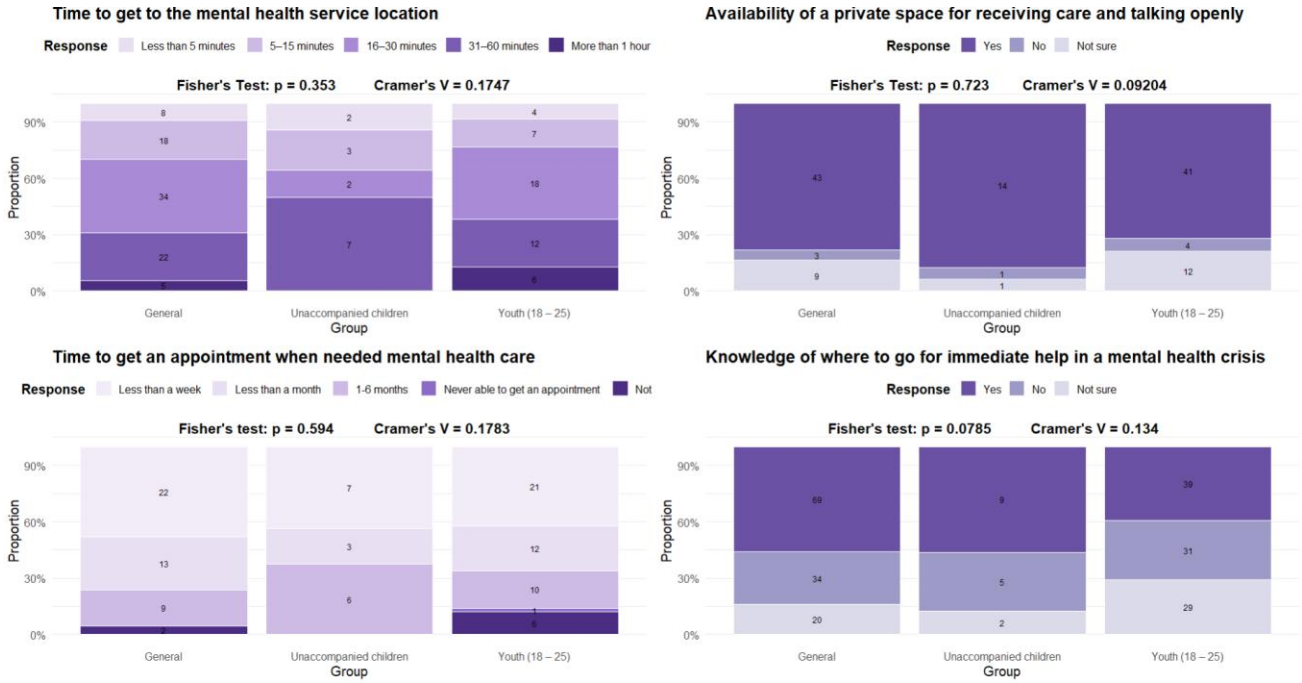

Figure 82: Non-significant differences across groups for the Availability and Accommodation dimension in Greece

In contrast, variation between groups was identified regarding awareness of mental health services available in the local area (Figure 85). Pairwise comparisons indicated a statistically significant difference between the general population and youth aged 18–25 years (p = 0.003, Cramer's V = 0.241). No statistically significant difference was observed between the general population and unaccompanied children (p = 0.271, Cramer's V = 0.146; Table 78). Descriptive findings indicated that respondents in the youth group (18–25 years) reported lower levels of awareness of available mental health services compared with the general population. The corresponding effect size indicates a small to moderate association, suggesting meaningful differences in awareness between these groups.

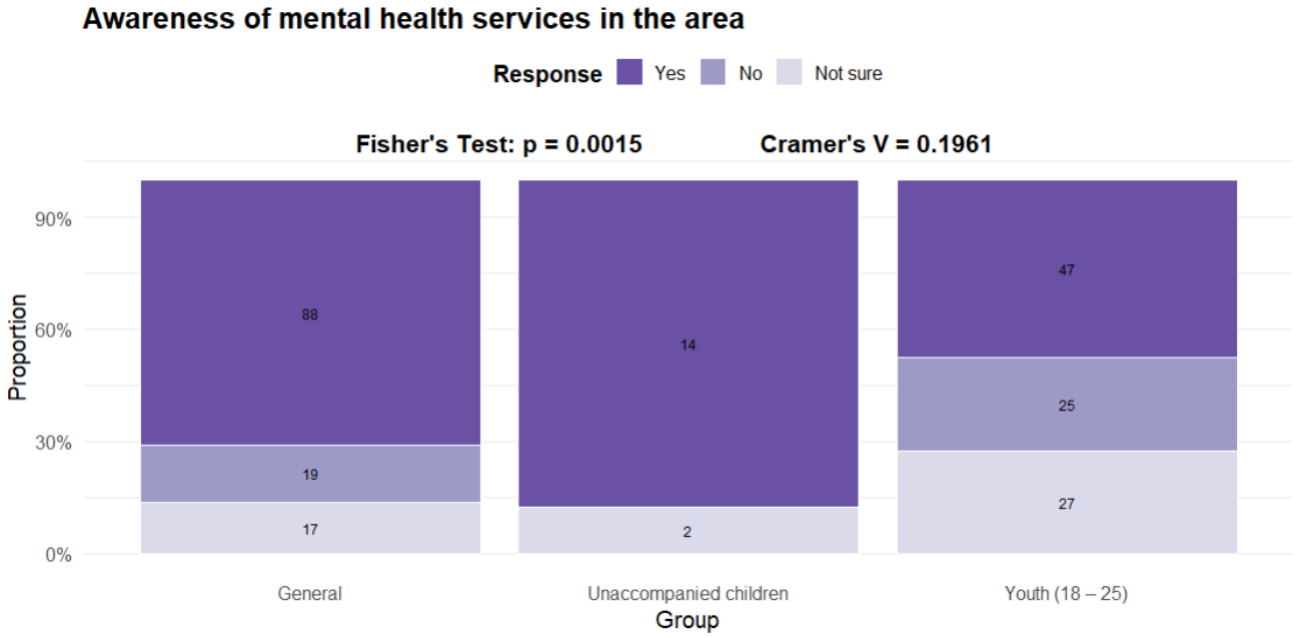

Figure 83: Fisher's exact test of the awareness of mental health services in the area item in Greece

Table 78: Pairwise comparison test of the awareness of mental health services in the area item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.271	0.146
General group : Youth (18 – 25)	0.003	0.241
Unaccompanied children : Youth (18 – 25)	0.008	0.286

Approachability

Within the Approachability dimension, several indicators did not demonstrate statistically significant differences between population groups. These included whether participants had encountered information on accessing mental health support, the ease of finding reliable information about mental health services, whether respondents had heard about experiences of other patients

regarding mental health services, and whether they had come across outreach programs related to mental health services (Figure 86; all p-values > 0.05).

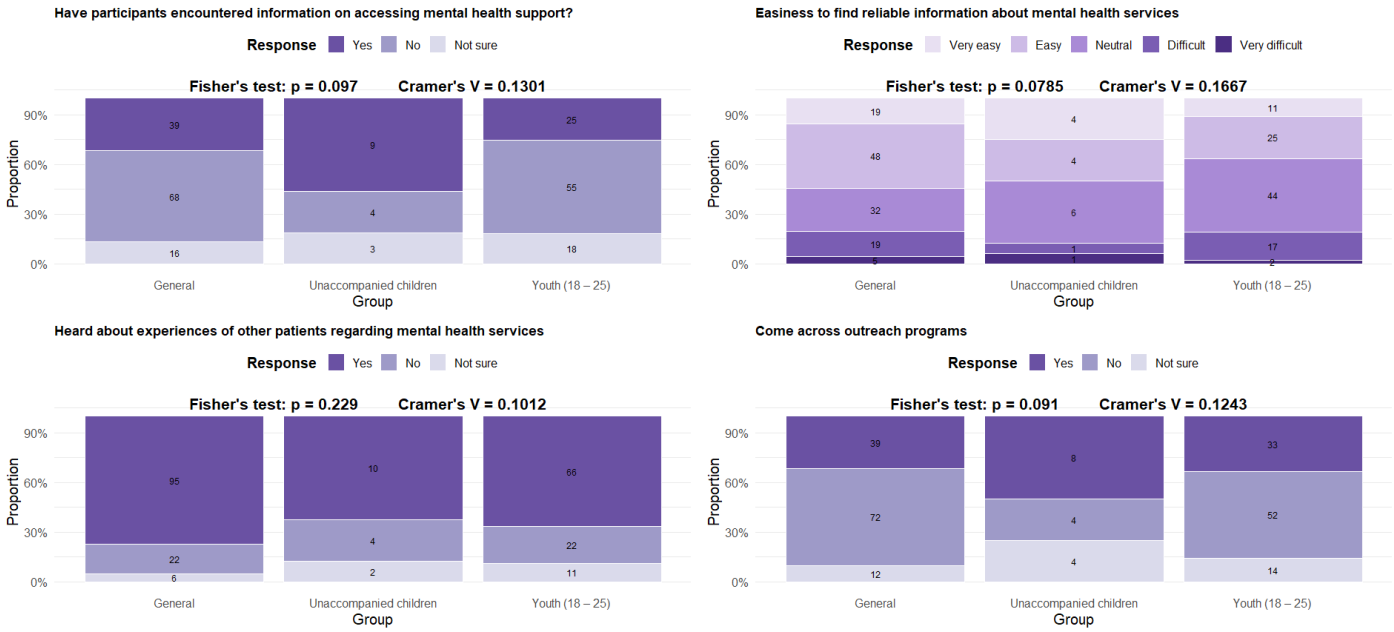

Figure 84: Non-significant differences across groups for the Approachability dimension

In contrast, statistically significant differences were identified regarding whether participants had been asked about their mental well-being during encounters with a family doctor, school counsellor, or social worker Figure 87. Pairwise comparisons indicated significant differences between the general population and unaccompanied children (p = 0.002, Cramer's V = 0.336), between the general population and youth aged 18–25 years (p = 0.003, Cramer's V = 0.243), and between unaccompanied children and youth aged 18–25 years (p = 0.011, Cramer's V = 0.275) (Table 79). Descriptive findings indicated that unaccompanied children were more frequently asked about their mental well-being compared with the other groups. The corresponding Cramer's V values indicate small to moderate associations, suggesting meaningful differences in how mental health discussions are initiated across population groups.

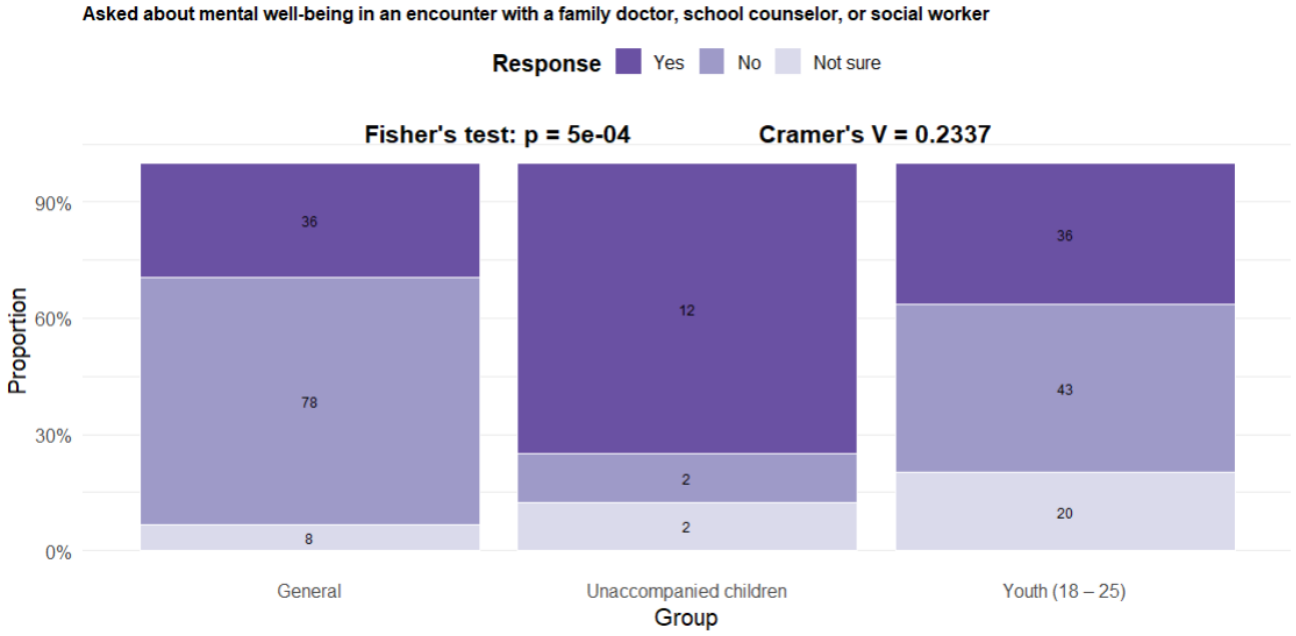

Figure 85: Fisher's exact test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Greece

Table 79: Pairwise comparison test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.002	0.336
General group : Youth (18 – 25)	0.003	0.243
Unaccompanied children : Youth (18 – 25)	0.011	0.275

Acceptability

Within the Acceptability dimension, most indicators did not demonstrate statistically significant differences between population groups. Specifically, no differences were observed regarding whether mental health services were perceived as sensitive to cultural beliefs and practices, the possibility to communicate with mental health providers in a preferred language, whether mental health professionals communicated respectfully with patients, whether patients' rights were protected against mistreatment or abuse, or whether mental health services were considered

trustworthy (Figure 88 & Figure 89; all p-values > 0.05).

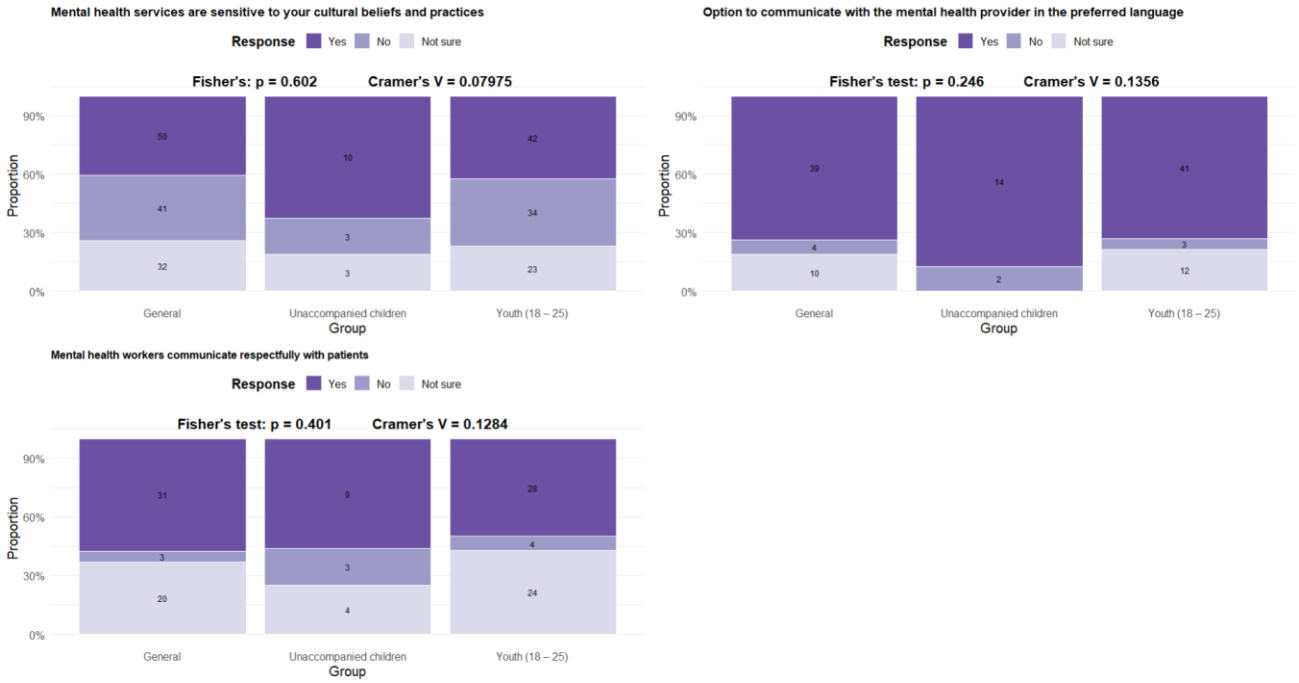

Figure 86: Non-significant differences across groups for the Acceptability dimension in Greece (1)

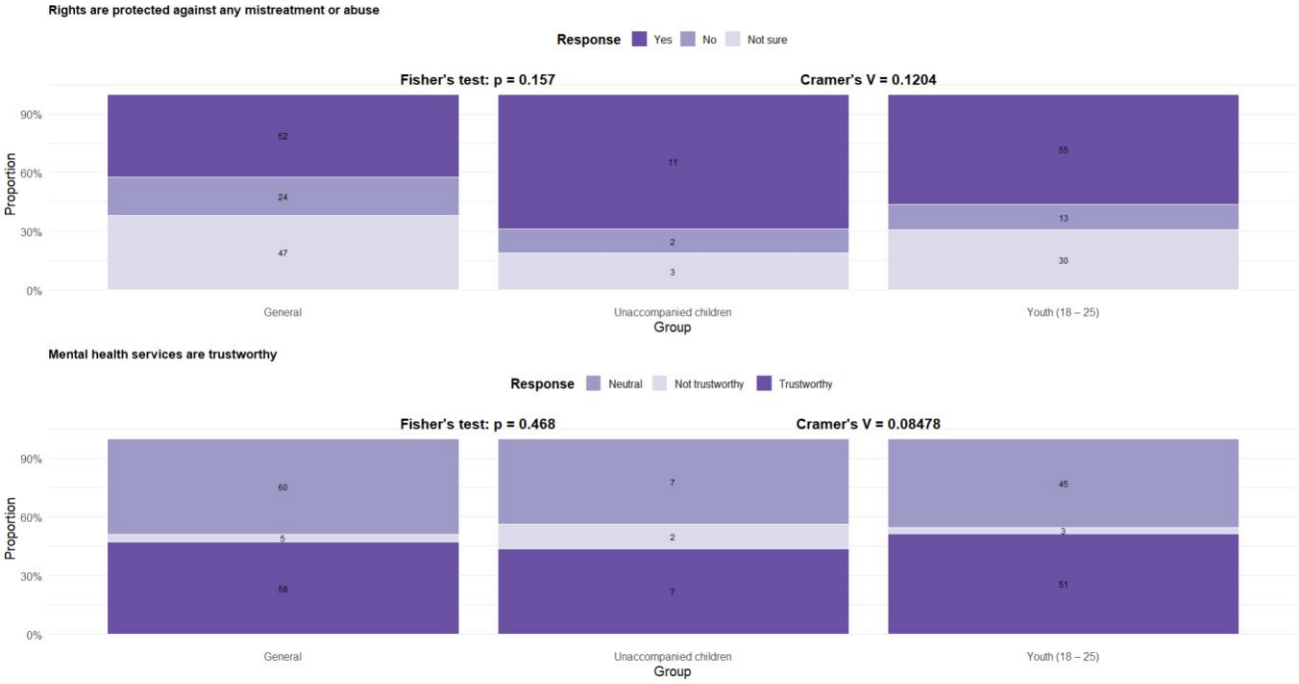

Figure 87: Non-significant differences across groups for the Acceptability dimension in Greece (2)

In contrast, statistically significant differences were observed regarding the option to choose one's own doctor or therapist (Figure 90). Pairwise comparisons (Table 80) indicated significant differences between the general population and unaccompanied children (p = 0.005, Cramer's V = 0.418), as well as between unaccompanied children and youth aged 18–25 years (p = 0.020, Cramer's V = 0.319). No statistically significant difference was observed between the general

population and youth aged 18–25 years (p = 0.396, Cramer's V = 0.129). Descriptive findings indicated that unaccompanied children were less likely to report having the option to choose their own doctor or therapist compared with other groups. The corresponding Cramer's V values indicate moderate associations, particularly for comparisons involving unaccompanied children, suggesting meaningful differences in autonomy related to provider choice.

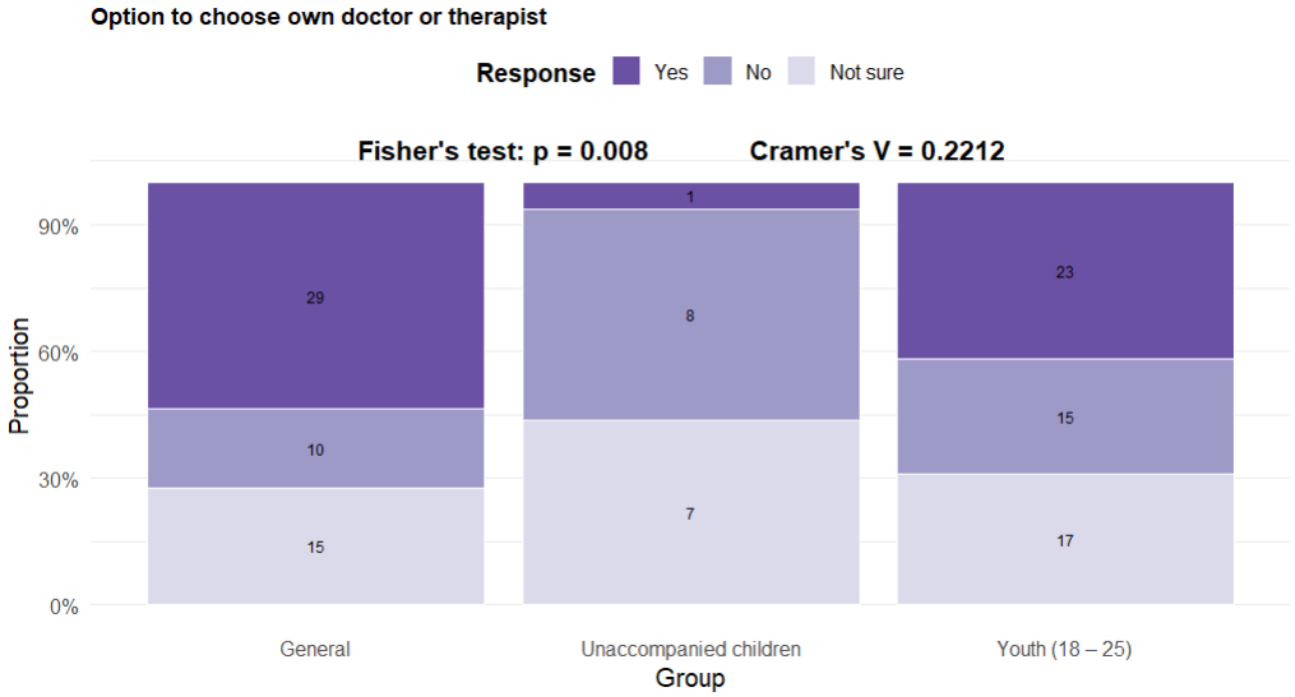

Figure 88: Fisher's exact test of the option to choose own doctor or therapist item in Greece

Table 80: Pairwise comparison test of the option to choose own doctor or therapist item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.005	0.418
General group : Youth (18 – 25)	0.396	0.129
Unaccompanied children : Youth (18 – 25)	0.020	0.319

Affordability

Within the Affordability dimension, several indicators did not demonstrate statistically significant differences between population groups. These included not taking prescribed medication due to cost, delayed or avoided mental healthcare due to financial constraints in the past 12 months, and

difficulty accessing mental healthcare due to additional costs (Figure 91; all p-values > 0.05).

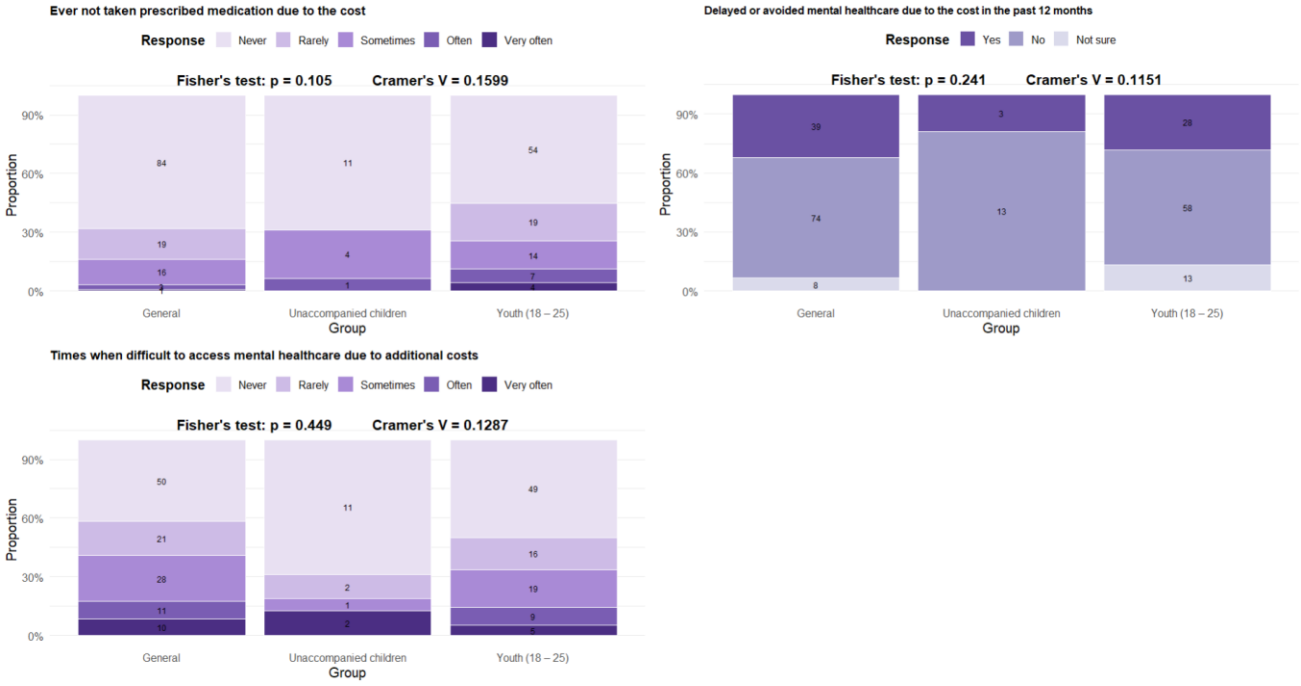

Figure 89: Non-significant differences across groups for the Affordability dimension in Greece

In contrast, statistically significant differences were observed regarding the possibility of accessing mental health services through public programs or services free of charge or at low cost (Figure 92) Pairwise comparisons (Table 81) indicated significant differences between the general population and unaccompanied children (p = 0.002, Cramer's V = 0.550), as well as between the general population and youth aged 18–25 years (p = 0.002, Cramer's V = 0.327). No statistically significant difference was observed between unaccompanied children and youth aged 18–25 years (p = 0.066). Descriptive findings indicated that respondents in the general population reported fewer opportunities to access publicly funded or low-cost mental health services compared with youth and unaccompanied children. The corresponding effect sizes indicate moderate to large associations,

particularly for comparisons involving unaccompanied children.

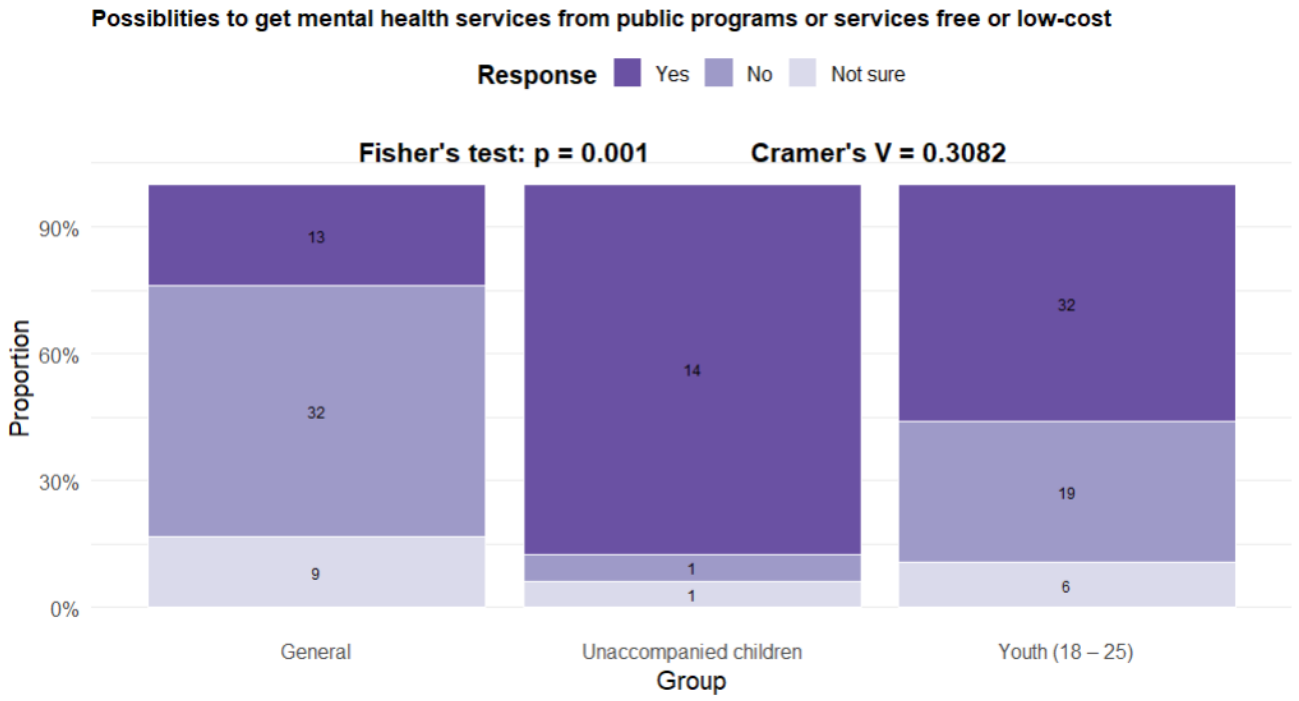

Figure 90: Fisher's exact test of the possibilities to get mental health services from public programs or services free or low cost item in Greece

Table 81: Pairwise comparison test of the possibilities to get mental health services from public programs or services free or low cost item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.002	0.550
General group : Youth (18 – 25)	0.002	0.327
Unaccompanied children : Youth (18 – 25)	0.066	0.275

Differences were also identified regarding health insurance coverage for mental health services (Figure 93). Pairwise comparisons (Table 82) indicated a statistically significant difference between the general population and youth aged 18–25 years (p = 0.006, Cramer's V = 0.271), while other group comparisons were not statistically significant. Descriptive findings suggested variation in reported insurance coverage between these groups. The observed effect size indicates a small to

moderate association.

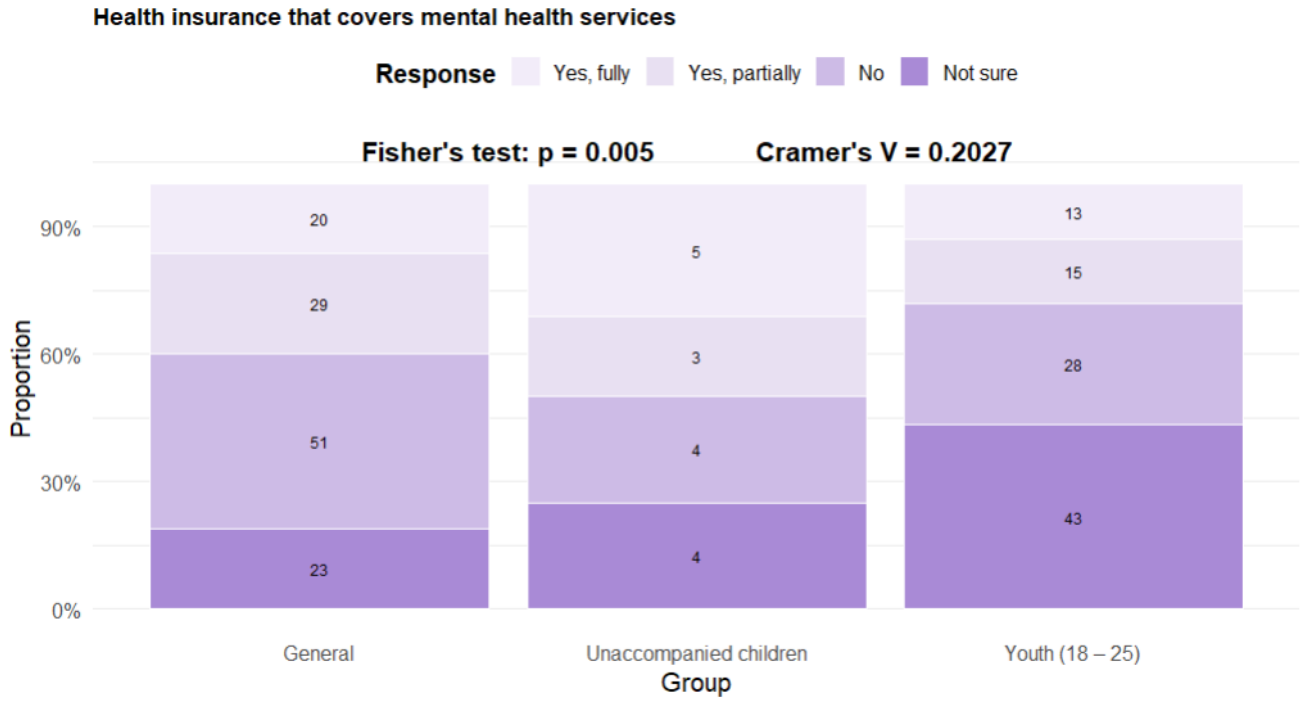

Figure 91: Fisher's exact test of the health insurance that covers mental health services item in Greece

Table 82: Pairwise comparison test of the health insurance that covers mental health servicess item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.369	0.151
General group : Youth (18 – 25)	0.006	0.271
Unaccompanied children : Youth (18 – 25)	0.362	0.191

Further variation was observed regarding difficulty accessing mental healthcare due to loss of income (Figure 94). Pairwise comparisons (Table 83) identified a statistically significant difference between the general population and youth aged 18–25 years (p = 0.039, Cramer's V = 0.239), while other comparisons did not reach statistical significance. These findings suggest modest differences in income-related financial barriers between these groups.

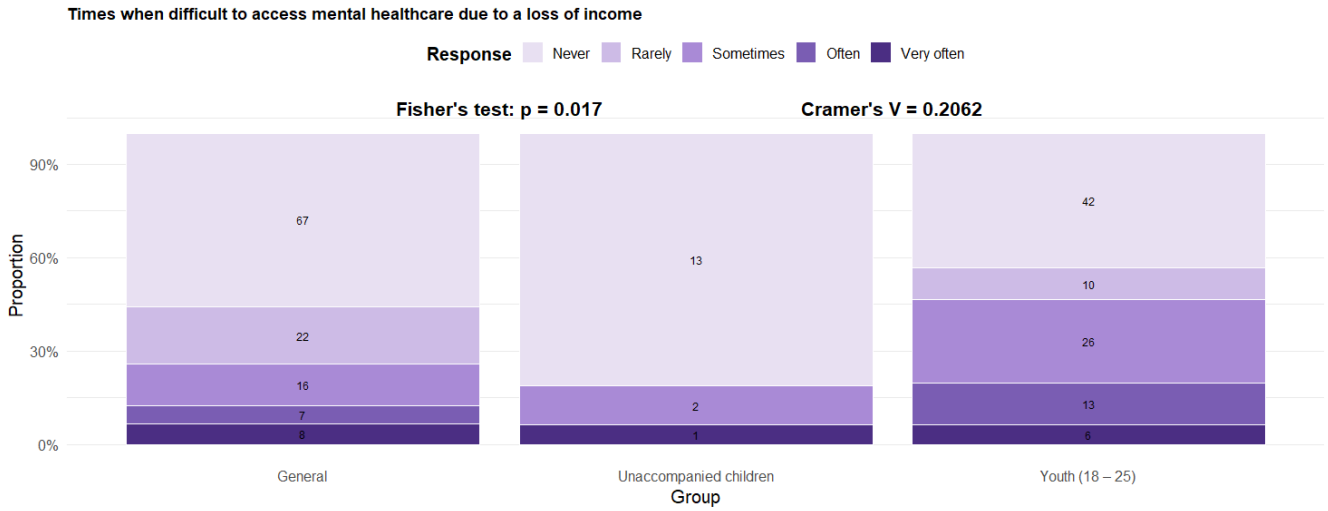

Figure 92: Fisher's exact test of the times when difficult to access mental healthcare due to a loss of income item in Greece

Table 83: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.252	0.200
General group : Youth (18 – 25)	0.039	0.239
Unaccompanied children : Youth (18 – 25)	0.110	0.282

Additional differences were identified regarding whether respondents had been offered financial support or discounts to reduce or cover the costs of care (Figure 95) Pairwise comparisons (Table 84) indicated statistically significant differences between the general population and unaccompanied children (p = 0.008, Cramer's V = 0.402), between the general population and youth aged 18–25 years (p = 0.008, Cramer's V = 0.300), and between unaccompanied children and youth aged 18–25 years (p = 0.017, Cramer's V = 0.299). Descriptive findings indicated that financial support was reported more frequently among youth and unaccompanied children compared with the general population. The corresponding effect sizes indicate moderate associations, suggesting meaningful

variation in access to financial assistance.

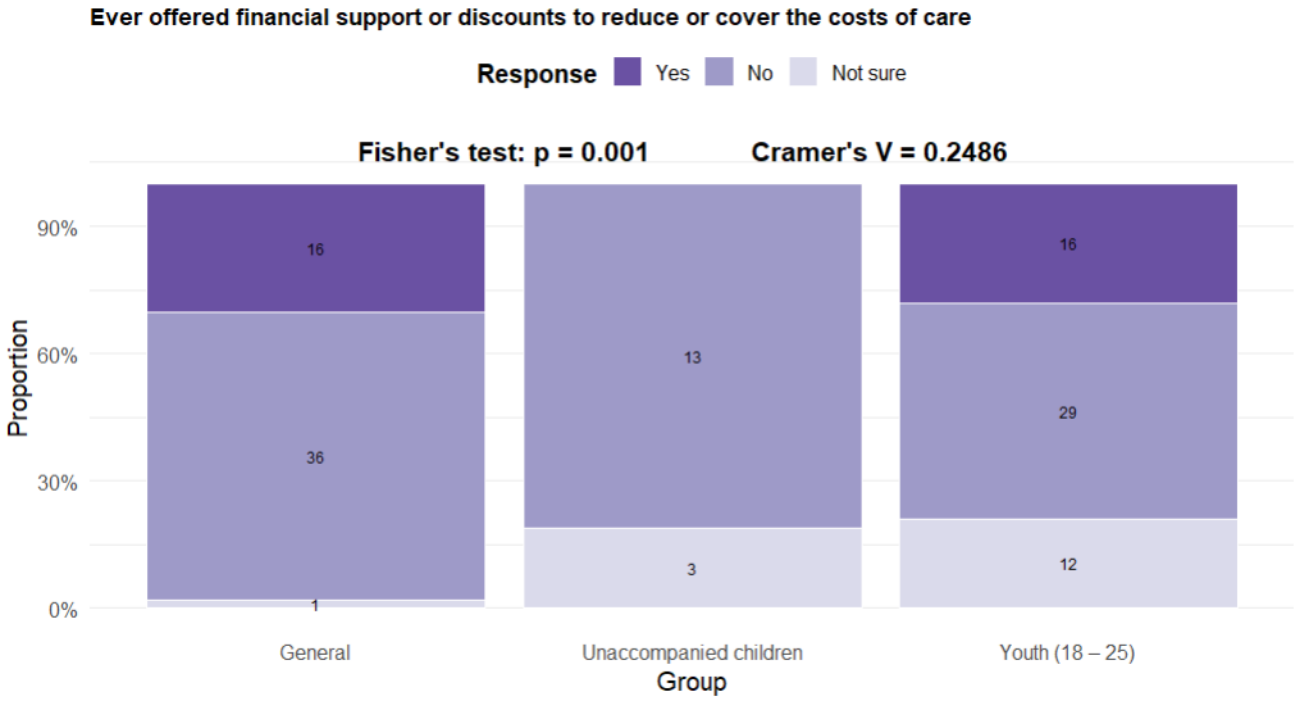

Figure 93: Fisher's exact test of the ever offered financial support or discounts to reduce or cover the costs of care item in Greece

Table 84: Pairwise comparison test of the ever offered financial support or discounts to reduce or cover the costs of care item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.008	0.402
General group : Youth (18 – 25)	0.008	0.300
Unaccompanied children : Youth (18 – 25)	0.017	0.299

Although variation was also observed regarding whether services provided help with payment options, insurance questions, or financial assistance (Figure 96), pairwise comparisons did not identify statistically significant differences between specific group combinations after adjustment (all adjusted p-values > 0.05; Table 85). These findings suggest that overall differences may exist, but

specific group-level differences were not clearly attributable.

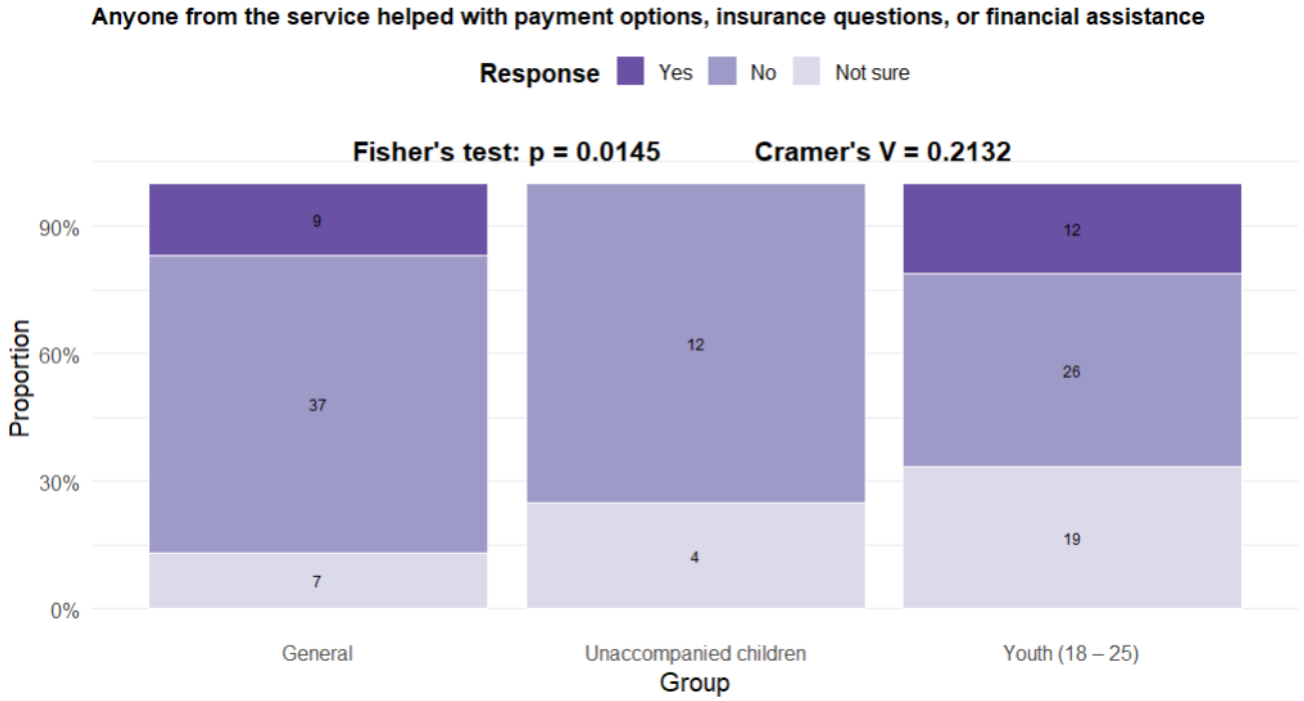

Figure 94: Fisher's exact test of the anyone from the service helped with payment options, insurance questions, or financial assistance item in Greece

Table 85: Pairwise comparison test of the anyone from the service helped with payment options, insurance questions, or financial assistance item in Greece

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Unaccompanied children	0.127	0.236
General group : Youth (18 – 25)	0.074	0.265
Unaccompanied children : Youth (18 – 25)	0.098	0.280

Appropriateness

Within the Appropriateness dimension, none of the assessed indicators demonstrated statistically significant differences between population groups. Specifically, no differences were observed regarding whether mental health professionals treated clients with courtesy and respect, whether providers explained information in a way that was easy to understand, or whether sufficient time was spent during consultations (Figures 97-100; all p-values > 0.05). These findings indicate that several core aspects of provider–patient interaction were experienced similarly across the general population, youth aged 18–25 years, and unaccompanied children. Similarly, no statistically significant differences were identified regarding the perceived helpfulness or relevance of mental

health services, whether cultural beliefs and practices were considered, or whether respondents reported involvement in setting treatment goals or care plans. In addition, perceptions that providers considered broader life circumstances and that referrals between services occurred smoothly did not differ between groups. Further indicators related to continuity of care also showed no statistically significant variation. These included the ease of scheduling follow-up appointments, the possibility of seeing the same provider consistently, and whether users received invitations to provide feedback regarding their treatment. Likewise, perceptions that feedback was used to improve services, and whether support was offered to caregivers or family members, were comparable across all groups.

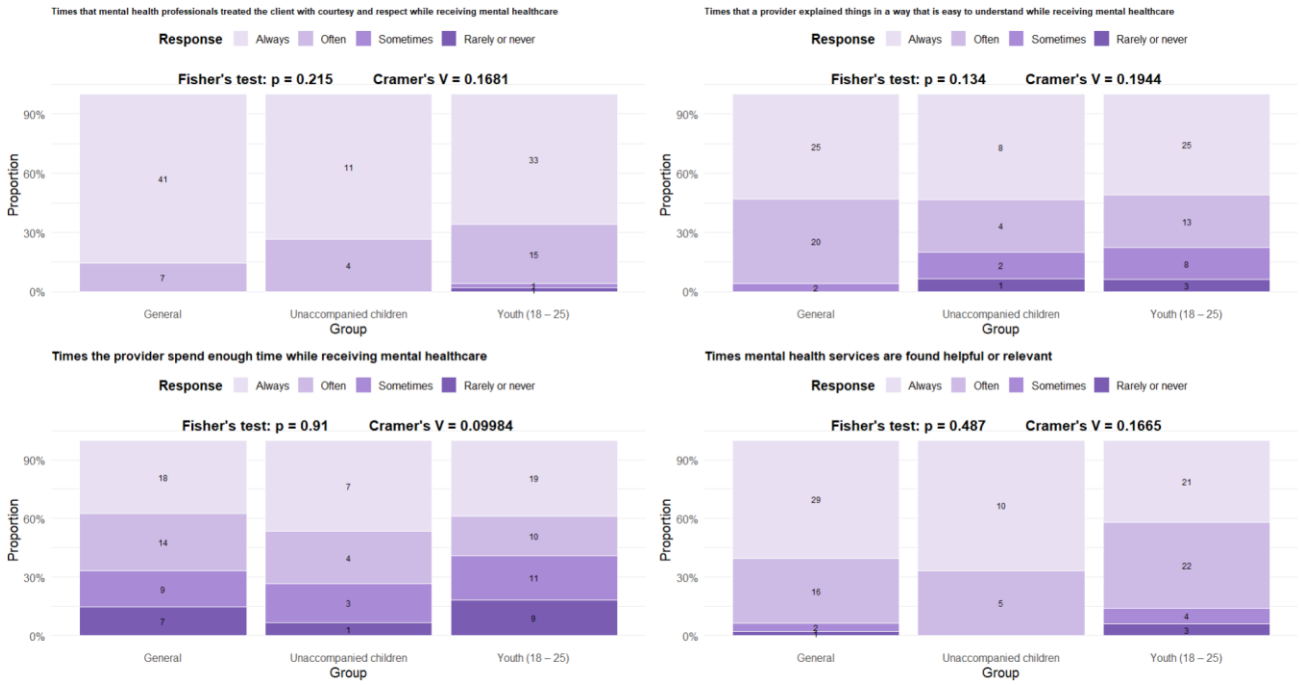

Figure 95: Non-significant differences across groups for the Appropriateness dimension in Greece (1)

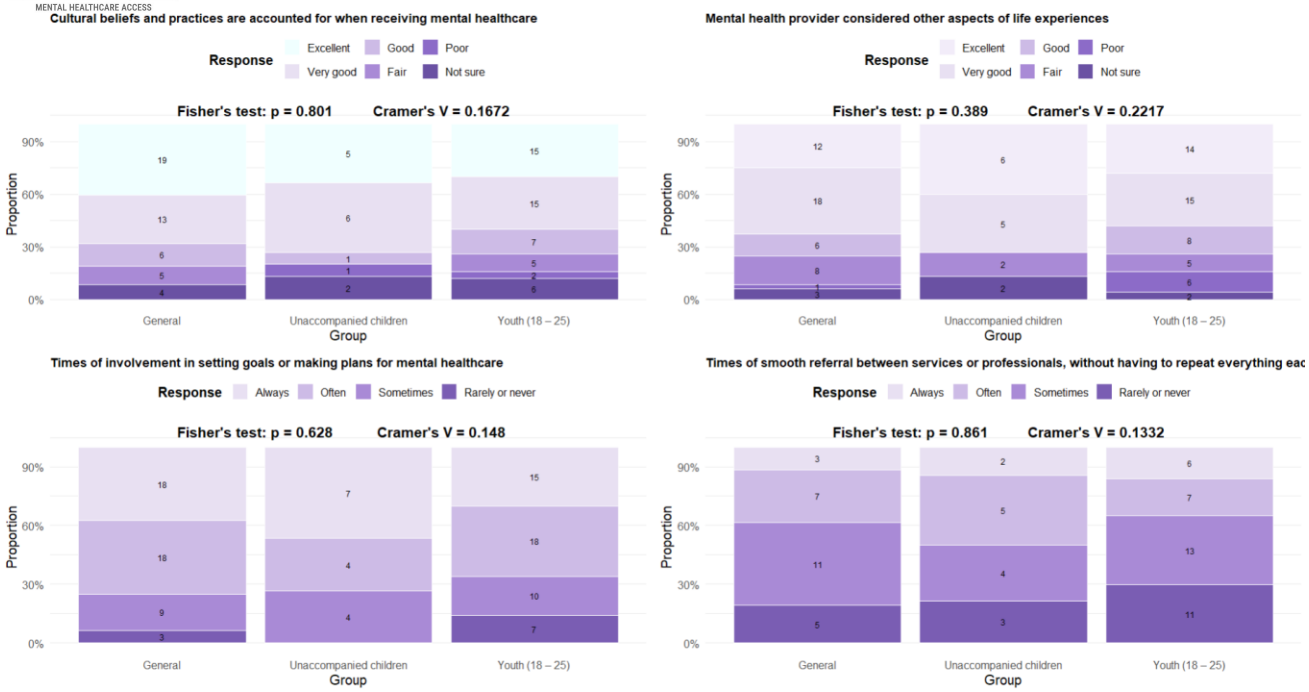

Figure 96: Non-significant differences across groups for the Appropriateness dimension in Greece (2)

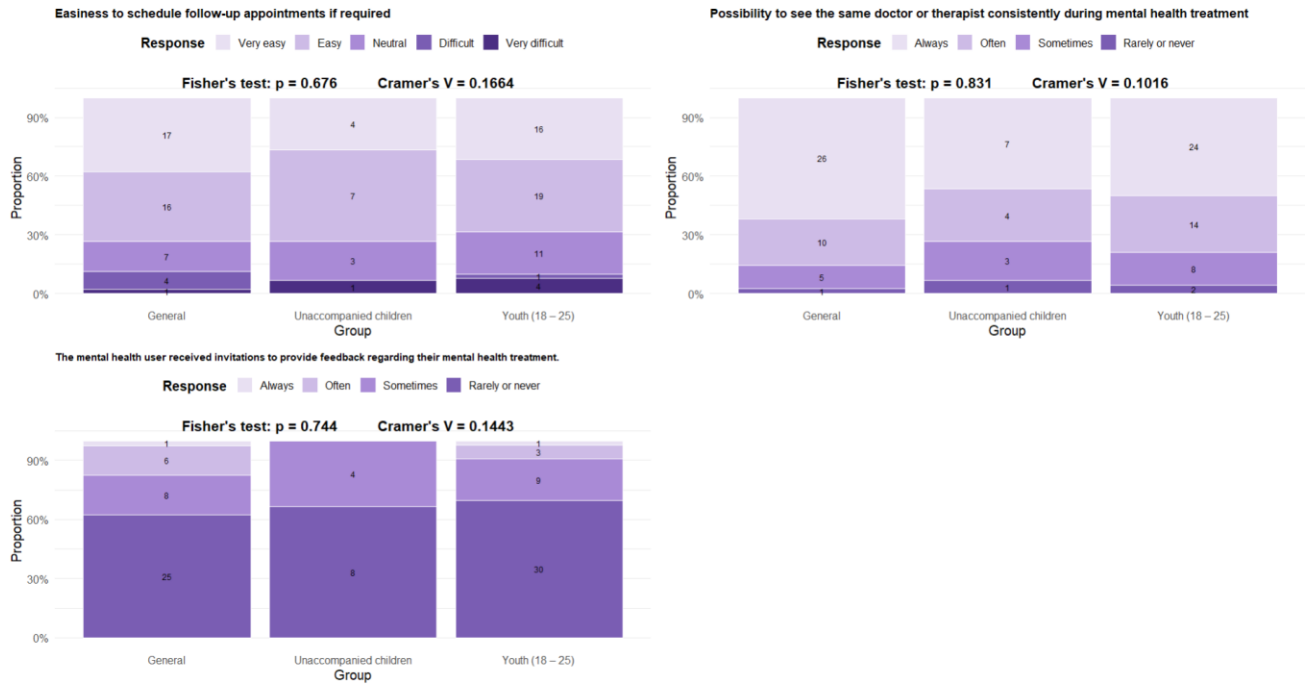

Figure 97: Non-significant differences across groups for the Appropriateness dimension in Greece (3)

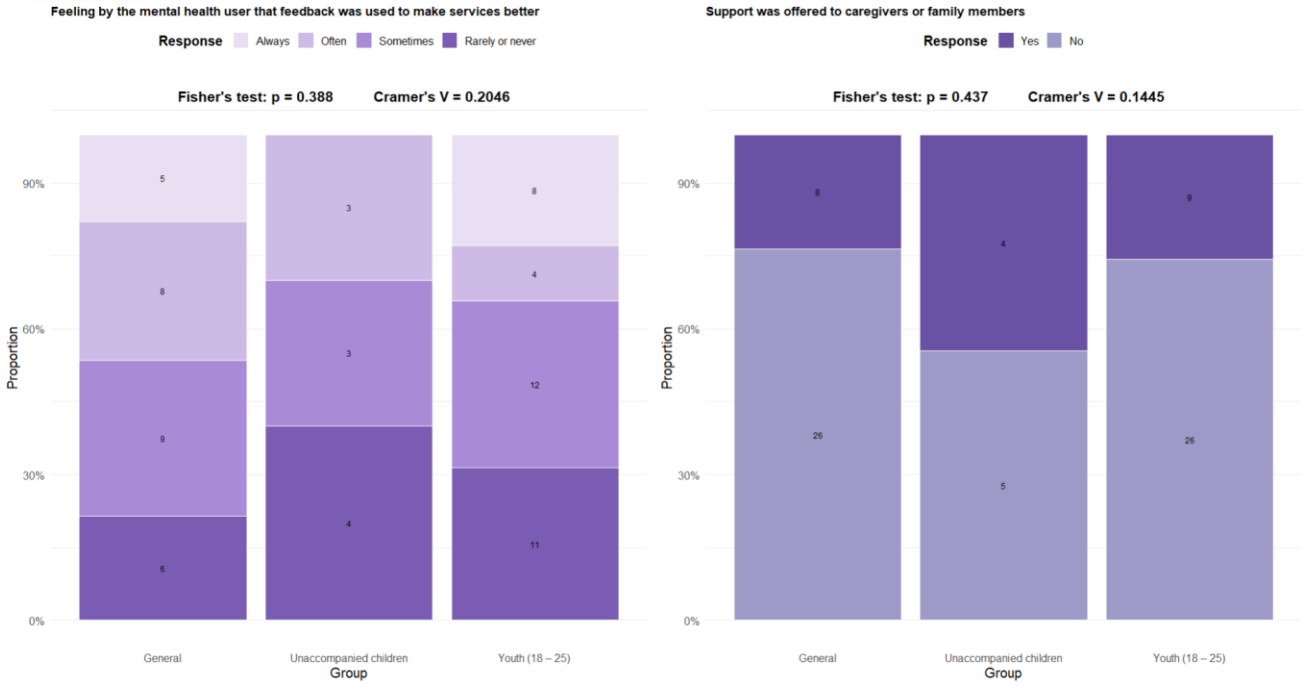

Figure 98: Non-significant differences across groups for the Appropriateness dimension in Greece (4)

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, could not be directly compared with national reference values for Greece, as no national EQ-5D-5L value set or population norm dataset specific to Greece was available at the time of analysis. Consequently, health-related quality of life results are reported descriptively without direct comparison to national benchmarks.

Self-perceived health

Self-perceived health was assessed using items aligned with those included in the EU Statistics on Income and Living Conditions (EU-SILC) Greece dataset, enabling comparison with national distributions reported through Eurostat EU-SILC Greece data.[12]. As subgroup-specific data for youth and unaccompanied children were not available in EU-SILC Greece, comparisons were conducted primarily at the overall country level. Within the present dataset, most respondents reported good or very good health across all population groups. In the general population, 44.6% reported good health and 41.1% reported very good health. Among unaccompanied children, responses were more evenly distributed, with 37.5% reporting fair health and 37.5% reporting good health. Youth aged 18–25 years similarly reported predominantly good or very good health (44.8% and 31.3%, respectively) (Table 86). When compared with national estimates from the EU-SILC Greece dataset, the distribution observed in the present study appears broadly comparable, with relatively

low proportions reporting poor health and the majority reporting good or very good health at the population level (Table 87)

Table 86: Self-perceived health in the dataset of Greece

	General group	Unaccompanied children	Youth (18-25)
Very bad, *n (%)*	0 (0.0)	0.0	0 (0.0)
Bad, *n (%)*	3 (2.7)	0.0	5 (5.2)
Fair (neither good nor bad), *n (%)*	11 (9.8)	6 (37.5)	18 (18.8)
Good, *n (%)*	50 (44.6)	6 (37.5)	43 (44.8)
Very good, *n (%)*	46 (41.1)	4 (25.0)	30 (31.3)
Missing, *n (%)*	2 (1.8)	0 (0.0)	0 (0.0)

Table 87: Self-perceived health in the dataset of EU-SILC Greece

	Total group
Very bad, %	1.6
Bad, %	5.6
Fair (neither good nor bad), %	14.9
Good, %	30.6
Very good, %	47.3

Activity limitations

Functional limitations were assessed using indicators corresponding to those included in the EU-SILC Greece dataset, enabling comparison with national activity limitation distributions[13]. Across study groups, the majority of respondents reported no limitations in daily activities, particularly among the general population (83.9%) and unaccompanied children (81.3%). A somewhat higher proportion of youth aged 18–25 years reported limitations (26.0%) compared with other groups (Table 88). Comparison with national-level data from EU-SILC Greece indicates that the proportion of respondents reporting no limitations in the present dataset is broadly comparable to national estimates, although slightly higher proportions of moderate limitations were observed among youth participants (Table 89).

Table 88: Activity limitations in the dataset of Greece

	General group	Unaccompanied children	Youth (18-25)
Severely limited, *n (%)*	1 (0.9)	0 (0.0)	5 (5.2)
Limited, *n (%)*	15 (13.4)	3 (18.8)	25 (26.0)
Not limited, *n (%)*	94 (83.9)	13 (81.3)	66 (68.8)
Missing, *n (%)*	2 (1.8)	0 (0.0)	0 (0.0)

Table 89: Activity limitations in the EU-SILC dataset of Greece

	Total country
Severely limited, %	9.0
Limited, %	9.5
Not limited, %	81.6

Unmet need for care

Information on unmet need for healthcare was collected using indicators aligned with those included in the EU-SILC Greece dataset, enabling triangulation with national estimates reported through Eurostat EU-SILC Greece data.[14]. Within the present dataset, several reasons for unmet need were reported across groups. Among the general population, cost-related barriers were frequently reported, with 18.8% indicating that care was too expensive. Among youth aged 18–25 years, similar patterns were observed, with 20.8% reporting cost-related unmet need and 14.6% indicating time-related barriers. Among unaccompanied children, waiting lists (31.3%) and fear of medical examination (25.0%) were reported relatively frequently (Table 90). In contrast, national-level estimates from EU-SILC Greece indicate that a large proportion of the general population reports no unmet healthcare needs, with only a small proportion reporting specific barriers such as cost or waiting lists. Compared with these national estimates, the present dataset suggests higher levels of reported unmet need, particularly among youth and unaccompanied children (Table 91).

Table 90: Unmet need for care in the dataset of Greece

	General group	Unaccompanied children	Youth (18 – 25)
Too expensive, *n (%)*	21 (18.8)	0 (0.0)	20 (20.8)

Too far to travel, *n (%)*	3 (2.7)	0 (0.0)	7 (7.3)
No time, *n (%)*	15 (13.4)	0 (0.0)	14 (14.6)
Didn't know any good doctor or specialist, *n (%)*	10 (8.9)	1 (6.3)	14 (14.6)
Waiting list, *n (%)*	14 (12.5)	5 (31.3)	16 (16.7)
Fear of doctor, hospital examination or treatment, *n (%)*	6 (5.4)	4 (25.0)	8 (8.3)
Wanted to wait and see if problem got better on its own, *n (%)*	10 (8.9)	2 (12.5)	20 (20.8)
Other reason, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)
No unmet needs to declare, *n (%)*	77 (68.8)	9 (56.3)	47 (49.0)
Missing, *n (%)*	2 (1.8)	0 (0.0)	0 (0.0)

Table 91: Unmet need for care in the EU-SILC dataset of Greece

	Total country
Too expensive, *%*	0.0
Too far to travel, *%*	0.0
No time, *%*	0.0
Didn't know any good doctor or specialist, *%*	0.0
Waiting list, *%*	0.0
Fear of doctor, hospital examination or treatment, *%*	0.0
Wanted to wait and see if problem got better on its own, *%*	0.0

Other reason, %	4.9
No unmet needs to declare, %	95.1

Depression severity

Depressive symptom severity was assessed using items aligned with those included in the European Health Interview Survey (EHIS) Greece dataset, enabling comparison with national mental health distributions reported through Eurostat EHIS Greece data.[15]. Across all study groups, depressive symptoms were reported at varying levels of severity. Within the general population, mild depressive symptoms were most frequently reported (39.3%), while 33.9% reported no or minimal symptoms. Among unaccompanied children, mild symptoms were also common (50.0%), although a smaller proportion reported no or minimal symptoms (12.5%). Among youth aged 18–25 years, moderate and moderately severe symptoms were reported more frequently compared with the general population (Table 92). National reference values derived from the EHIS Greece dataset indicate that the majority of the general population reports no or minimal depressive symptoms, with only small proportions reporting moderate or severe symptoms (Table 93). Compared with these national estimates, the present dataset suggests higher levels of depressive symptom severity, particularly among youth and unaccompanied children.

Table 92: Depression severity in the dataset of Greece

	General group	Unaccompanied children	Youth (18 – 25)
Severe, *n (%)*	4 (3.6)	0.0	11 (4.9)
Moderately severe, *n (%)*	4 (3.6)	2 (12.5)	22 (9.8)
Moderate, *n (%)*	17 (15.2)	4 (25.0)	35 (15.6)
Mild, *n (%)*	44 (39.3)	8 (50.0)	90 (40.2)
None or minimum, *n (%)*	38 (33.9)	2 (12.5)	60 (26.8)
Missing, *n (%)*	5 (4.5)	0 (0.0)	6 (2.7)

Table 93: Depression severity in the EHIS dataset of Greece

	Total country
Severe, %	0.2
Moderately severe, %	0.4
Moderate, %	1.3
Mild, %	4.8

None or minimum, %	93.3

4.5.2 Qualitative results

Approachability

Information awareness

Information about mental health services in Greece is consistently described across the interviews as present but fragmented, professionally mediated rather than structurally embedded, and effectively inaccessible to the most vulnerable individuals without organisational intermediation. No single coordinated, multilingual information infrastructure exists, and the gap falls most heavily on unaccompanied minors and young refugees whose language competence, digital literacy, and institutional affiliation vary enormously.

Awareness campaigns are described as insufficient and unevenly distributed. Although the COVID-19 pandemic expanded the visibility of telephone support lines and online resources, these gains are partial: those who are not technologically fluent remain structurally excluded from the online information environment, even where content nominally exists. As one provider observed: *"There is a problem with accessibility. In many places, mental health services are still not available, and awareness campaigns are not being carried out as they should be"* (GIVMED, Provider-1).

For unaccompanied minors specifically, the language barrier compounds the absence of centralised information, rendering even professionally held knowledge practically inaccessible: *"There is no comprehensive information available for someone who wishes to reach out to mental health services"* (GIVMED, CSO-1). The challenge is so profound that even professionals experience difficulty navigating the system: *"I believe that access to information is difficult. Even we, as professionals, experience this difficulty in terms of where to find information and where to start"* (GIVMED, CSO-2).

Access to information is further stratified by housing situation and institutional affiliation. Young people aged 18–25 are somewhat better served through internet-based channels, while unaccompanied minors' access depends entirely on whether they are in a structured facility or under formal protection. Those living on the street have no access at all; those in facilities benefit from the awareness of the caregiving professionals around them (GIVMED, Provider-2). Civil society organisations partially fill the gap through face-to-face outreach and awareness activities, but these efforts do not reach those

in the most precarious circumstances: *"People who live in precarious conditions do not have access to this information*" (GIVMED, CSO-3). The consistent result is a self-reinforcing exclusion in which information reaches those already connected to support systems while failing those most isolated.

Barriers to recognising or seeking help

Barriers to help-seeking operate across individual, cultural, and structural levels and are mutually reinforcing. At the individual level, low mental health literacy is a pervasive and cross-cutting finding. Among refugee populations in particular, a fundamental psychoeducation gap means that people may be unable to distinguish emotional difficulties from practical problems. Where survival needs, such as housing, legal status, and employment, remain unresolved, managing emotional distress is rarely experienced as a priority: *"A first barrier is psychoeducation. The people we work with, depending on their age and level of maturity, often struggle to distinguish emotional difficulties from practical issues. We are referring to a refugee population, so we understand that their needs are much more immediate and tangible"* (GIVMED, CSO-1).

Structural barriers compound individual ones. Language exclusion is identified as a decisive obstacle across the interviews. Digital booking systems, while useful for Greek-speaking youth, are inaccessible to those who do not speak the language. A further administrative barrier unique to this population is the absence of AMKA (Social Security Registration Number) for some undocumented children, meaning that formal system entry is structurally blocked regardless of clinical need: *"Some children do not have an AMKA; therefore, if they are not insured, they cannot book an appointment"* (GIVMED, Provider-2).

Stigma, operating simultaneously at self, social, family, and institutional levels, is identified as the most pervasive barrier of all and is developed further under Acceptability. Crucially, it operates even before the decision to seek help is consciously made stigma shapes whether distress is privately acknowledged at all, not only whether help is eventually sought. For unaccompanied minors and young refugees, stigma is amplified by cultural frameworks in countries of origin that equate help-seeking with weakness, shame, or madness (GIVMED, CSO-2 & CSO-3).

A further barrier specific to this population concerns the transition out of structured accommodation. Anxiety about managing independently after turning 18 — including uncertainty about how to book appointments without organisational support — represents a form of anticipated loss of access: *"They worry about how they will manage things on their own — such as who will book their appointments"* (GIVMED, CSO-2). Organisations attempt to mitigate this through progressive health literacy building

and supported practice of navigational skills, though this requires sustained relational investment that is not always achievable.

Acceptability

Cultural and social fit

The alignment between mental health services and the cultural and social expectations of the populations served by GIVMED is characterised across the interviews as deeply contingent on the type and funding model of the provider. A consistent pattern emerges: targeted, population-specific services demonstrate greater cultural responsiveness, while the public system is marked by a lack of multicultural training, absent interpreter provision, and a tendency to treat cultural diversity as an administrative complication rather than a clinical and relational dimension of care.

The Greek public health system's limited multicultural capacity is a structural deficit rather than a matter of individual professional inadequacy. Training initiatives have been designed but not implemented: *"A public initiative that took place a few years ago involved training staff working in a public hospital; however, the fact that it was never actually implemented is a characteristic example"* (GIVMED, CSO-1). The consequence is that cultural responsiveness remains dependent on individual initiative rather than systemic provision, and professionals working with diverse populations must adapt their practice without institutional support: *"I believe there is a very large deficit in this area. In general, there is no training on how to receive and work with different people, and this makes things difficult in many aspects, such as diagnosis and therapeutic follow-up"* (GIVMED, Provider-2).

The absence of professional interpreters in the public sector is identified as a particularly consequential structural barrier. Without interpretation, users may doubt whether their cultural background, beliefs, and experiences will be adequately understood, generating a form of systemic distrust before care has even begun: *"Precisely because there is no interpreter, people may believe that their culture and beliefs will not be recognised. Whatever they say may not be clearly understood"* (GIVMED, CSO-3). Interpreters are instead provided by civil society organisations that step in to cover a gap the public system does not formally acknowledge.

Among refugee and migrant populations, a deeper cultural barrier to acceptability is the perception of mental health care as incompatible with immediate survival pressures. This is not a rejection of care but a contextual reprioritisation: *"The main concern for a vulnerable group is that mental health, in their view, is perceived as a luxury that they cannot afford at the moment. If someone has to deal with the need for legal action, finding housing, or securing employment, they do not consider mental health to be a priority"* (GIVMED, CSO-1). Services that do not account for this prioritisation will not be experienced as culturally aligned regardless of their clinical quality.

A significant and consistent finding across the interviews is that once individuals do engage with a professional, the care encounter itself is frequently experienced as positive. Cultural and social barriers are therefore concentrated at the point of engagement rather than in the quality of care received: *"When a minor or a young person finally reaches a mental health professional and begins attending sessions, we have observed, in a large proportion of cases, a very positive response, regardless of the individuals' cultural and social background"* (GIVMED, CSO-2). This suggests that appropriately supported pathways to engagement could substantially improve acceptability without requiring transformation of the care encounter itself.

Stigma

Stigma emerges across all interviews as the single most powerful barrier to mental health service access for the populations GIVMED serves. Its operation is multi-layered: self-stigma, social stigma rooted in peer and family judgment, culturally specific stigma shaped by countries of origin, and institutional stigma embedded in how the formal health system treats people with mental health histories. The scope of this is captured in the observation that stigma is not merely a factor among many but the primary mechanism preventing engagement: *"Its role is decisive. It is essentially 100% of what prevents people from approaching mental health services, or rather, even before that, from accepting it themselves"* (GIVMED, Provider-1).

For unaccompanied minors and young refugees, stigma carries additional biographical and cultural weight, shaped by norms in countries of origin that frame mental health help-seeking as evidence of madness, weakness, or social failure. Help-seeking is equated with psychiatric hospitalisation and the permanent label of 'crazy': *"Needing help regarding one's mental health is often immediately translated into the idea of 'being crazy' or 'not being crazy' — with the fear that one might be hospitalised. This is also connected to religion, culture, and family attitudes"* (GIVMED, CSO-2). Family attitudes can be actively prohibitive, with some young people explicitly forbidden by their families from receiving mental health care on the grounds that they were simply tired rather than unwell (GIVMED, CSO-2). The depth of stigma as a cultural phenomenon is powerfully illustrated by responses to even basic information provision. Stigma reaches the point where contact with information materials is itself experienced as contaminating: *"there are still people who do not want to even touch an informational leaflet, in case they might 'catch' something"* (GIVMED, Provider-1). Perhaps most strikingly: *"there are people who say that they would rather have cancer than bipolar disorder"* (GIVMED, Provider-1). This comparison speaks to the profound social devaluation of mental illness relative to physical disease.

For people living in precarious conditions, the fear of being labelled 'crazy' or incapable of self-management is not merely social embarrassment but an existential threat to the fragile sense of competence and control on which daily functioning depends: *"There is a very strong stigma surrounding mental illness, which is also connected to perceptions of a person's integrity. Beyond the 'label of being crazy,' there is also the concern that something like this would make someone appear incapable of managing themselves. As a result, this becomes another barrier, since a person living in precarious conditions will find it very difficult to accept their own vulnerability"* (GIVMED, CSO-1).

Efforts to address stigma are present across the system such as awareness sessions in schools, psychoeducation by organisations including the Red Cross, confidentiality practices to protect young people from peer judgment within shared accommodation, and community-based awareness activities by refugee and migration organisations. The approach that appears most effective is open, normalising, and community-directed communication: "*To combat it, we talk about mental illness. We speak openly about the fact that health is not only physical but also mental. We talk about depression, panic attacks, the reversibility of most mental disorders, and the importance of early diagnosis"* (GIVMED, Provider-2). However, such initiatives are described as almost entirely absent from the public sector, leaving stigma reduction as a function of civil society rather than a systemic health policy commitment (GIVMED, CSO-3).

Availability

Distribution and sufficiency of services

All interviews converge on a diagnosis of severe structural under-provision in the Greek public mental health system. Geographic inequalities are marked: services remain concentrated in major urban centres with university hospitals, while large parts of the country, particularly islands and rural areas, remain effectively uncovered. Movement toward a Community Care model has begun, but its implementation is incomplete, and the reform has not yet produced the intended geographic distribution of services: *"The unequal distribution of both Community Units and Early Intervention Units constitutes a major issue. Geographic barriers, along with economic and social factors, represent the main challenges"* (GIVMED, Provider-1).

The staffing crisis is the most acute dimension of under-provision. Child psychiatry is among the most underrepresented medical specialties not only in Greece but globally: "*Psychiatrists are fewer than what is needed to meet existing needs, and child psychiatrists are among the most underrepresented medical specialties worldwide. It has been estimated that the total number of child psychiatrists who have completed their specialisation in Greece is around 500–600"* (GIVMED, CSO-1). This shortage is compounded for unaccompanied minors by a recent policy decision reducing the psychologist

staffing ratio at accommodation facilities from one per 15 children to one per 30 — a decision characterised as *"indicative of what the system is willing to pay for mental health"* (GIVMED, CSO-2).

The systemic vulnerability of services is further compounded by the governance and funding model of the public sector. Psychiatric reform in Greece was intended to create sectorised care close to place of residence, but this reform was never adequately resourced. Services dependent on project-based or annual contract funding operate under conditions of permanent insecurity: *"They will operate only as long as funding exists, functioning under a condition of insecurity"* (GIVMED, Provider-2). The annual contract system for professional staff prevents the institutional continuity that complex and long-term presentations require.

Even in major urban centres, demand consistently exceeds capacity. Referrals to external services by civil society organisations encounter the same shortage: *"There are not enough services, even in large urban centres... there are not enough mental health facilities and services to meet the existing needs"* (GIVMED, CSO-3). Civil society organisations have stepped into the gap left by public under-provision, but their role is that of an intermediary rather than a provider of last resort: they can facilitate access to services, but they cannot substitute for services that do not exist.

Timing, format, and accessibility of delivery

Even where services nominally exist, their practical usability is significantly constrained by rigidity of operating hours, insufficient capacity, and prohibitive waiting times. The public system operates largely within standard morning administrative hours, and the requirement for administrative staff presence means that clinical services cannot routinely extend into afternoon slots even when clinicians are available. The result is a service structure that is, by design, poorly suited to the scheduling realities of vulnerable populations: *"Unfortunately, the services do not meet people's needs, as many individuals require consistent follow-up and psychotherapeutic support, which can only be provided to a very small extent"* (GIVMED, Provider-2).

Waiting times represent the most acute expression of under-capacity. In child psychiatry, waiting lists for non-emergency cases exceed three months, meaning a minor requiring hospitalisation who is not in immediate acute crisis may wait three months for admission. The psychotherapy situation is so severe that it was the subject of a professional conference posing the question: *"Psychotherapy in the public sector: necessity or utopia?"* (GIVMED, Provider-2). Even when cases eventually reach the system, follow-up is compromised by frequent turnover of resident doctors, preventing the formation of stable therapeutic relationships: "*Psychiatric care is unable to meet the existing demand, and*

whatever happens after three months is only a drop in the ocean compared to the ongoing needs" (GIVMED, CSO-1).

The picture is more encouraging within civil society organisations, where appointments can sometimes be arranged within a week and the care process is described as more responsive once initiated. A consistent finding is that the quality of professional engagement improves markedly once the barriers to system entry have been overcome: "*When you manage to enter the system and the process begins, things tend to improve. Once we reach that point, there is attentiveness, promptness, and good communication on their part"* (GIVMED, CSO-2). The challenge is entry, not the care that follows.

Mobile mental health units and telemedicine are noted as partial structural responses to geographic barriers. Mobile units staffed by mental health professionals collaborate with municipalities to deliver home-based care to individuals who cannot afford transport or lack public transport access. Telepsychiatry, which developed during the COVID-19 pandemic, holds potential for further development (GIVMED, Provider-2). Both innovations remain under-developed relative to the scale of need, but their existence represents a meaningful, if insufficient, shift in delivery model.

Affordability

Direct and indirect costs

Direct costs within the formally free public system are not consistently identified as the primary financial barrier for individuals with documentation and insurance access. The more significant affordability failures are indirect and structural: the public system's incapacity regularly forces individuals toward private care whose costs are entirely prohibitive, while transportation costs and the informal caregiving burden create further layers of financial hardship.

The private mental health market functions as the effective exit valve for public system failures, but it is unreachable for the populations GIVMED serves. Unaccompanied minors in semi-independent accommodation receive approximately €150 per month for all living expenses — an amount that structurally precludes any private therapeutic engagement: *"A minor living in semi-independent accommodation receives about €150 per month to cover their needs. As you can understand, it is impossible for them to include psychotherapy within that amount"* (GIVMED, CSO-1). A further consequence of private-sector dependence is that certain therapeutic approaches — play therapy being a notable example — are not available in any public service, meaning they are accessible only through private payment that is entirely unattainable for this population without external funding (GIVMED, CSO-1).

Transportation costs constitute a significant indirect barrier, particularly for individuals living outside structured accommodation settings or in geographically remote areas. These costs compound with private service fees when the public system cannot meet clinical need, producing a cumulative burden that is practically insurmountable: *"The cost of transportation — especially when the distance is long — acts as a deterrent, even more so when it is combined with the cost of seeking services in the private sector, which is unaffordable for such a population"* (GIVMED, CSO-2).

An often-overlooked affordability dimension is the indirect economic burden on informal caregivers. When public services are unable to support individuals with mental health needs, care defaults to families. This reduces caregivers' capacity to work, increases household expenses, and creates a progressive deterioration in both the individual's and the family's financial situation: *"The family's personal expenses increase, while the time available for the caregiver to work and secure financial resources decreases"* (GIVMED, Provider-1). This burden falls on families regardless of their own financial capacity to absorb it.

Support mechanisms

Formal financial support mechanisms exist but are practically inadequate, inconsistently applied, and subject to ongoing retrenchment. Social insurance through OPEKA provides health coverage for those outside formal employment, but benefit amounts are described as too low to cover actual needs (GIVMED, Provider-1). A European directive requiring the support of informal carers, who are described as playing a decisive role in mental health care delivery, has not been implemented in practice (GIVMED, Provider-1).

Within residential facilities for unaccompanied minors, embedded psychologist provision represents the most meaningful existing support mechanism. However, a recent policy decision has reduced the staffing ratio from one psychologist per 15 children to one per 30, signalling a clear retreat from this provision. This is characterised not merely as a resource constraint but as a statement of institutional priority: "The change is enormous and indicative of what the system is willing to pay for mental health. It is one of the first professional roles that was cut" (GIVMED, CSO-2).

Beyond formal mechanisms, financial support for mental health care rests almost entirely on private foundations and civil society initiatives. Foundations such as Stavros Niarchos fund psychotherapeutic services, and individual organisations are sometimes able to cover costs for specific children on a case-by-case basis. This arrangement, however, is not systematic and cannot function as a rights-based provision: *"funding does exist, but it mainly comes from foundations and private initiatives, rather than from public funding directed toward this area"* (GIVMED, CSO-1).

Access thereby becomes contingent on networks and organisational capacity rather than on entitlement — an inequitable and unstable foundation.

The public sector's own employment model further compounds the fragility of financial structures. Professional staff are employed on annual contracts from the Ministry of Health, creating precarious positions that undermine institutional continuity and the formation of stable long-term therapeutic relationships: *"The staff are funded mainly by the Ministry of Health through annual contracts, which creates precarious positions"* (GIVMED, Provider-2). In a system where relationships are therapeutically central, structural employment precarity is also a clinical problem.

Appropriateness

Fit and usefulness of care

The appropriateness of care is described across the interviews as bifurcated: strong at the level of individual professional encounters within civil society and targeted settings and significantly compromised within the public psychiatric system under conditions of structural overload. When care is resourced, individualised, and multidisciplinary, it is experienced as fitting and useful; when delivered under conditions of under-capacity, it fails to meet individual needs regardless of professional intent.

A deeply embedded institutional assumption shapes the public system's approach to appropriateness: mental health treatment is culturally presumed to belong in hospital settings, reinforcing medicalisation and limiting community-based alternatives. When services do exist outside hospital contexts, they face the additional burden of stigma-driven rejection: *"Where they do exist, they are not accepted as they should be. This can cause trauma and greater resistance, together with the side effects that medications may have"* (GIVMED, Provider-1). Appropriate care is thus blocked not only by system failures but by the cultural framework through which services are perceived.

The failure of appropriateness at the level of the public psychiatric system is most starkly illustrated by conditions in child and adolescent psychiatry. Structural overload renders individual-level appropriateness structurally impossible: clinicians may assess between 30 and 100 children per on-call shift with a single bed available, and may hesitate to allocate even that bed knowing the same situation will recur the following day: *"In a child and adolescent psychiatric clinic, during a single on-call shift doctors may examine between 30 and 100 children, while having only one available bed"* (GIVMED, CSO-1). Under these conditions, adequate assessment, treatment planning, and relational continuity are structurally precluded.

In civil society settings, multidisciplinary and person-centred approaches enable a meaningfully different standard of appropriateness. When a child is referred for care, a psychologist first assesses needs before a multidisciplinary team determines which professional is best placed to lead ongoing work: *"targeted support is provided so that the professional is closer to what the child themselves needs. Beyond needs, each person has a different way of coping, and for this reason we try to ensure that the support offered is as targeted as possible"* (GIVMED, CSO-3).

Cultural appropriateness in practice is illustrated by the example of medication schedule adjustments during Ramadan, coordinated between organisation staff and healthcare professionals to respect the religious fasting practices of Muslim beneficiaries: *"Even though Ramadan states that when you are ill you are allowed to take medication, we still communicate with healthcare professionals and adjust the timing and the medications with great respect for both this practice and the individual"* (GIVMED, CSO-2). The fact that beneficiaries continue to attend — despite cultural and social barriers — is itself interpreted as evidence that care is experienced as respectful and meaningful.

Quality of interaction and respect

The quality of individual provider-user interactions is broadly characterised as strong at the interpersonal level, with a critical structural qualification: professional commitment and relational quality are consistent, while systemic constraints limit what those interactions can ultimately achieve. Problems in care quality are attributed to the system rather than to the professionals working within it: *"The mental health professionals in the country are, in the majority of cases, truly people who respond to their work with commitment. Whatever problems may exist tend to concern the system itself and its constraints — for example, appointments, the lack of staff, and the shortage of beds"* (GIVMED, CSO-2).

Where therapeutic relationships are given the conditions to develop, they are characterised by mutual respect, patient listening, and a deliberate effort to understand individual modes of expression. This relational quality is identified as the foundation of effective care: *"It requires the development of a relationship based on mutual respect, safety, and trust. What matters is that we understand people and seek ways to approach them"* (GIVMED, Provider-2). Cultural diversity requires professionals to manage their own assumptions and reactions continuously – work that, in the absence of systematic training, depends on individual motivation rather than institutional support.

The most meaningful indicator of interaction quality cited across the interviews is not formal satisfaction measurement but voluntary continued engagement. Beneficiaries who continue to attend services over time, and unaccompanied minors who, upon reaching adulthood, seek out the

organisations that supported them in childhood, provide a powerful implicit endorsement of the relationships that have been built: *"The fact that people themselves continue to attend these services is, in itself, the greatest form of validation and confirmation of the relationship that has been developed"* (GIVMED, CSO-2).

Quality assurance at the system level remains poorly developed. The Ministry of Health only recently tasked the Organisation for Quality Assurance in Hospitals with developing indicators for measuring mental health services, and the process remains in its early stages: *"There is nothing that ensures quality to a large extent, and significant steps still need to be taken. It is something that is currently being developed"* (GIVMED, Provider-1). In the absence of formal mechanisms, quality is assessed informally in civil society settings through ongoing communication between beneficiaries, organisations, and professionals, with sustained attendance serving as the primary available proxy indicator.

One important nuance concerns the effect of familiarity on disclosure. Where professionals are embedded in the daily environment of beneficiaries, proximity — though generally a strength — can in some cases constrain rather than enable open communication: *"some beneficiaries feel the need to be referred to external services, as they may find it easier to express themselves to a health professional whom they do not see in their daily environment"* (GIVMED, CSO-3). This finding underlines the value of flexible, choice-based referral pathways rather than an exclusive reliance on embedded in-house provision.

4.6 France

4.6.1 Quantitative results

The sample comprises 569 respondents across four groups: General (n = 229), people with intellectual disabilities (n = 124), people with physical disabilities (n = 190), and people with both intellectual and physical disabilities (n = 26). Group counts are shown in Table 94.

Table 94: Distribution of participants across the included groups in France

General Group	Group with an intellectual disability	Group with a physical disability	Both intellectual & physical disabilities
N = 229	N = 124	N = 190	N = 26

Descriptive statistics by group are shown in Table 95. The mean age was 48.6 years in the General group, 44.4 in the intellectual disabilities group, 48.7 in the physical disabilities group, and 40.9 in the group with both intellectual and physical disabilities. Questionnaires were almost always completed by participants themselves (228/229, 124/124, 188/190, and 26/26, respectively), with only a few cases of assisted or proxy completion. Regarding sex at birth, females represented 59.4% of the General group (136/229), 60.5% of the intellectual disabilities group (75/124), 58.9% of the physical disabilities group (112/190), and 73.1% of the group with both (19/26). The corresponding proportions of males were 40.6%, 38.7%, 40.5%, and 23.1%. A small number of respondents selected “other” or did not report their sex. Most participants reported a gender identity that matched their sex assigned at birth: 99.1% in the General group, 95.2% in the intellectual disabilities group, 98.9% in the physical disabilities group, and 92.3% in the group with both. Only a small number reported a different gender identity or preferred not to answer. Across all groups, most respondents identified as heterosexual—91.3% in the General group, 75.8% in the intellectual disabilities group, 84.7% in the physical disabilities group, and 80.8% in the group with both. Other respondents identified as gay, lesbian, bisexual, “other,” or preferred not to say (see Table yy). Almost all participants reported living in France. Birth in France was reported by 92.1% of the General group, 96.8% of the intellectual disabilities group, 94.2% of the physical disabilities group, and all participants in the group with both. French citizenship was reported by 96.1%, 98.4%, 93.7%, and 96.2% of respondents, respectively, while smaller proportions reported citizenship of another EU country or a non-EU country. The average length of residence in France was 45.9 years in the General group, 43.0 years in the intellectual disabilities group, 46.3 years in the physical disabilities group, and 40.5 years in the group with both. Educational attainment (ISCED) varied across groups, but upper secondary education (ISCED 3) was the most common level: 28.8% in the

General group, 33.9% in the intellectual disabilities group, 35.8% in the physical disabilities group, and 34.6% in the group with both. A substantial proportion of respondents also reported post-secondary non-tertiary education (ISCED 4). Tertiary education was present in all groups, with Master's and Doctoral degrees more common in the General group. Use of mental health services in the past 12 months was reported by 48.9% (112/229) of participants in the General group, 87.1% (108/124) in the intellectual disabilities group, 52.1% (99/190) in the physical disabilities group, and 92.3% (24/26) in the group with both.

Table 95: Descriptive statistics of the different included groups in France

Demographic variable	General Group	Intellectual disabilities	Physical disabilities	Both intellectual & physical disabilities	Overall
Age, *mean (sd)*	48.6 (15.2)	44.4 (11.0)	48.7 (12.3%)	40.9 (11.4)	47.4 (13.4)
Questionnaire completed by, *n (%)*					
Respondent alone	228 (99.6%)	124 (100%)	188 (98.9%)	26 (100%)	566 (99.5%)
Respondent with help	1 (0.4%)	0 (0%)	1 (0.5%)	0 (0%)	2 (0.4%)
Someone else	9 (0%)	0 (0%)	1 (0.5%)	0 (0%)	1 (0.2%)
Sex at birth, *n (%)*					
Female	136 (59.4%)	75 (60.5%)	112 (58.9%)	19 (73.1%)	342 (60.1%)
Male	93 (40.6%)	48 (38.7%)	77 (40.5%)	6 (23.1%)	224 (39.4%)
Other	0 (0%)	1 (0.8%)	1 (0.5%)	1 (3.8%)	1 (0.2%)
Missing					2 (0.4%)
Gender the same as assigned at birth, *n (%)*					
Yes	227 (99.1%)	118 (95.2%)	188 (98.9%)	24 (92.3%)	557 (97.9%)
No	1 (0.4%)	4 (3.2%)	2 (1.1%)	1 (3.8%)	8 (1.4%)
Prefer not to say	1 (0.4%)	2 (1.6%)	0 (0%)	1 (3.8%)	4 (0.7%)
Sexual orientation, *n (%)*					
Heterosexual	209 (91.3%)	94 (75.8%)	161 (84.7%)	21 (80.8%)	485 (85.2%)
Gay	6 (2.6%)	6 (4.8%)	6 (3.2%)	0 (0%)	18 (3.2%)
Lesbian	2 (0.9%)	7 (5.6%)	3 (1.6%)	0 (0%)	12 (2.1%)
Bisexual	2 (0.9%)	5 (4.0%)	10 (5.3%)	3 (11.5%)	20 (3.5%)

Other	4 (1.7%)	7 (5.6%)	7 (3.7%)	1 (3.8%)	19 (3.3%)
Prefer not to say	6 (2.6%)	5 (4.0%)	3 (1.6%)	1 (3.8%)	15 (2.6%)
Country of residence, *n (%)*					
France	228 (99.6%)	124 (100%)	189 (99.5%)	26 (100%)	567 (99.6%)
Other	1 (0.4%)	0 (0%)	1 (0.5%)	0 (0%)	2 (0.4%)
Country of birth, *n (%)*					
Born in the country of residence	211 (92.1%)	120 (96.8%)	179 (94.2%)	26 (100%)	536 (94.2%)
In another country in the EU	8 (3.5%)	3 (2.4%)	6 (3.2%)	0 (0%)	17 (3.0%)
Born in another country outside the EU	10 (4.4%)	1 (0.8%)	5 (2.6%)	0 (0%)	16 (2.8%)
Citizen of country, *n (%)*					
Citizen of the country of residence	220 (96.1%)	122 (98.4%)	178 (93.7%)	25 (96.2%)	545 (95.8%)
No citizenship of the country of residence but that of another EU member state	2 (0.9%)	2 (1.6%)	8 (4.2%)	0 (0%)	12 (2.1%)
No citizenship of the country of residence but that of a country outside the EU	7 (3.1%)	0 (0%)	4 (2.1%)	1 (3.8%)	12 (2.1%)
Duration of stay in the country of residence, *mean years (SD)*	45.9 (17.8)	43.0 (12.9)	46.3 (15.6)	40.5 (11.8)	45.1 (15.9)
Highest level of education completed (ISCED), *n (%)*					
Early childhood education (ages 3	5 (2.2%)	7 (5.6%)	13 (6.8%)	0 (0%)	25 (4.4%)

and above), including pre-primary education and early childhood educational development (under 3). (ISCED 0)					
Primary education (also known as elementary or basic education). (ISCED 1)	7 (3.1%)	5 (4.0%)	11 (5.8%)	0 (0%)	23 (4.0%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	10 (4.4%)	13 (10.5%)	21 (11.1%)	6 (23.1%)	50 (8.8%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	66 (28.8%)	42 (33.9%)	68 (35.8%)	9 (34.6%)	185 (32.5%)
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	45 (19.7%)	36 (29.0%)	42 (22.1%)	5 (19.2%)	128 (22.5%)
Short-cycle third level education (programs typically lasting 2-3 years and leading to qualifications at a lower level than a	42 (18.3%)	16 (12.9%)	21 (11.1%)	3 (11.5%)	82 (14.4%)

bachelor's degree). (ISCED 5)					
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	14 (6.1%)	1 (0.8%)	6 (3.2%)	2 (7.7%)	23 (4.0%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	32 (14.0%)	2 (1.6%)	7 (3.7%)	0 (0%)	41 (7.2%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	8 (3.5%)	2 (1.6%)	1 (0.5%)	1 (3.8%)	12 (2.1%)
Use of mental health care in the previous 12 months, *n (%)*					
Yes	112 (48.9%)	108 (87.1%)	99 (52.1%)	24 (92.3%)	343 (60.3%)
No	117 (51.1%)	16 (12.9%)	91 (47.9%)	2 (7.7%)	226 (39.7%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Within the Availability and Accommodation dimension, most indicators demonstrated statistically significant differences between population groups. The only item that did not differ significantly between groups was the time required to travel to mental health service locations, indicating comparable geographic accessibility across the general population and disability groups (p-value > 0.05; Figure 101).

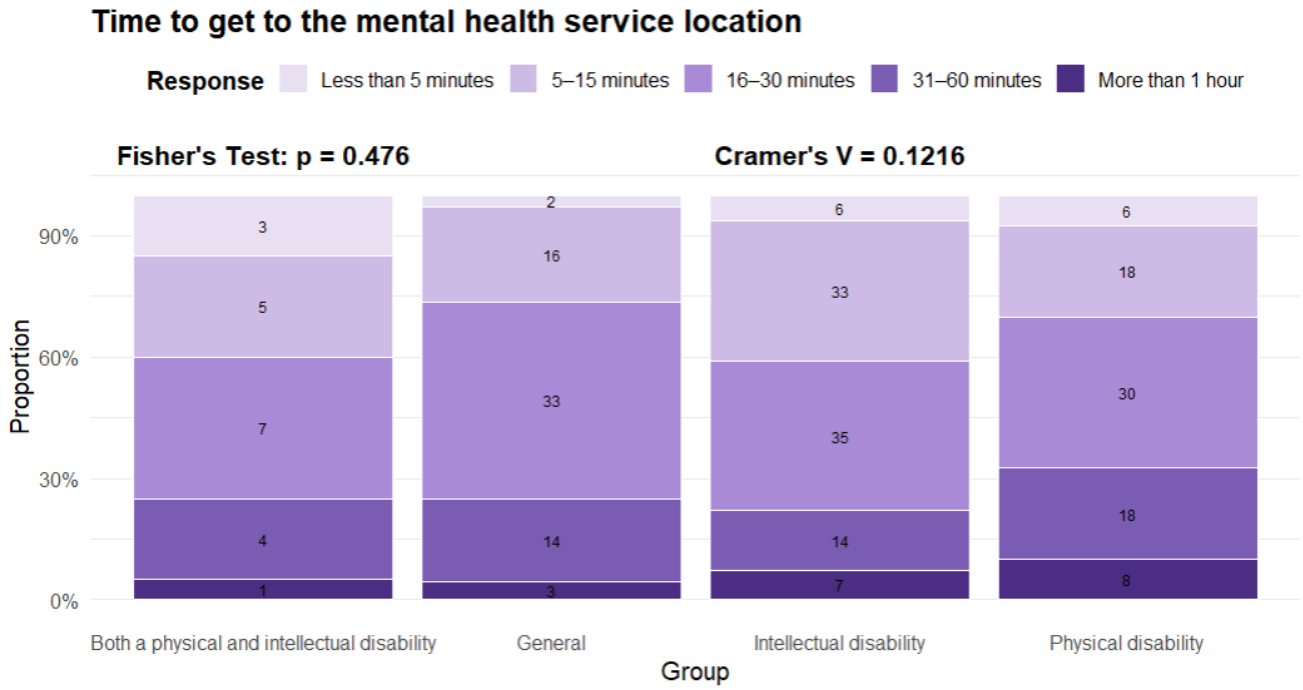

Figure 99: Non-significant difference across groups for the Availability & Accommodation dimension in France

In contrast, several other indicators revealed meaningful variation between groups, particularly when comparing the general population with individuals with intellectual disabilities. Significant differences were observed for awareness of mental health services in the local area (Table 96; Figure 102). Pairwise comparisons indicated statistically significant differences between the general population and the group with an intellectual disability ($p = 0.003$, Cramer's $V = 0.315$), as well as between the general population and the group with a physical disability ($p = 0.006$, Cramer's $V = 0.263$). No statistically significant differences were observed between the disability subgroups themselves. Descriptive findings suggest that awareness of available services was higher among disability groups compared to the general population. The corresponding effect sizes indicate small to moderate associations, suggesting meaningful differences in service awareness.

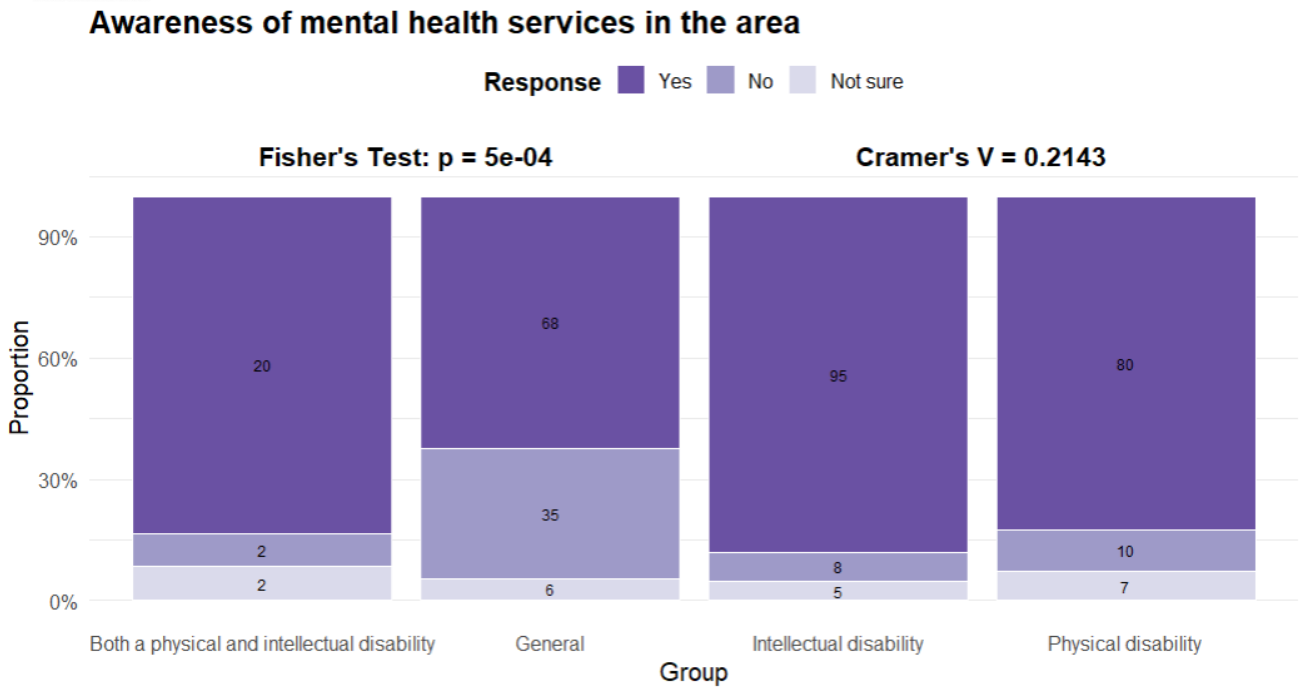

Figure 100: Fisher's exact test of the awareness of mental health services in the area item in France

Table 96: Pairwise comparison test of the awareness of mental health services in the area item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.074	0.205
Group with both a physical and intellectual disability : Group with an intellectual disability	0.832	0.066
Group with both a physical and intellectual disability : Group with a physical disability	1.000	0.030
General group : Group with an intellectual disability	0.003	0.315
General group : Group with a physical disability	0.006	0.263
Group with a intellectual disability : Group with a physical disability	0.807	0.078

Differences were also identified regarding the availability of a private space for receiving care and discussing concerns openly (Table 97 and Figure 103). Significant differences were observed between the general population and the group with an intellectual disability (p = 0.003, Cramer's V =

0.352), as well as between the general population and the group with a physical disability (p = 0.018, Cramer's V = 0.225). No significant differences were identified between the disability subgroups. The descriptive results show that the availability was experienced lower in the general group in comparison to the disability groups. The observed effect sizes ranged from small to moderate, with stronger differences involving the group with intellectual disabilities.

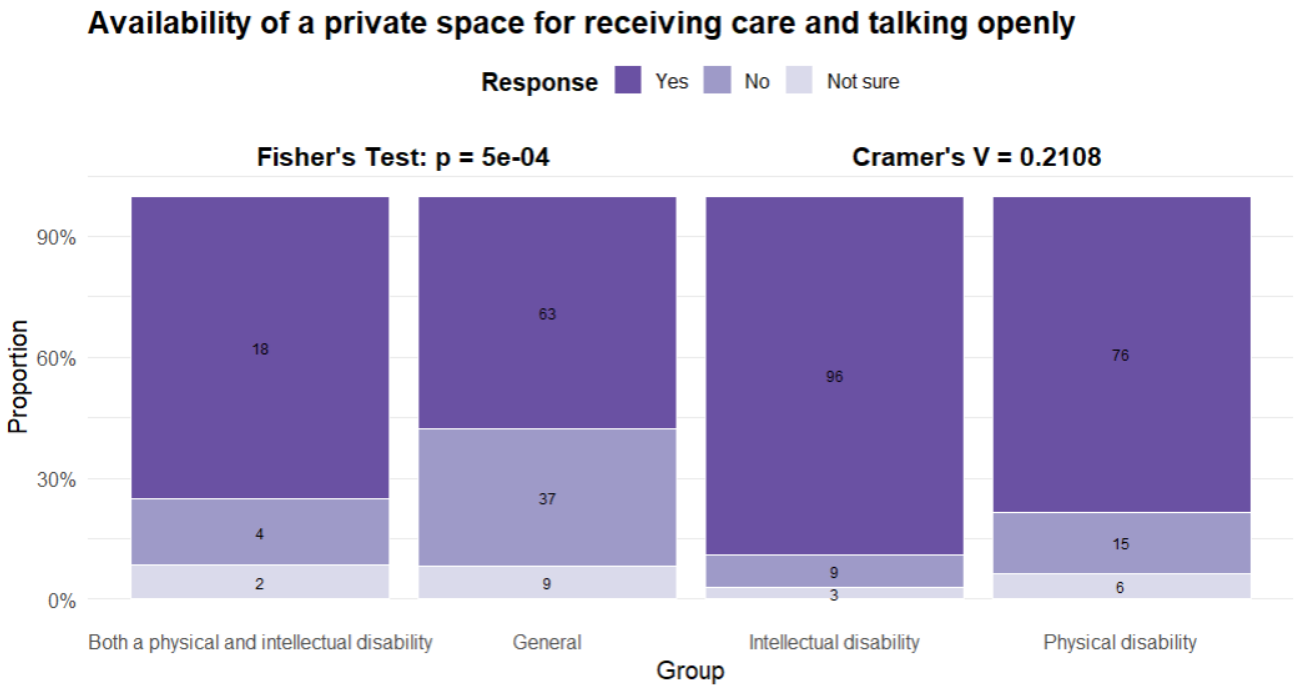

Figure 101: Fisher's exact test of the availability of a private space for receiving care and talking openly item in France

Table 97: Pairwise comparison test of the availability of a private space for receiving care and talking openly item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.324	0.147
Group with both a physical and intellectual disability : Group with an intellectual disability	0.232	0.161
Group with both a physical and intellectual disability : Group with a physical disability	0.846	0.039
General group : Group with an intellectual disability	0.003	0.352
General group : Group with a physical disability	0.018	0.225

Group with a intellectual disability : Group with a physical disability	0.212	0.144

Further variation was found in relation to time required to obtain an appointment when mental health care was needed (Figure 104 and Table 98). Statistically significant differences were observed between the group with both physical and intellectual disabilities and the group with intellectual disabilities (p = 0.035, Cramer's V = 0.378), as well as between the group with intellectual disabilities and the group with physical disabilities (p = 0.035, Cramer's V = 0.279). These findings suggest that waiting times may differ between disability subgroup. The corresponding effect sizes indicate moderate associations, suggesting meaningful differences in appointment accessibility.

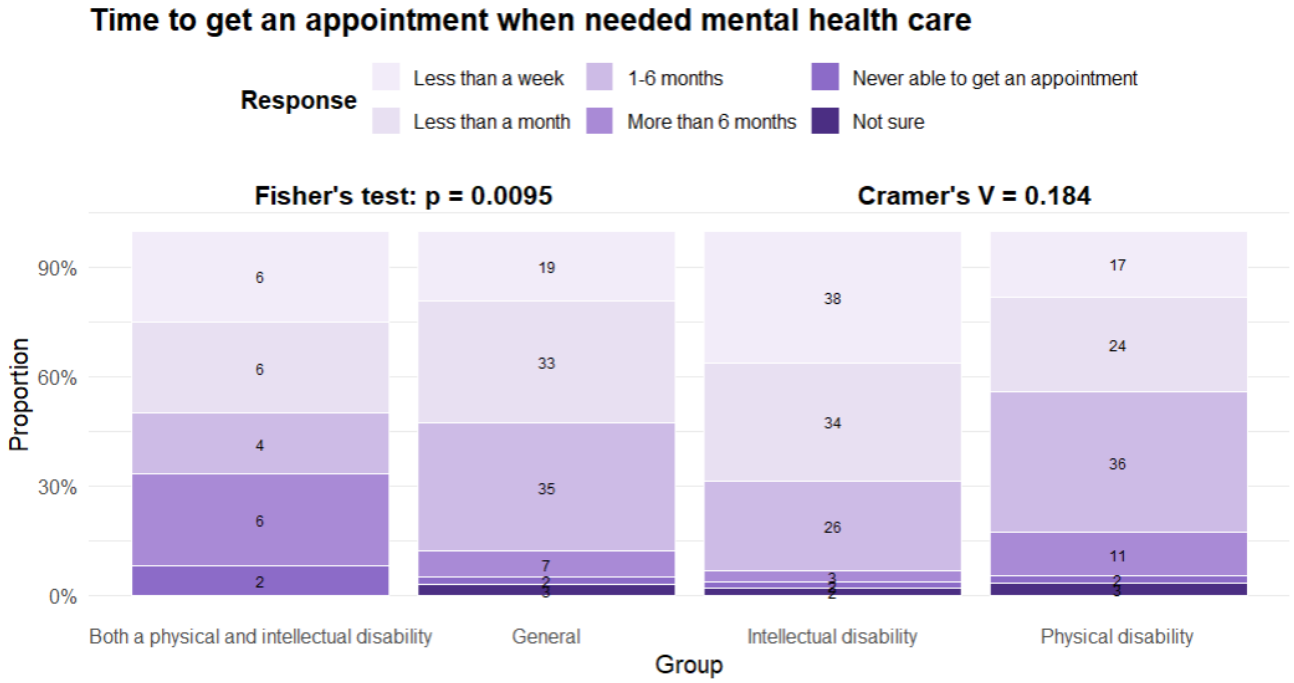

Figure 102: Fisher's exact test of the time to get an appointment when needed mental health care item in France

Table 98: Pairwise comparison test of the time to get an appointment when needed mental health care item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.082	0.310

Group with both a physical and intellectual disability : Group with an intellectual disability	0.035	0.378
Group with both a physical and intellectual disability : Group with a physical disability	0.143	0.267
General group : Group with an intellectual disability	0.117	0.214
General group : Group with a physical disability	0.799	0.108
Group with a intellectual disability : Group with a physical disability	0.035	0.279

Significant differences were also identified for knowledge of where to seek immediate help during a mental health crisis (Figure 105, Table 99). Differences were observed between the general population and the group with intellectual disabilities (p = 0.003, Cramer's V = 0.372), as well as between the group with intellectual disabilities and the group with physical disabilities (p = 0.011, Cramer's V = 0.239). The descriptive findings suggest that crisis-related knowledge may be more consistent among individuals with intellectual disabilities compared to other groups. The effect sizes indicate small to moderate associations, highlighting meaningful differences in crisis awareness.

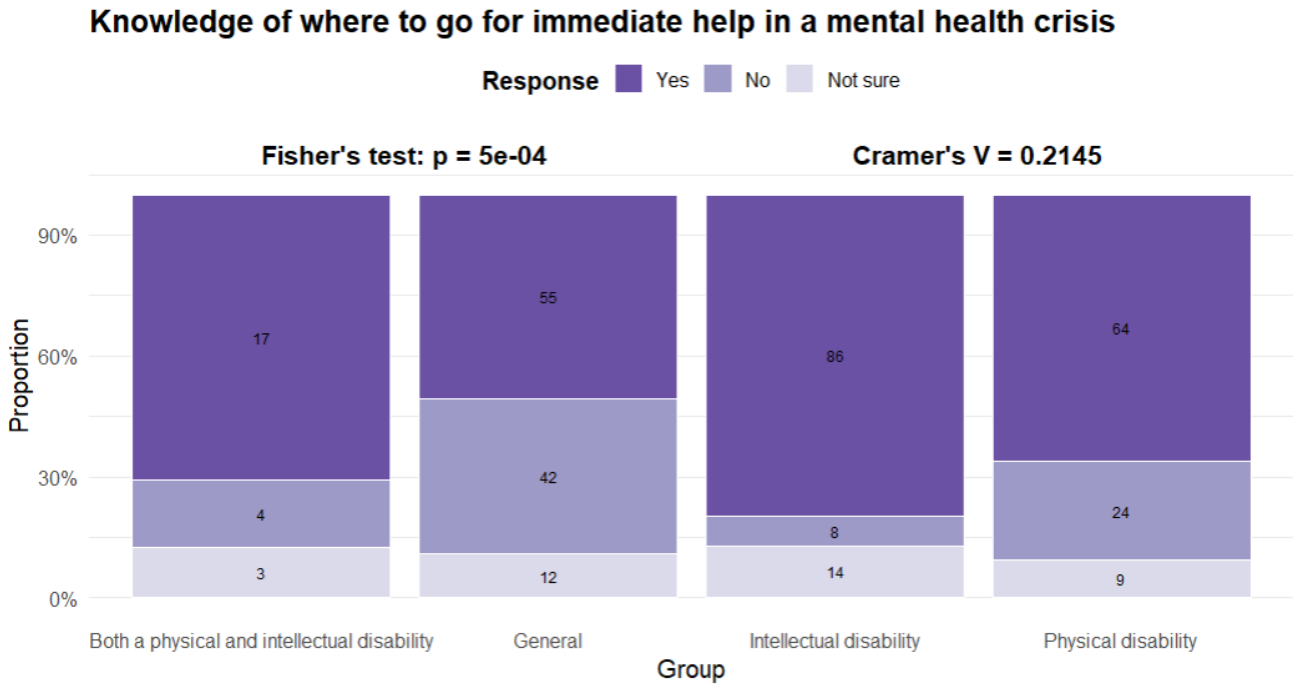

Figure 103: Fisher's exact test of the knowledge of where to go for immediate help in a mental health crisis item in France

Table 99: Pairwise comparison test of the knowledge of where to go for immediate help in a mental health crisis item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.178	0.179
Group with both a physical and intellectual disability : Group with an intellectual disability	0.419	0.125
Group with both a physical and intellectual disability : Group with a physical disability	0.643	0.081
General group : Group with an intellectual disability	0.003	0.372
General group : Group with a physical disability	0.158	0.161
Group with a intellectual disability : Group with a physical disability	0.011	0.239

Approachability

Within the Approachability dimension, two indicators did not demonstrate statistically significant differences between the population groups. These included the ease of understanding spoken or written information about mental health services, as well as whether respondents were asked about their mental wellbeing during encounters with a family doctor, school counsellor, or social worker and being invited in research related to mental health (Figure 106; all p-values > 0.05). These findings suggest that basic communication clarity and routine wellbeing discussions were experienced similarly across the general population and disability groups.

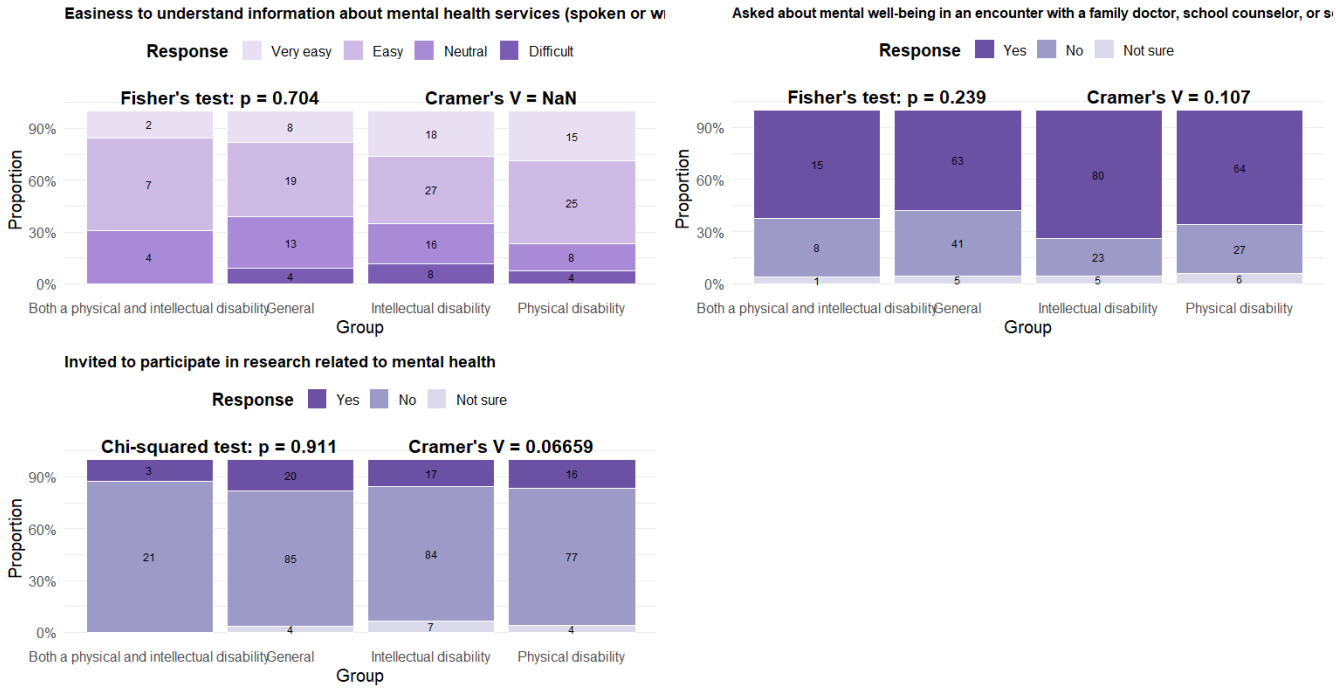

Figure 104: Non-significant differences across groups for the Approachability dimension in France

In contrast, several other indicators within this dimension showed statistically significant variation, particularly involving individuals with intellectual disabilities. Significant differences were observed regarding whether participants had encountered information on accessing mental health support (Table 100; Figure 107). Pairwise comparisons indicated a statistically significant difference between the general population and the group with an intellectual disability ($p = 0.003$, Cramer's $V = 0.310$), while no significant differences were identified between other group combinations. Descriptive findings suggest that individuals with intellectual disabilities reported encountering such information more frequently than respondents from the general population. The corresponding effect size indicates a moderate association, suggesting meaningful differences in initial exposure to service-related information.

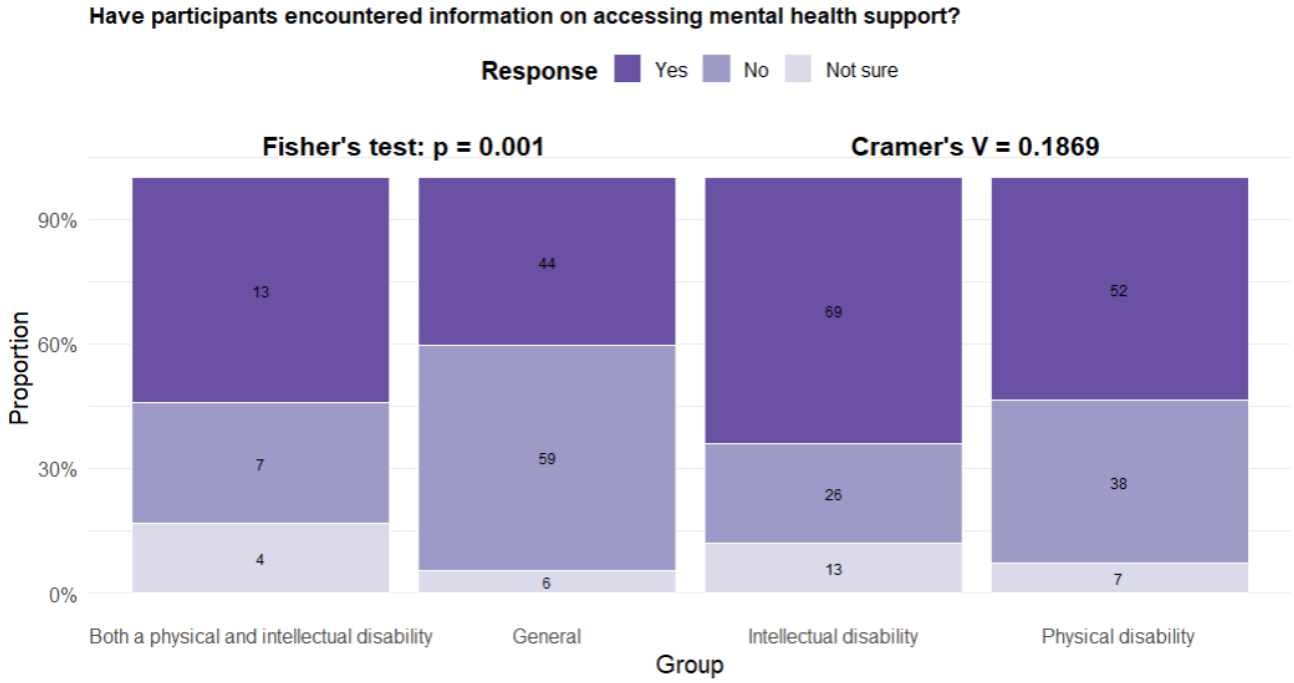

Figure 105: Fisher's exact test of the have participants encountered information on accessing mental health support item in France

Table 100: Pairwise comparison test of the have participants encountered information on accessing mental health support item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.100	0.223
Group with both a physical and intellectual disability : Group with an intellectual disability	0.634	0.079
Group with both a physical and intellectual disability : Group with a physical disability	0.354	0.141
General group : Group with an intellectual disability	0.003	0.310
General group : Group with a physical disability	0.152	0.150
Group with an intellectual disability : Group with a physical disability	0.112	0.169

For the item assessing the ease of finding reliable information about mental health services, no statistically significant differences were observed between groups. In one comparison, Cramer's V could not be calculated due to limited cell counts, which may reflect small subgroup sizes rather than the absence of meaningful variation (Figure 108; Table 101).

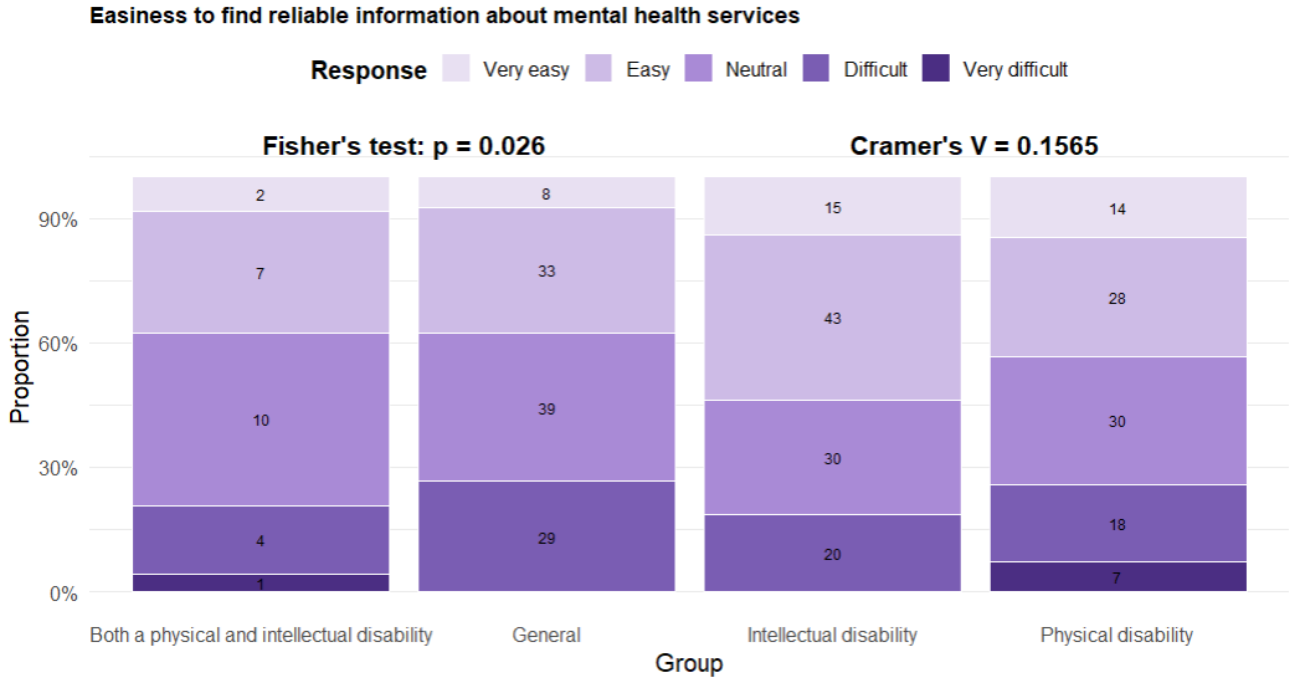

Figure 106: Fisher's exact test of the easiness to find reliable information about mental health services item in France

Table 101: Pairwise comparison test of the easiness to find reliable information about mental health services item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.407	0.204
Group with both a physical and intellectual disability : Group with an intellectual disability	0.327	0.228
Group with both a physical and intellectual disability : Group with a physical disability	0.882	0.112
General group : Group with an intellectual disability	0.187	NC
General group : Group with a physical disability	0.072	0.243
Group with an intellectual disability : Group with a physical disability	0.093	0.218

Variation was also observed in relation to whether respondents had come across outreach programs related to mental health services (Figure 109; Table 102). A statistically significant difference was identified between the general population and the group with an intellectual disability ($p = 0.015$, Cramer's $V = 0.235$). The effect size indicates a small to moderate association, suggesting meaningful but moderate differences between groups.

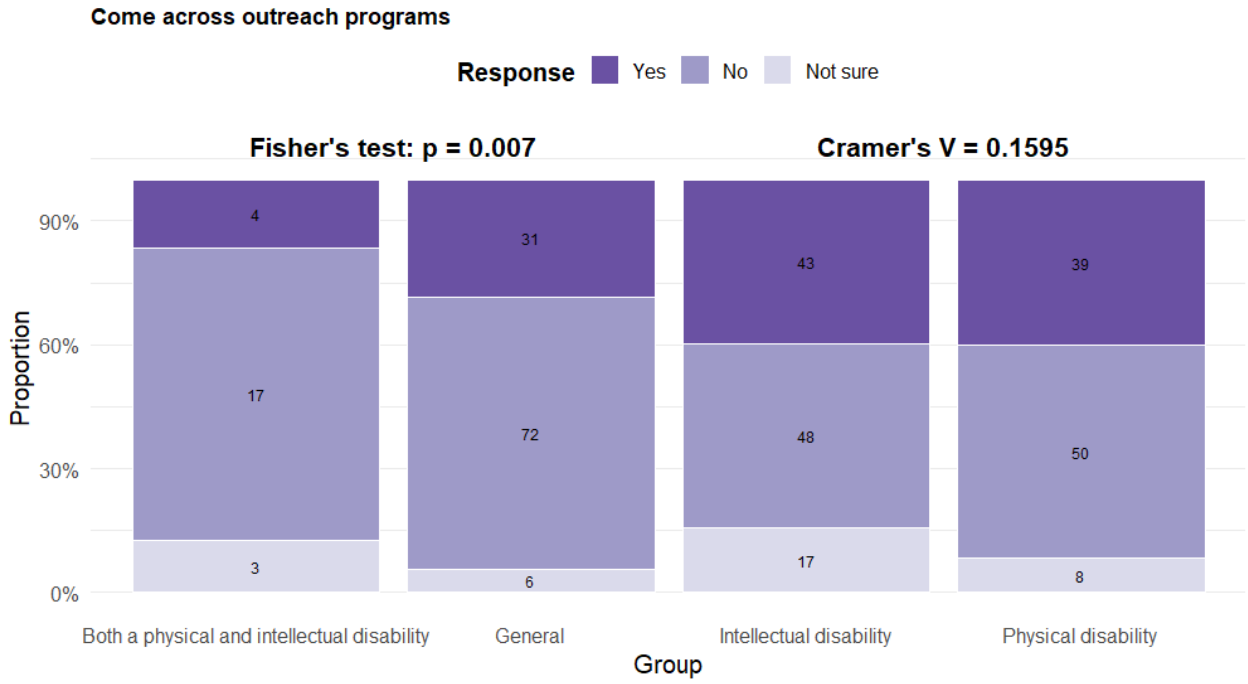

Figure 107: Fisher's exact test of the come across outreach programs item in France

Table 102: Pairwise comparison test of the come across outreach programs item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.241	0.138
Group with both a physical and intellectual disability : Group with an intellectual disability	0.139	0.211
Group with both a physical and intellectual disability : Group with a physical disability	0.139	0.197
General group : Group with an intellectual disability	0.015	0.235
General group : Group with a physical disability	0.141	0.148
Group with an intellectual disability : Group with a physical disability	0.241	0.119

Similarly, statistically significant differences were identified for whether respondents had heard about experiences of other patients regarding mental health services (Figure 110; Table 103). Differences were observed between the general population and the group with an intellectual disability (p = 0.003, Cramer's V = 0.283), as well as between the group with intellectual disabilities and the group with physical disabilities (p = 0.009, Cramer's V = 0.235). The corresponding effect

sizes indicate small to moderate associations, suggesting meaningful differences in peer-related information exposure.

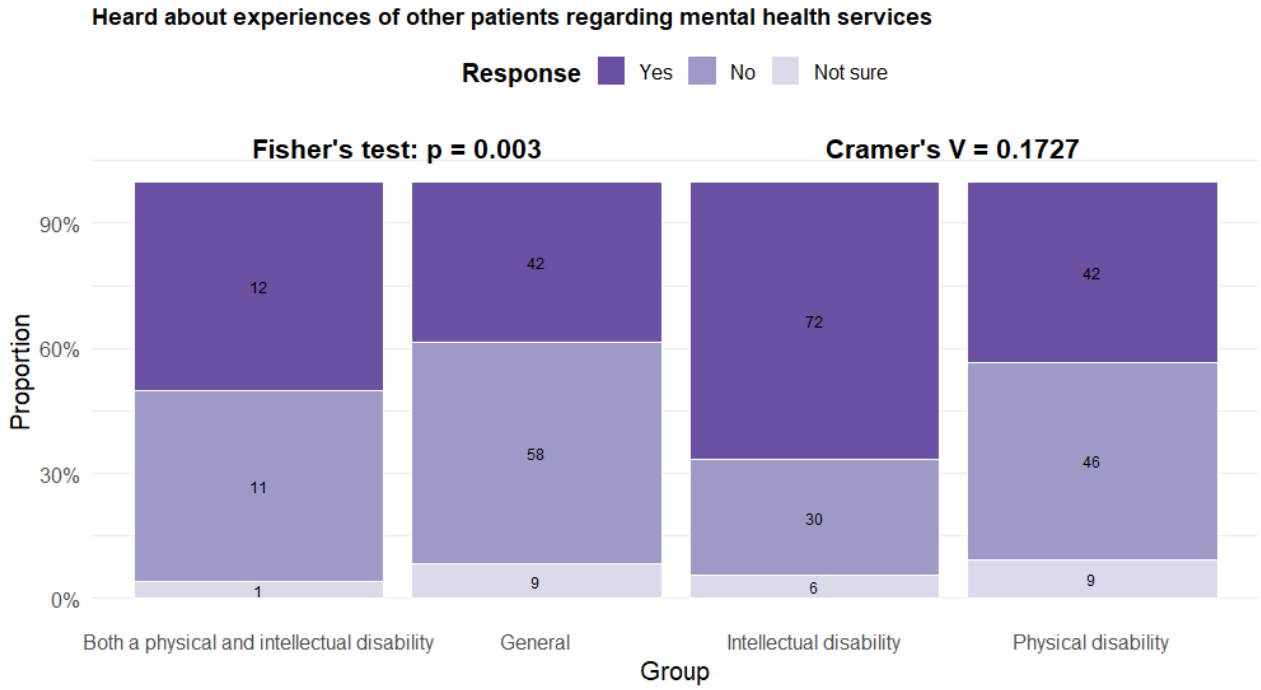

Figure 108: Fisher's exact test of the heard about experiences of other patients regarding mental health services item in France

Table 103: Pairwise comparison test of the heard about experiences of other patients regarding mental health services item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.781	0.098
Group with both a physical and intellectual disability : Group with an intellectual disability	0.530	0.150
Group with both a physical and intellectual disability : Group with a physical disability	0.781	0.082
General group : Group with an intellectual disability	0.003	0.283
General group : Group with a physical disability	0.781	0.058
Group with an intellectual disability : Group with a physical disability	0.009	0.235

Acceptability

Within the Acceptability dimension, none of the analysed indicators demonstrated statistically significant differences between the population groups. Specifically, no statistically significant variation was observed regarding the option to communicate with mental health providers in a preferred language, the possibility to choose one's own doctor or therapist, perceptions that mental health professionals communicate respectfully, whether patients' rights were protected against mistreatment or abuse, or whether mental health services were considered trustworthy (Figure 111 and Figure 112; all p-values > 0.05). These findings suggest that perceptions of respectful care, provider choice, communication, and patient protection were broadly comparable across the general population and disability groups.

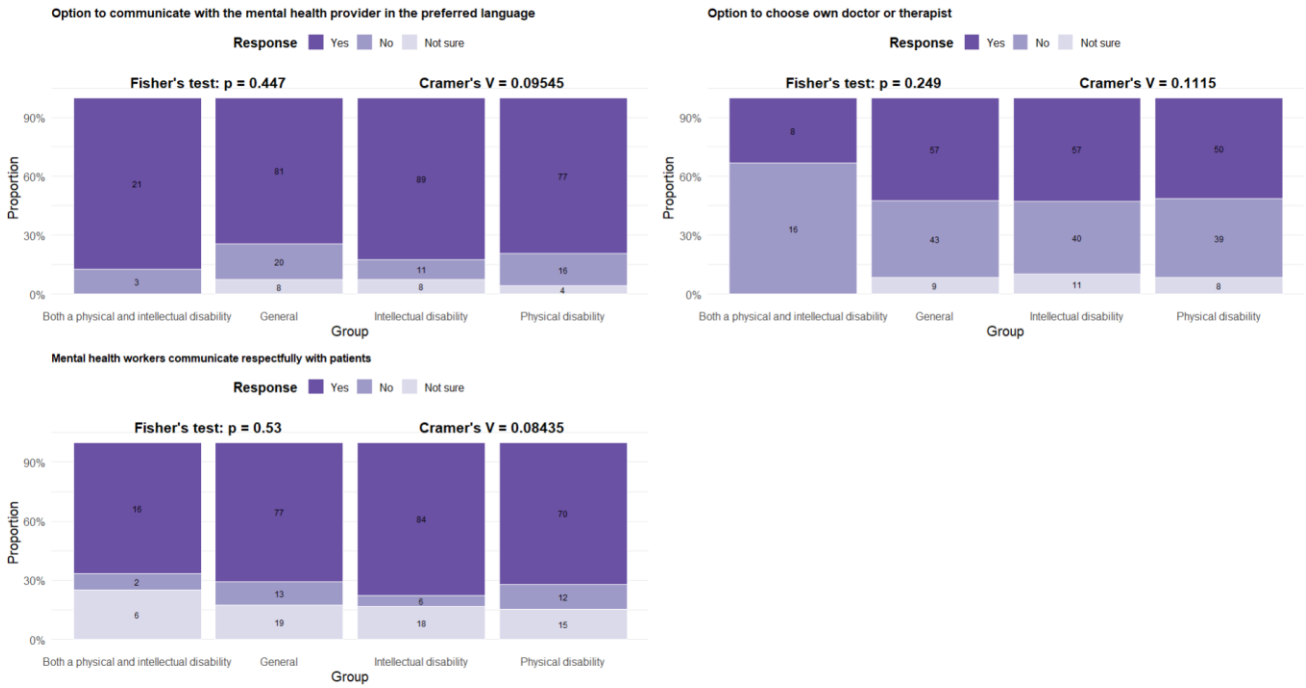

Figure 109: Non-significant differences across groups for the Acceptability dimension in France (1)

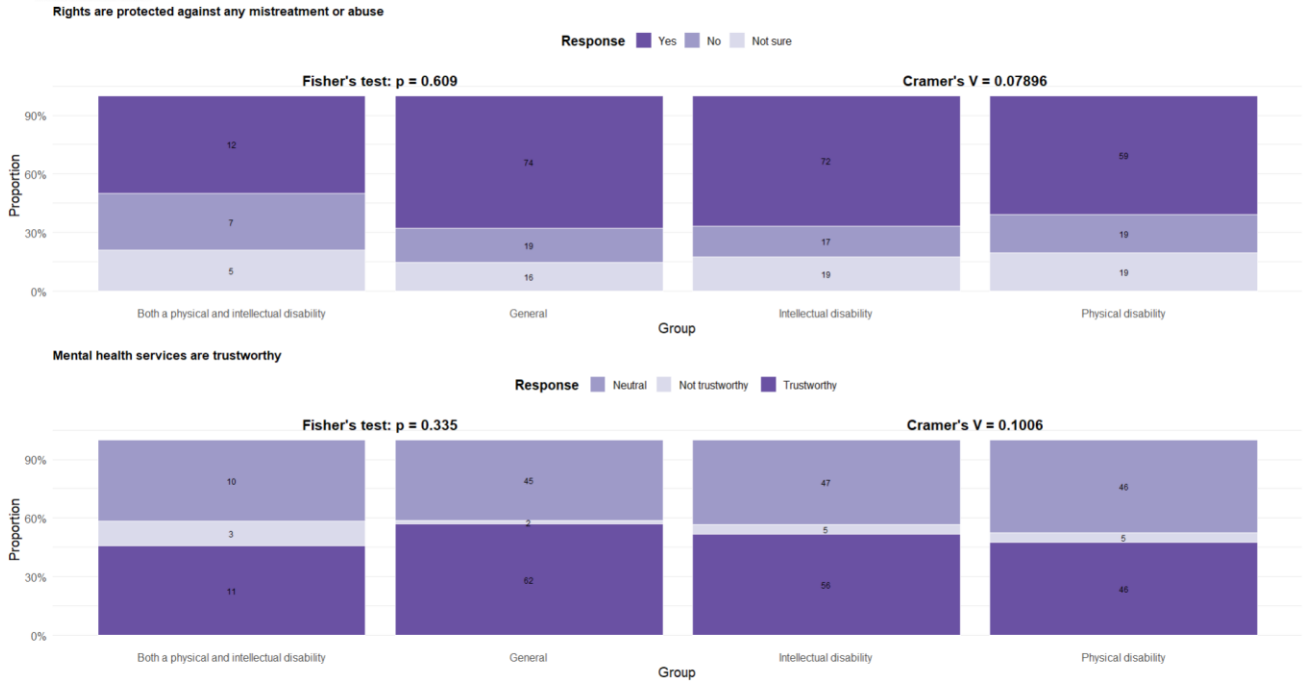

Figure 110: Non-significant differences across groups for the Acceptability dimension in France (2)

Similarly, perceptions that mental health services are sensitive to cultural beliefs and practices did demonstrate statistically significant differences between groups initially, but after pairwise comparison no statistical significant p-values were reached (all adjusted p-values > 0.05) (Figure 113; Table 104)

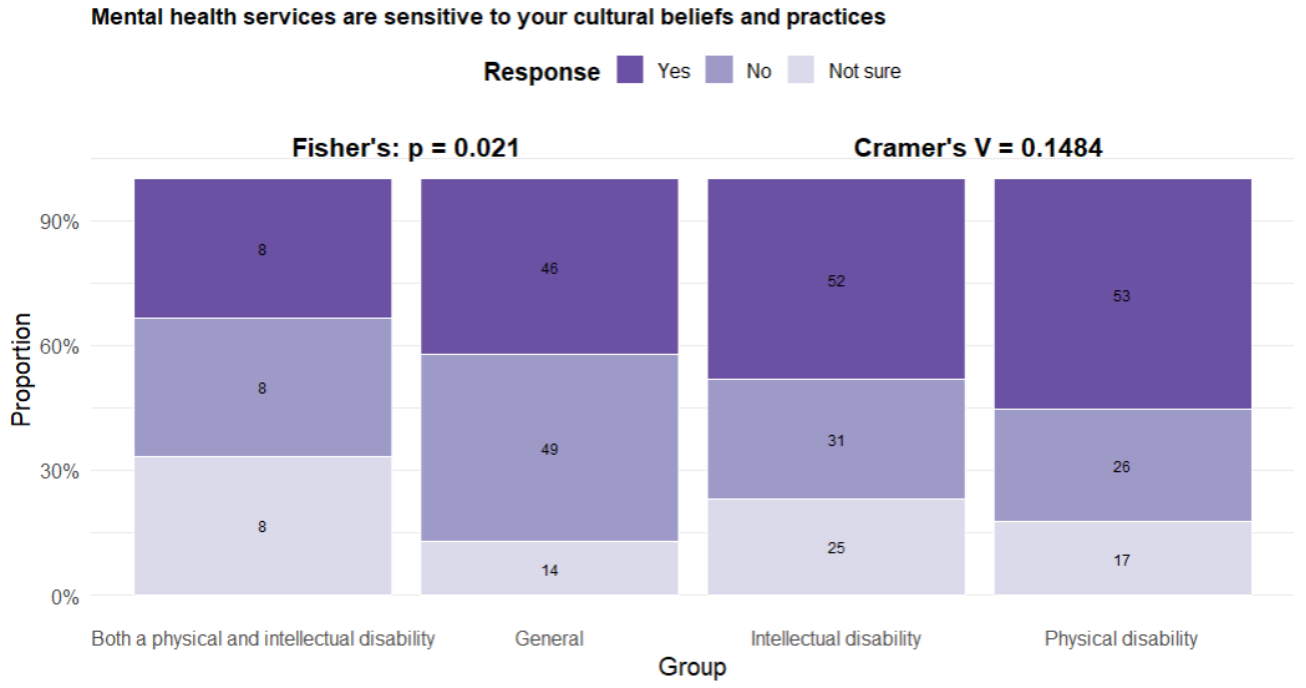

Figure 111: Fisher's exact test of the mental health services are sensitive to your cultural beliefs and practices item in France

Table 104: Pairwise comparison test of the mental health services are sensitive to your cultural beliefs and practices item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.151	0.212
Group with both a physical and intellectual disability : Group with an intellectual disability	0.448	0.120
Group with both a physical and intellectual disability : Group with a physical disability	0.158	0.190
General group : Group with an intellectual disability	0.102	0.186
General group : Group with a physical disability	0.102	0.185
Group with an intellectual disability : Group with a physical disability	0.553	0.079

Affordability

Within the Affordability dimension, several indicators did not demonstrate statistically significant differences between the population groups. These included health insurance coverage for mental health services and delayed or avoided mental healthcare due to cost within the past 12 months (Figure 114; all p-values > 0.05). These findings suggest that overall insurance-related access and recent cost-related avoidance of care were broadly comparable across the general population and

disability groups.

Figure 112: Non-significant differences across groups for the Affordability dimension in France

In contrast, differences were observed for several other affordability-related indicators, particularly when comparing the general population with individuals with intellectual disabilities. A statistically significant difference was identified for the possibility of obtaining mental health services through public programs or services free of charge or at low cost (Figure 115; Table 105). Pairwise comparisons indicated significant differences between the general population and the group with an intellectual disability ($p = 0.003$, Cramer's $V = 0.376$), as well as between the general population and the group with both physical and intellectual disabilities ($p = 0.036$, Cramer's $V = 0.248$) and between the general population and the group with a physical disability ($p = 0.036$, Cramer's $V = 0.208$). These findings suggest variation in perceived access to subsidized services, with disability groups reporting different experiences compared to the general population. The corresponding effect sizes ranged from small to moderate, indicating meaningful differences between groups.

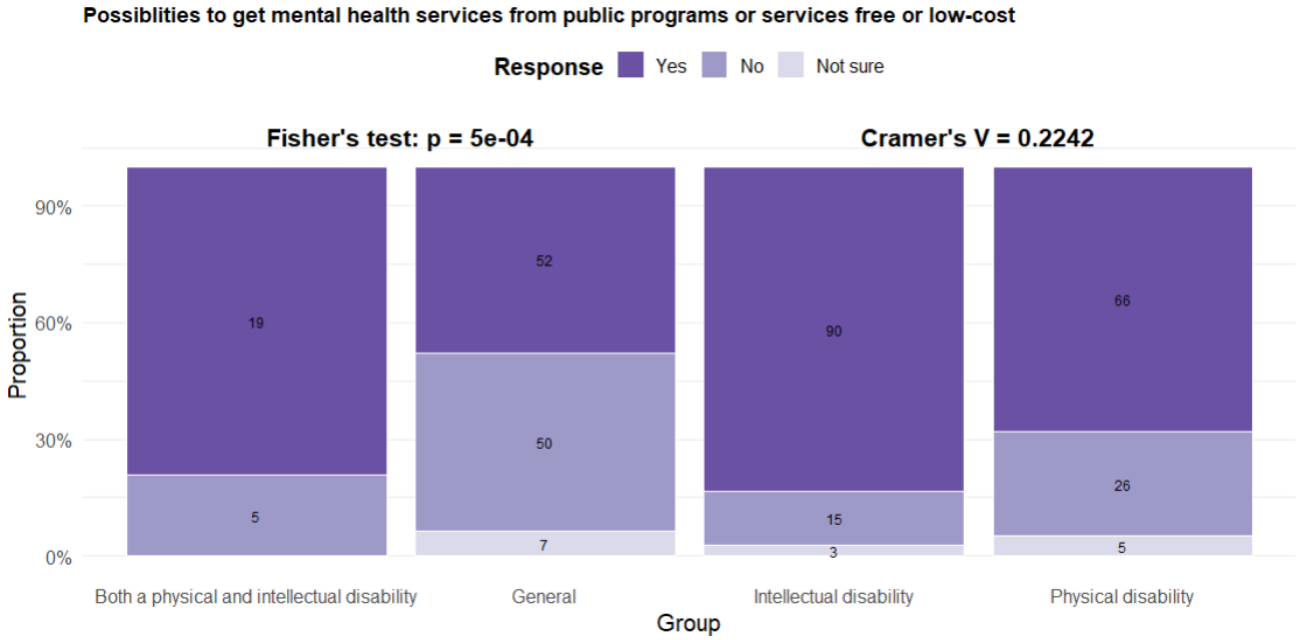

Figure 113: Fisher's exact test of the possibilities to get mental health services from public programs or services free or low-cost item in France

Table 105: Pairwise comparison test of the possibilities to get mental health services from public programs or services free or low-cost item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.036	0.248
Group with both a physical and intellectual disability : Group with an intellectual disability	0.752	0.100
Group with both a physical and intellectual disability : Group with a physical disability	0.752	0.123
General group : Group with an intellectual disability	0.003	0.376
General group : Group with a physical disability	0.036	0.208
Group with an intellectual disability : Group with a physical disability	0.058	0.179

For the indicator assessing whether respondents had not taken prescribed medication due to cost, an overall statistical difference was initially observed (p = 0.025; Figure 116, Table 106). However, subsequent pairwise comparisons did not identify statistically significant differences between specific groups (all adjusted p-values > 0.05). This suggests that although overall variation may exist, specific group-level differences could not be clearly identified.

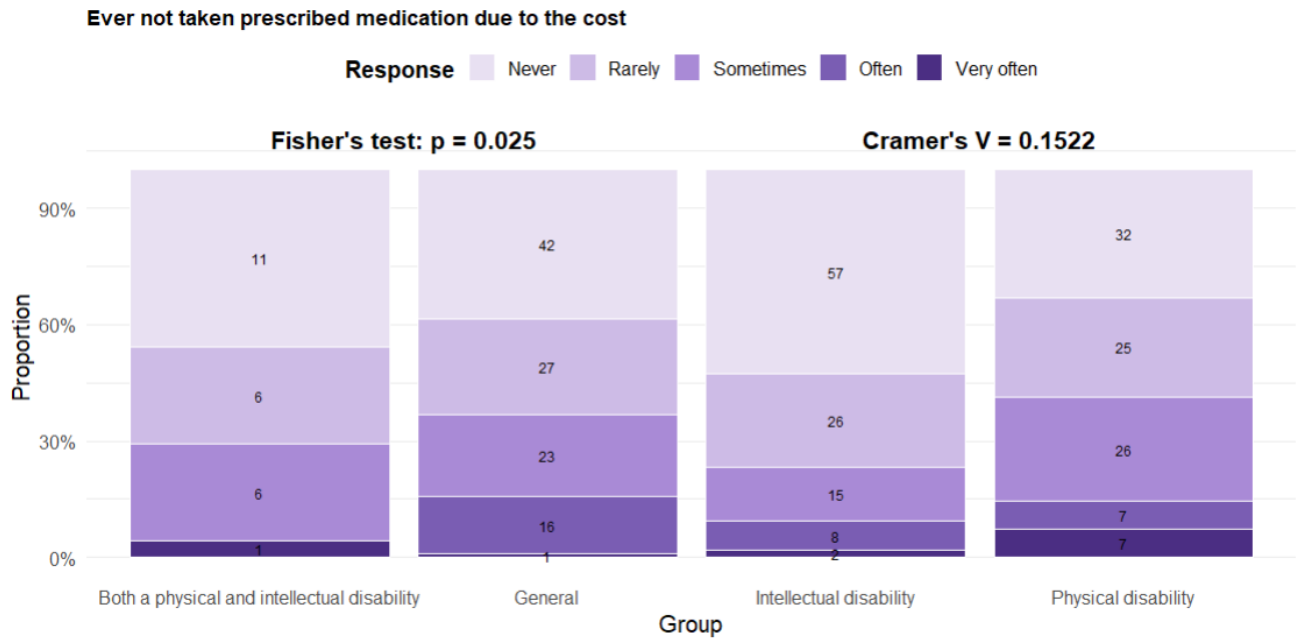

Figure 114: Fisher's exact test of the ever not taken prescribed medication due to the cost item in France

Table 106: Pairwise comparison of the ever not taken prescribed medication due to the cost item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.244	0.200
Group with both a physical and intellectual disability : Group with an intellectual disability	0.432	0.173
Group with both a physical and intellectual disability : Group with a physical disability	0.704	0.155
General group : Group with an intellectual disability	0.228	0.179
General group : Group with a physical disability	0.195	0.209
Group with an intellectual disability : Group with a physical disability	0.072	0.245

Further differences were observed regarding difficulty accessing mental health services due to loss of income (Figure 117; Table 107). Statistically significant differences were identified between the general population and the group with both physical and intellectual disabilities (p = 0.023, Cramer's V = 0.325), between the general population and the group with intellectual disabilities (p = 0.003, Cramer's V = 0.317), and between the group with intellectual disabilities and the group with physical disabilities (p = 0.023 Cramer's V = 0.245). These findings suggest that income-related financial

barriers were experienced differently across disability groups. The corresponding effect sizes indicate small to moderate associations, suggesting meaningful differences in financial vulnerability.

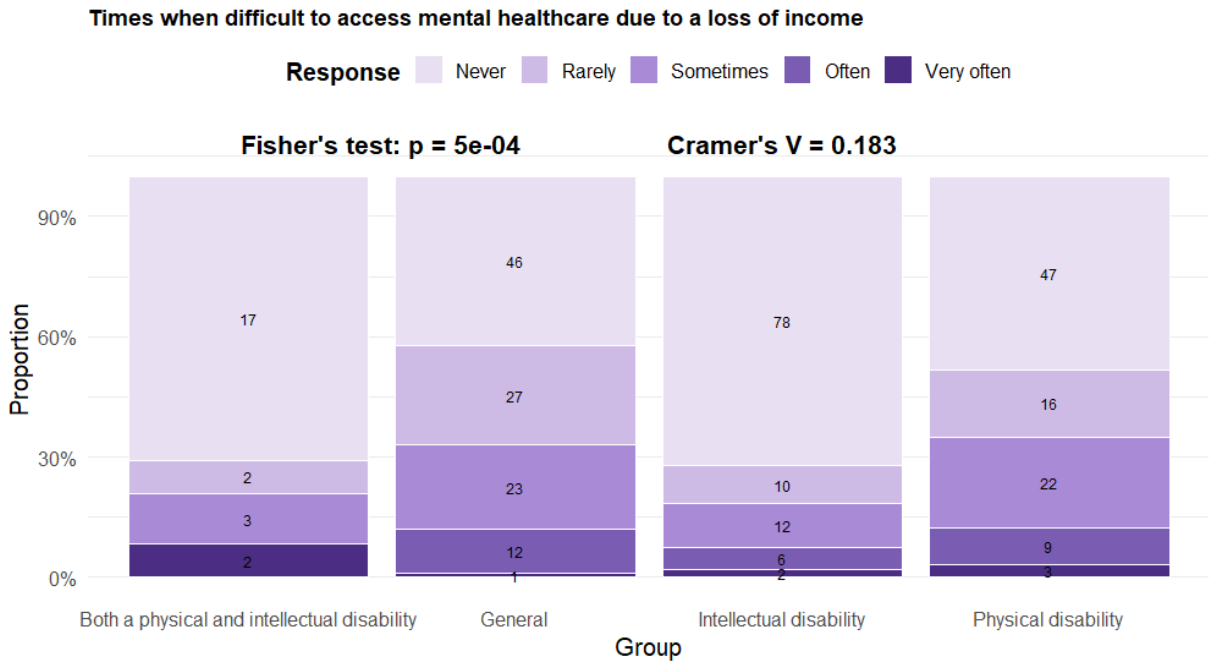

Figure 115: Fisher's exact test of the times when difficult to access mental healthcare due to a loss of income item in France

Table 107: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.023	0.325
Group with both a physical and intellectual disability : Group with an intellectual disability	0.472	0.177
Group with both a physical and intellectual disability : Group with a physical disability	0.202	0.243
General group : Group with an intellectual disability	0.003	0.317
General group : Group with a physical disability	0.476	0.132
Group with a intellectual disability : Group with a physical disability	0.023	0.245

Differences were also identified regarding whether respondents had been offered financial support or discounts to reduce or cover the costs of care (Figure 118; Table 108). A statistically significant difference was observed between the general population and the group with intellectual disabilities (p = 0.021, Cramer's V = 0.240), suggesting variation in the availability or perception of financial support across groups.

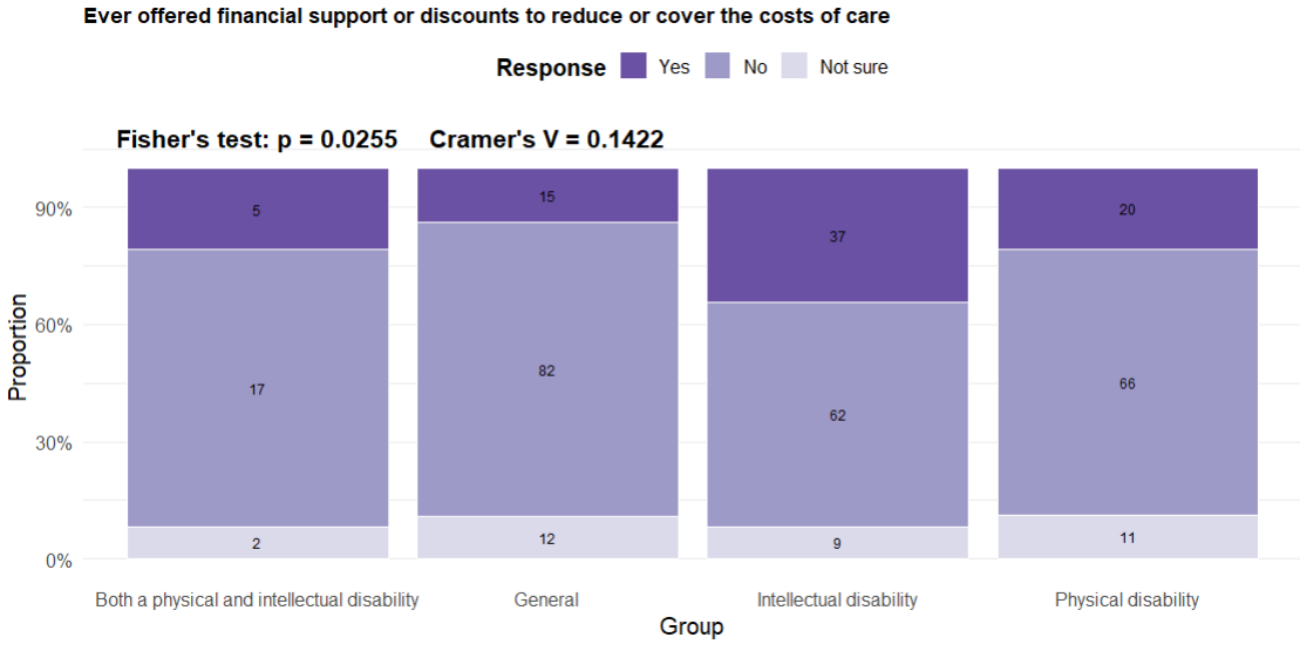

Figure 116: Fisher's exact test of the ever offered financial support or discounts to reduce or cover the costs of care item in France

Table 108: Pairwise comparison test of the ever offered financial support or discounts to reduce or cover the costs of care item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.889	0.079
Group with both a physical and intellectual disability : Group with an intellectual disability	0.630	0.114
Group with both a physical and intellectual disability : Group with a physical disability	1.000	0.039
General group : Group with an intellectual disability	0.021	0.240
General group : Group with a physical disability	0.630	0.093
Group with an intellectual disability : Group with a physical disability	0.246	0.153

Similarly, statistically significant differences were found for whether service providers offered assistance with payment options, insurance questions, or financial guidance (Figure 119; Table

109). Differences were identified between the general population and the group with intellectual disabilities (p = 0.026, Cramer's V = 0.206), as well as between the group with intellectual disabilities and the group with physical disabilities (p = 0.026, Cramer's V = 0.215). These findings suggest variation in the level of administrative and financial support available across groups. The observed effect sizes indicate small associations, suggesting modest but meaningful differences.

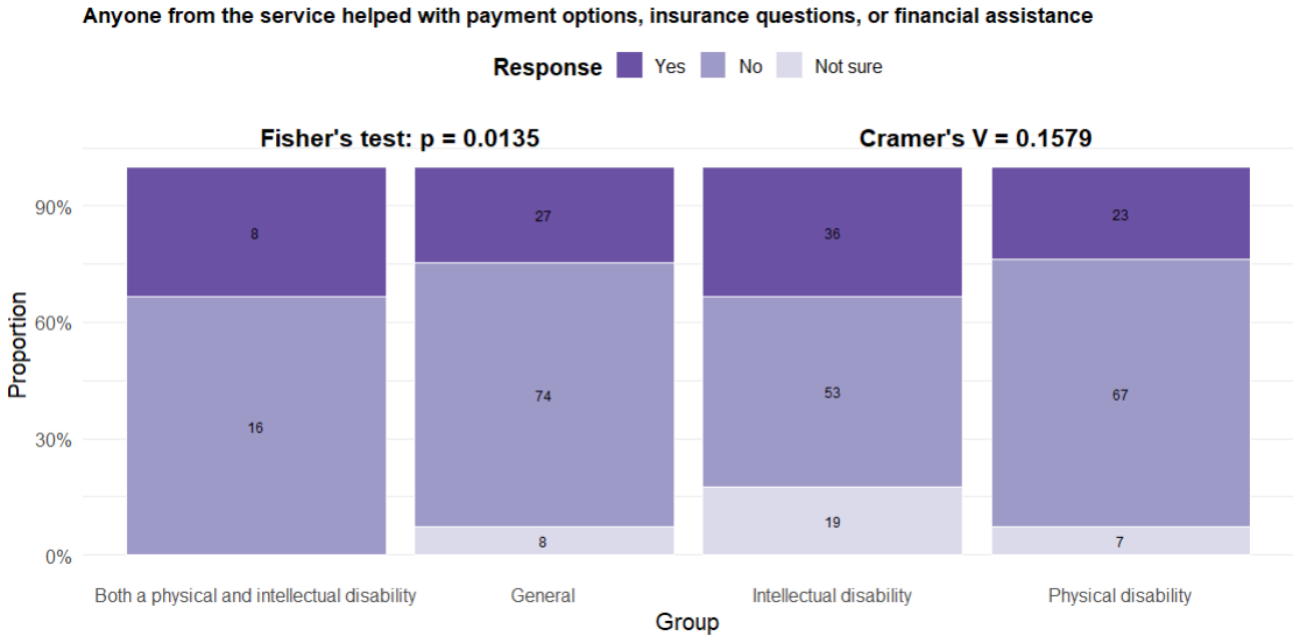

Figure 117: Fisher's exact test of the anyone from the service helped with payment options, insurance questions, or financial assistance item in France

Table 109: Pairwise comparison test of the anyone from the service helped with payment options, insurance questions, or financial assistance item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.444	0.132
Group with both a physical and intellectual disability : Group with an intellectual disability	0.110	0.202
Group with both a physical and intellectual disability : Group with a physical disability	0.444	0.142
General group : Group with an intellectual disability	0.026	0.206
General group : Group with a physical disability	0.972	0.013
Group with an intellectual disability : Group with a physical disability	0.026	0.215

Within the Appropriateness dimension, the majority of indicators did not demonstrate statistically significant differences between population groups. These included perceptions related to whether providers spent sufficient time during consultations, whether services were perceived as helpful or relevant, whether cultural beliefs and practices were taken into account, and whether users were involved in setting treatment goals. In addition, no statistically significant differences were observed for smooth referral between services, ease of scheduling follow-up appointments, continuity of care with the same provider, or whether users were invited to provide feedback regarding their treatment (Figure 120 & Figure 121; all p-values > 0.05). These findings suggest that several structural and organizational aspects of care were experienced similarly across the general population and disability groups.

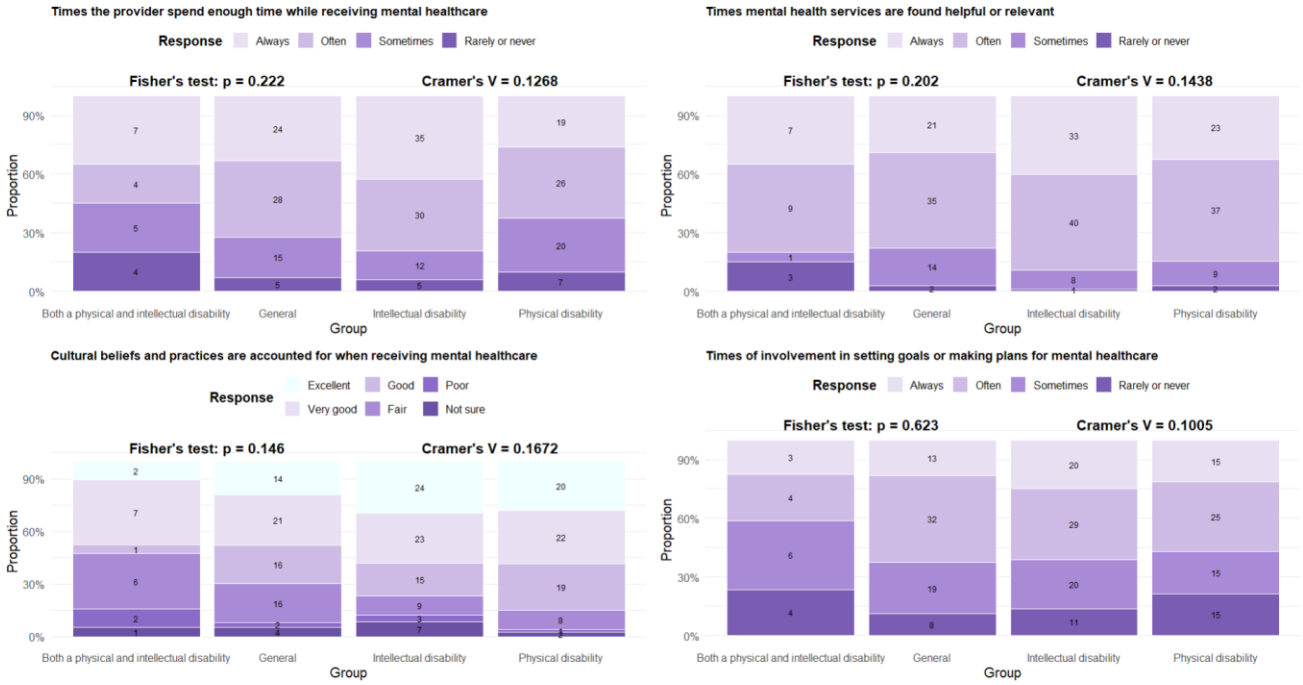

Figure 118: Non-significant differences across groups for the Appropriateness dimension in France (1)

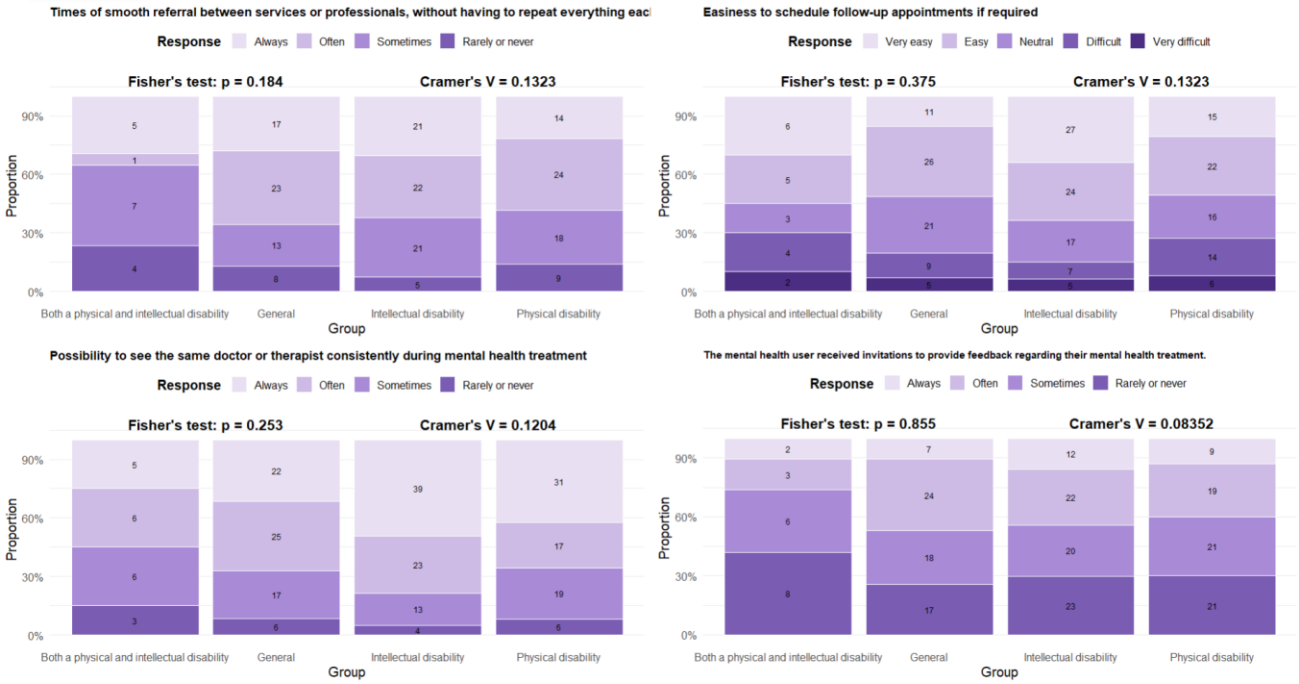

Figure 119: Non-significant differences across groups for the Appropriateness dimension in France (2)

However, a number of indicators related to interpersonal communication, responsiveness to user needs, and perceived service improvement showed statistically significant differences between groups (Figure 122; Table 110). Significant variation was observed regarding whether mental health professionals treated clients with courtesy and respect. Statistically significant differences were identified between the general population and the group with intellectual disabilities ($p = 0.006$, Cramer's $V = 0.312$), and between the group with intellectual disabilities and the group with physical disabilities ($p = 0.003$, Cramer's $V = 0.335$). These findings suggest that perceptions of respectful treatment varied across disability groups, with moderate effect sizes indicating meaningful differences in interpersonal experiences during care.

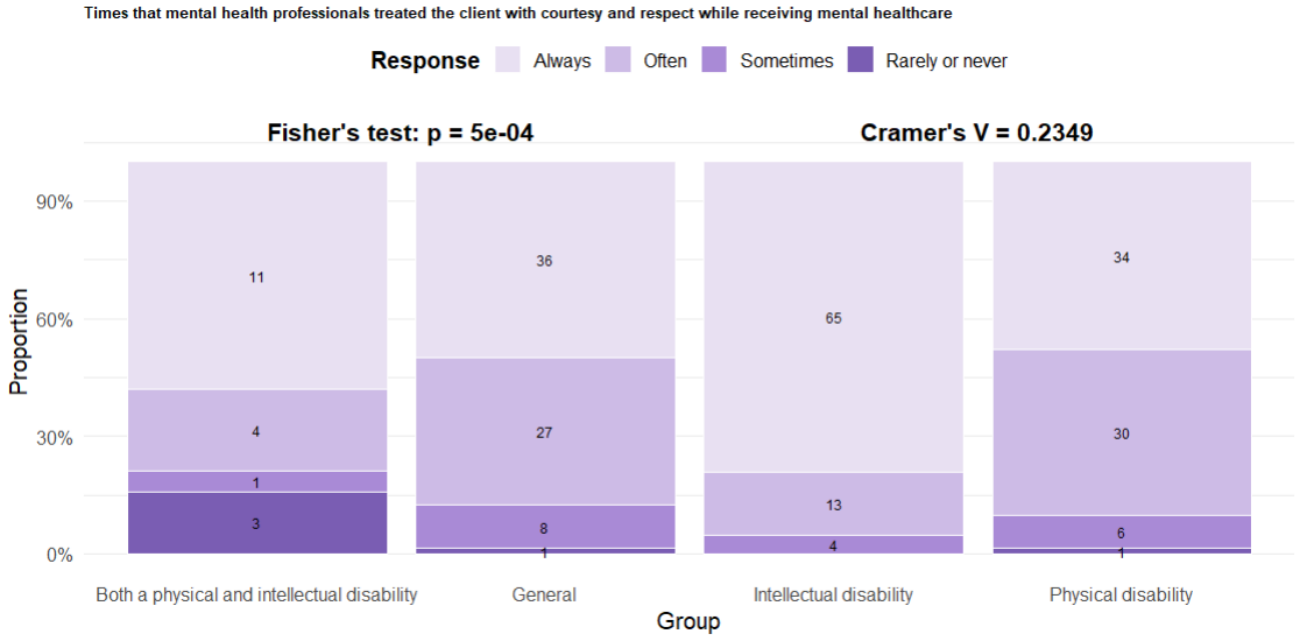

Figure 120: Fisher's exact test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare item in France

Table 110: Pairwise comparison test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.060	0.314
Group with both a physical and intellectual disability : Group with an intellectual disability	0.028	0.374
Group with both a physical and intellectual disability : Group with a physical disability	0.045	0.321
General group : Group with an intellectual disability	0.006	0.312
General group : Group with a physical disability	0.885	0.059
Group with an intellectual disability : Group with a physical disability	0.003	0.335

Differences were also observed regarding whether providers explained information in a way that was easy to understand (Figure 123 and Table 111). A statistically significant difference was identified between the group with intellectual disabilities and the group with physical disabilities (p = 0.042, Cramer's V = 0.274), suggesting variation in communication clarity across disability groups. The corresponding effect size indicates a small to moderate association, suggesting meaningful but

moderate differences.

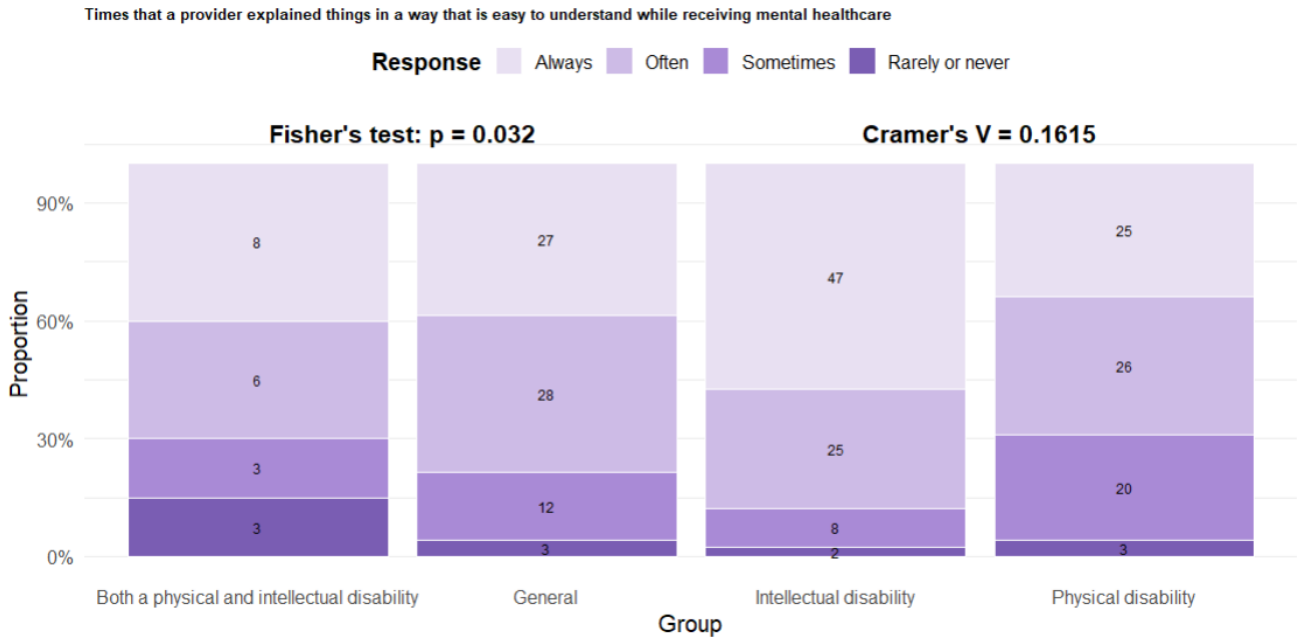

Figure 121: Fisher's exact test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in France

Table 111: Pairwise comparison test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.044	0.187
Group with both a physical and intellectual disability : Group with an intellectual disability	0.264	0.252
Group with both a physical and intellectual disability : Group with a physical disability	0.368	0.211
General group : Group with an intellectual disability	0.264	0.193
General group : Group with a physical disability	0.571	0.119
Group with an intellectual disability : Group with a physical disability	0.042	0.274

Further statistically significant differences were identified regarding whether mental health providers considered broader life circumstances during care (Figure 124, Table 112). Significant differences were observed between the general population and the group with both physical and intellectual disabilities (p = 0.013, Cramer's V = 0.421), as well as between the combined disability group and both the intellectual disability group (p = 0.011, Cramer's V = 0.439) and the physical disability

group (p = 0.011, Cramer's V = 0.446). These findings suggest that individuals with combined disabilities may experience distinct differences in how their life circumstances are considered during treatment. The corresponding effect sizes indicate moderate associations, suggesting notable variation in individualized care experiences.

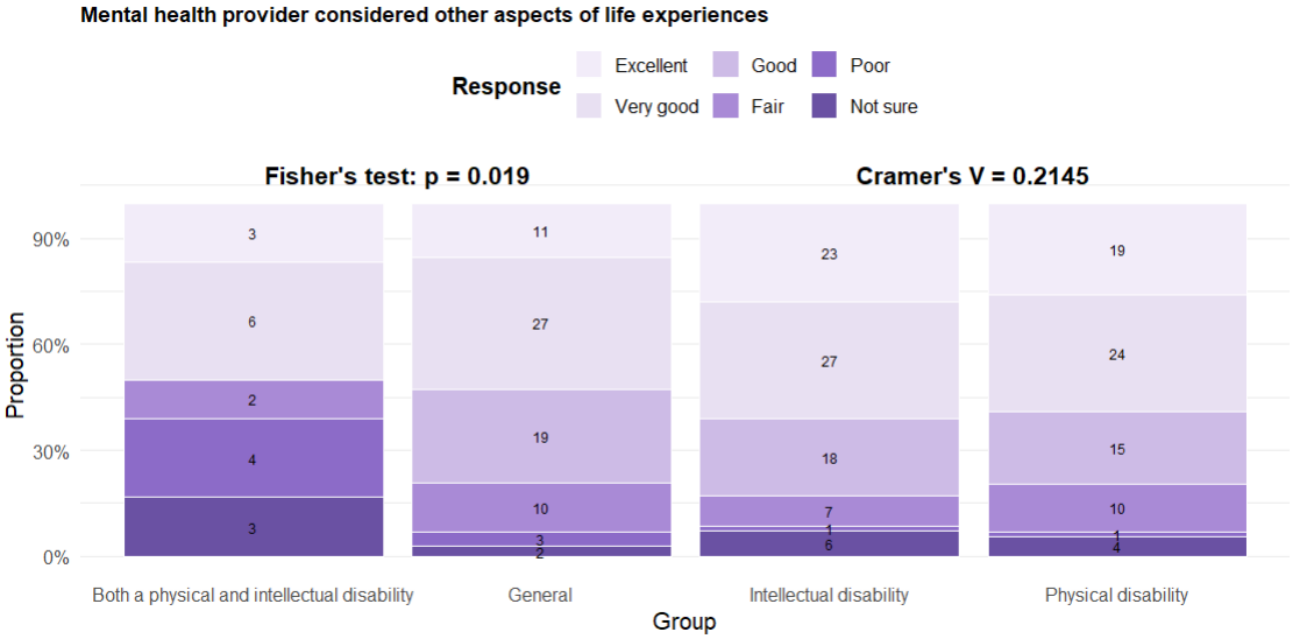

Figure 122: Fisher's exact test of the mental health provider considered other aspects of life experiences item in France

Table 112: Pairwise comparison test of the mental health provider considered other aspects of life experiences item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.013	0.421
Group with both a physical and intellectual disability : Group with an intellectual disability	0.011	0.439
Group with both a physical and intellectual disability : Group with a physical disability	0.011	0.446
General group : Group with an intellectual disability	0.320	0.216
General group : Group with a physical disability	0.630	0.175
Group with an intellectual disability : Group with a physical disability	0.934	0.090

Finally, statistically significant differences were identified regarding whether users felt that their feedback contributed to improving services (Figure 125 and Table 113). Differences were observed between the general population and the group with both physical and intellectual disabilities (p = 0.005, Cramer's V = 0.489), between the combined disability group and the group with intellectual

disabilities (p = 0.005, Cramer's V = 0.452), and between the combined disability group and the group with physical disabilities (p = 0.024, Cramer's V = 0.372). These findings indicate variation in perceptions of service responsiveness across groups, with effect sizes ranging from moderate to large, suggesting meaningful differences in how feedback processes are experienced.

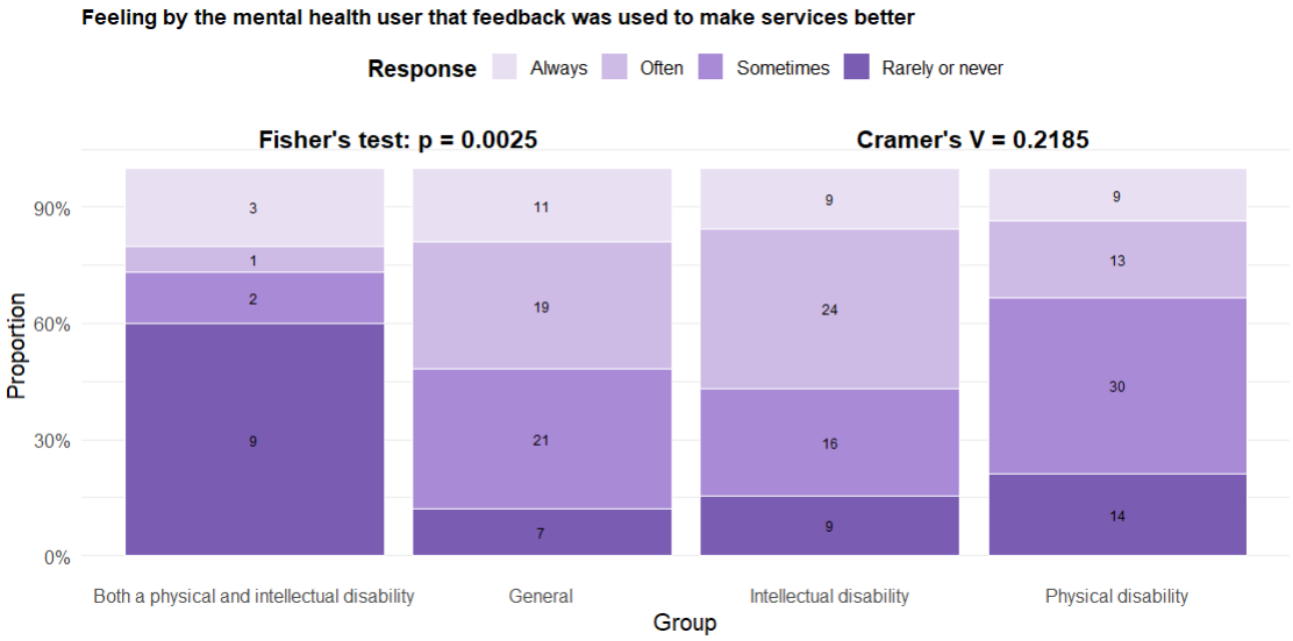

Figure 123: Fisher's exact test of the feeling by the mental health user that feedback was used to make services better item in France

Table 113: Pairwise comparison test of the feeling by the mental health user that feedback was used to make services better item in France

Comparison	P Value adjusted Fisher test	Cramer's V
General group : Group with both a physical and intellectual disability	0.005	0.489
Group with both a physical and intellectual disability : Group with an intellectual disability	0.005	0.452
Group with both a physical and intellectual disability : Group with a physical disability	0.025	0.372
General group : Group with an intellectual disability	0.651	0.121
General group : Group with a physical disability	0.242	0.196
Group with an intellectual disability : Group with a physical disability	0.078	0.256

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, showed varying utility values across population groups. The overall mean utility score in the present dataset was 0.614 (SD = 0.300). Group-specific means were 0.724 (SD = 0.219) for the general group, 0.475 (SD = 0.324) for the physical disability group, 0.683 (SD = 0.246) for the intellectual disability group, and 0.358 (SD = 0.377) for respondents with both intellectual and physical disabilities. Reference values derived from a French population dataset, as reported by Gautier et al. (2023)[18], indicated a mean EQ-5D utility value of 0.915. Compared with this national reference value, mean utility scores observed in the present dataset were descriptively lower across all study groups. The largest difference was observed among respondents with both intellectual and physical disabilities, who demonstrated substantially lower utility values compared with national reference data.

Self-perceived health

Self-perceived health was assessed using indicators aligned with those included in EU-SILC France, enabling comparison with national distributions reported through Eurostat EU-SILC France dataset[12]. Within the present dataset, variation in self-perceived health was observed across groups. Among the general group, 16.2% reported good health and 4.8% reported very good health, while higher proportions of respondents in disability groups reported fair or bad health. In particular, respondents with both intellectual and physical disabilities reported the highest proportions of poor health, including 15.4% reporting very bad health and 38.5% reporting bad health (Table 114).In comparison, EU-SILC France national data indicated that 41.2% of respondents reported good health and 26.0% reported very good health, with smaller proportions reporting poor health (Table 115). Compared with these national distributions, the study population, particularly individuals with disabilities, reported less favourable self-perceived health outcomes

Table 114: Self-perceived health in the dataset of France

	General group	Group with an intellectual disability	Group with a physical disability	Group with both a physical and intellectual disability.
Very bad, *n (%)*	1 (0.4)	4 (3.2)	9 (4.7)	4 (15.4)
Bad, *n (%)*	16 (7.0)	28 (22.6)	46 (24.2)	10 (38.5)

Fair (neither good nor bad), *n (%)*	44 (19.2)	51 (41.1)	25 (13.2)	6 (23.1)
Good, *n (%)*	37 (16.2)	23 (18.5)	10 (5.3)	2 (7.7)
Very good, *n (%)*	11 (4.8)	2 (1.6)	7 (3.7)	2 (7.7)
Missing, *n (%)*	120 (52.4)	16 (12.9)	93 (48.9)	2 (7.7)

Table 115: Self-perceived health in the dataset of EU-SILC France

	Total country
Very bad, %	1.3
Bad, %	7.7
Fair (neither good nor bad), %	23.8
Good, %	41.2
Very good, %	26.0

Activity limitations

Functional limitations were evaluated using indicators corresponding to those reported in EU-SILC France, enabling comparison with national activity limitation patterns.[13]. Within the present dataset, substantial levels of functional limitation were reported across disability groups. Specifically, 20.0% of respondents with physical disabilities and 34.6% of respondents with both intellectual and physical disabilities reported being severely limited in daily activities. In contrast, 3.9% of the general group reported severe limitations (Table 116). National reference values from EU-SILC France indicated that 9.9% of respondents reported severe limitations, 15.9% reported limitations, and 74.2% reported no activity limitations (Table 117). Compared with these national distributions, the present dataset showed markedly higher levels of functional limitation, particularly among respondents with combined disabilities.

Table 116: Activity limitations in the dataset of France

	General group	**Group with an intellectual disability**	**Group with a physical disability**	**Group with both a physical and intellectual disability.**
Severely limited, *n (%)*	9 (3.9)	14 (11.3)	38 (20.0)	9 (34.6)

Limited, *n (%)*	45 (19.7)	64 (51.6)	55 (28.9)	14 (53.8)
Not limited, *n (%)*	55 (24.0)	30 (24.2)	4 (2.1)	1 (3.8)
Missing, *n (%)*	120 (52.4)	16 (12.9)	93 (48.9)	2 (7.7)

Table 117: Activity limitations in the EU-SILC dataset of France

	Total country
Severely limited, %	9.9
Limited, %	15.9
Not limited, %	74.2

Unmet need for care

Information on unmet healthcare needs was collected using indicators aligned with those included in EU-SILC France, allowing comparison with national-level estimates reported through Eurostat EU-SILC France datasets[14]. Across all study groups, multiple reasons for unmet healthcare needs were reported. The most frequently reported barrier was waiting lists, affecting 17.0% of the general group, 19.4% of respondents with intellectual disabilities, 17.9% of respondents with physical disabilities, and 42.3% of respondents with combined disabilities. Cost-related barriers were also frequently reported, particularly among respondents with combined disabilities, where 26.9% reported unmet need due to costs (Table 118). In comparison, EU-SILC France national data indicated substantially lower levels of unmet need across all categories. For example, 3.1% reported cost-related unmet need, while 92.7% reported no unmet healthcare needs (Table 119). Compared with these national reference values, unmet need was reported more frequently across all study groups, particularly among individuals with combined disabilities.

Table 118: Unmet need for care in the dataset of France

	General group	Group with an intellectual disability	Group with a physical disability	Group with both a physical and intellectual disability.
Too expensive, *n (%)*	24 (10.5)	17 (13.7)	31 (16.3)	7 (26.9)
Too far to travel, *n (%)*	13 (5.7)	18 (14.5)	18 (9.5)	8 (30.8)
No time, *n (%)*	9 (3.9)	4 (3.2)	7 (3.7)	1 (3.8)

Didn't know any good doctor or specialist, *n (%)*	11 (4.8)	16 (12.9)	13 (6.8)	3 (11.5)
Waiting list, *n (%)*	39 (17.0)	24 (19.4)	34 (17.9)	11 (42.3)
Fear of doctor, hospital examination or treatment, *n (%)*	9 (3.9)	17 (13.7)	8 (4.2)	3 (11.5)
Wanted to wait and see if problem got better on its own, *n (%)*	13 (5.7)	22 (17.7)	22 (11.6)	3 (11.5)
Other reason, *n (%)*	0 (0.0)	8 (6.5)	3 (1.6)	4 (15.4)
No unmet needs to declare, *n (%)*	41 (17.9)	43 (34.7)	19 (10.0)	6 (23.1)
Missing, *n (%)*	120 (52.4)	16 (12.9)	94 (49.5)	2 (7.7)

Table 119: Unmet need for care in the EU-SILC dataset of France

	Total country
Too expensive, *%*	3.1
Too far to travel, *%*	0.5
No time, *%*	1.2
Didn't know any good doctor or specialist, *%*	0.2
Waiting list, *%*	1.2
Fear of doctor, hospital examination or treatment, *%*	0.3
Wanted to wait and see if problem got better on its own, *%*	0.2
Other reason, *%*	0.8
	92.7

Depression severity

Depressive symptom severity was assessed using indicators aligned with those included in EHIS France, enabling comparison with national mental health distributions reported through Eurostat EHIS France datasets[15]. Within the present dataset, higher proportions of respondents reported moderate to severe depressive symptoms compared with national reference distributions. Notably, 38.5% of respondents with combined disabilities reported severe depressive symptoms, compared with 3.9% in the general group and 8.9% in both intellectual and physical disability groups individually (Table 120). National reference values from EHIS France indicated substantially lower proportions of severe depressive symptoms (0.5%) and higher proportions of respondents reporting no or minimal symptoms (66.8%). Compared with these national data, depressive symptom severity appeared more pronounced within disability groups, particularly among respondents with both intellectual and physical disabilities (Table 121).

Table 120: Depression severity in the dataset of France

	General group	Group with an intellectual disability	Group with a physical disability	Group with both a physical and intellectual disability.
Severe, *n (%)*	9 (3.9)	11 (8.9)	17 (8.9)	10 (38.5)
Moderately severe, *n (%)*	17 (7.4)	17 (13.7)	21 (11.1)	6 (23.1)
Moderate, *n (%)*	23 (10.0)	31 (25.0)	23 (12.1)	4 (15.4)
Mild, *n (%)*	37 (16.2)	28 (22.6)	28 (14.7)	3 (11.5)
None or minimum, *n (%)*	23 (10.0)	21 (16.9)	8 (4.2)	1 (3.8)
Missing, *n (%)*	120 (52.4)	16 (12.9)	93 (48.9)	2 (7.7)

Table 121: Depression severity in the EHIS dataset of France

	Total country
Severe, %	0.5
Moderately severe, %	2.1
Moderate, %	6.9
Mild, %	23.7

None or minimum, %	66.8

4.6.2 Qualitative results

Approachability

Information awareness and access

Information about mental health services and social rights is consistently described across the LADAPT interviews as formally present within the French system but practically inaccessible to people with severe and persistent mental illness, particularly at the critical transition between hospital discharge and community reintegration. The problem is not an absence of information, but a structural mismatch between how information is organized and what people in acute vulnerability are able to engage with. From an academic perspective, the situation is bluntly assessed: *"The current level is poor; it's not working at all. So we have an inadequate level of information"* (LADAPT, Policymaker). This is echoed by civil society, where *"the average citizen facing mental health challenges doesn't intuitively have in mind the resources they can access"* (LADAPT, Civil Society-2).

The fragmentation of information is bound up with a broader deficit in health literacy among the vulnerable population. Access to care is already difficult for the average patient, but for someone also managing the cognitive and emotional weight of serious mental illness, system navigation becomes overwhelmingly complex: *"Access to the healthcare system is still relatively complex, and we have identified the need for support to facilitate access to care within the framework of common law"* (LADAPT, Researcher-2). This difficulty is compounded by the fact that much of what the healthcare system requires assumes capacities that are inconsistently available to this population, such as reading, form completion and digital registration. Even highly educated users struggle to navigate the system: *"However, where we haven't made progress is in addressing the complexity. We don't understand the diversity of services, support options, and professions. You have to become an expert on organizations to find your way around"* (LADAPT, Researcher-1).

A particular structural bottleneck is the digitisation of administrative procedures, which has proceeded without adequate attention to the realities of post-hospitalisation life. The priority upon leaving hospital is not accessing an online portal but securing food and shelter: *"Accessing one's rights today requires having a computer and knowing all the codes (one code for Social Security, one for the Family Allowance Fund, etc.). It's very complex"* (LADAPT, Researcher-2). Digital access barriers thus compound health literacy deficits, producing a layered exclusion from information that is nominally

universal. The end result is that engagement with the system is reactive and crisis-driven rather than proactive: *"Ultimately, what's most accessible is emergency care in a crisis, while we desperately lack simple information when things aren't too bad"* (LADAPT, Researcher-1).

The concept of the "therapeutic screen": healthcare professionals who are themselves afraid of the mental health presentations they encounter and do not understand how to address them, is identified as a significant barrier to information transmission within the healthcare system. Somatic care providers, rather than signposting or supporting access to mental health services, effectively create a barrier at the point of contact: *"We have healthcare professionals who are afraid of the mental health issues presented to them because they don't understand these disorders or how to address them"* (LADAPT, Researcher-2). This phenomenon blocks information flow at a critical node and is reinforced by the historical opacity of the psychiatric sector itself: *"But these campaigns don't fully cover information on accessing mental health services, given that we have a complex and opaque system from the perspective of mental health services"* (LADAPT, Policymaker).

Community-based approaches such as peer-led community groups represent the most promising identified strategies for improving information awareness. Users who organise through informal networks of recovery and peer learning is an effective information dissemination mechanism beca*use it centres the lived experience of those most excluded: "What I think is that there have been movements (particularly among psychiatrists and support workers) that have been developing for the last ten or fifteen years around the concept of recovery in mental health*" (LADAPT, Civil Society-1). Peer support is identified as one of the most effective relational bridges between institutional knowledge and those who most need access to it, and informal networks remain decisive: *"When you have a network, information flows, it circulates, and you manage to access it"* (LADAPT, Civil Society-1). This bottom-up information flow is increasingly visible from the academic side too: *"Now things are changing because information is being disseminated by the people directly affected, and they are organizing themselves to seek out information; support networks are starting to emerge"* (LADAPT, Policymaker).

Barriers to recognising or seeking help

Barriers to recognising and seeking help for those with a severe and persistent mental illness in France are multi-layered and mutually reinforcing, operating across individual, systemic, and societal dimensions. A foundational barrier is the absence of health literacy at the individual level, but this is inseparable from the conditions of vulnerability in which the population lives. *"Access to the healthcare system is still relatively complex, and we have identified the need for support to facilitate access to care within the framework of common law"* (LADAPT, Researcher-2). Civil society describes the same recognition gap in concrete experiential terms: *"People weren't necessarily used to listening to*

themselves, in the sense that… when you have physical illnesses, it's very clear, like a cold. However, when it comes to mental health, it's more subtle" (LADAPT, Civil Society-2).

Stigma operates as a powerful structural barrier at every stage of recognition and help-seeking, including within the healthcare system itself. The vulnerable population remains, as one respondent frames it, a societal blind spot: approximately five percent of the population who are outside the system and for whom the question of what place society reserves for people who are different remains unresolved (LADAPT, Researcher-2). This formulation captures the extent to which barriers to help-seeking are not merely individual failures but expressions of collective stigmatisation: *"What place do we reserve in society for people who are different? Are we able to provide them with the same level of public health care?"* (LADAPT, Researcher-2). Another researcher links the same dynamic to a deficit in basic mental health education: *"but there's a need for education for the entire population: the idea that, just as we go to the dentist for a toothache, we should be able to consult a professional when we're experiencing emotional distress or when we perceive certain warning signs"* (LADAPT, Researcher-1). Academic analysis adds that *"People are not informed about when to seek care. And very specifically regarding mental health, there is the stigma, the taboo that haunts people's willingness to speak out"* (LADAPT, Policymaker).

Within the healthcare system, the compartmentalisation of medical specialties creates a specific help-seeking barrier. Psychiatrists no longer treat somatic problems, and general practitioners distance themselves from mental health presentations, explicitly telling themselves and their patients that psychiatric conditions are outside their scope of practice: *"The compartmentalization of medical specialties means that psychiatrists no longer treat somatic problems, and that general practitioners say to themselves, 'I'm not a psychiatrist'"* (LADAPT, Researcher-2). This professional fragmentation means that even patients who are present to healthcare are not reliably directed toward appropriate support. The academic perspective traces the same barrier to inadequate primary care training and access: *"Access to level one, with a general practitioner referring to level two, also seems to be a barrier"* (LADAPT, Policy maker). Civil society reinforces the point about institutional silos: *"I know that public authorities have been trying to work on this issue for some time. It's not easy because there are professional cultures, work habits, and a whole historical tradition of operation that makes things difficult"* (LADAPT, Civil Society-2).

Post-hospitalisation, the challenge shifts from initial help-seeking to re-engagement with care. Psychiatric stabilisation is identified as only the first step; reintegration into social and community life is what enables sustained engagement with any form of care or self-management: *"Psychiatric care is necessary for stabilization, but afterwards, what matters most is social integration. Reestablishing social connections allows for many other things to happen"* (LADAPT, Researcher-2). Without this social foundation, the conditions for sustained help-seeking do not exist. The very nature of mental

distress can itself paralyse help-seeking behaviour: *"The very nature of suffering is sometimes the inability to ask for help, the paralysis*" (LADAPT, Researcher-1).

Acceptability

Stigma and societal dimensions

Stigma is identified across all five interviews as the central acceptability barrier for the vulnerable population in France, operating simultaneously at the level of public culture, professional practice, and the design of the healthcare system itself. Unlike stigma that attaches primarily to cultural minority status or immigration background, stigma in the LADAPT context is a condition of severe mental illness per se, embedded in deeply held societal assumptions about difference, dangerousness, and social worth. As one researcher puts it, *"There is a real inequality: those with resources and networks manage, but there is increased stigmatization and a greater risk of discrimination for vulnerable populations"* (LADAPT, Researcher-1). Civil society identifies the same dynamic in the way negative stereotypes function as a disincentive to engage with services: *"The negative stereotypes associated with mental health present people with such negative preconceived notions that they distance themselves from it"* (LADAPT, Civil Society-2).

The public discourse on mental health that has expanded significantly since COVID-19 is acknowledged as a positive development, but with an important qualification: it has not primarily engaged with the most stigmatised conditions. The increased visibility of distress, burnout, and psychological suffering in workplaces and schools is welcomed, but it risks obscuring the continued marginalisation of those with severe and persistent mental illnesses: *"We haven't even discussed the severe and persistent mental health disorders that were the initial topic of discussion"* (LADAPT, Researcher-2). Destigmatisation gains are unevenly distributed and do not automatically reach those who need them most. The academic analysis confirms that the COVID period was a catalyst for broader awareness: *"During the COVID-19 pandemic, there was a growing awareness that everyone is affected by mental health. This helped to break down the barriers between those perceived as 'ill' and those perceived as healthy"* (LADAPT, Policymaker). Generational shifts are also visible: *"On that point, I think things are changing: young people talk about it much more easily"* (LADAPT, Researcher-1).

Within healthcare itself, professional stigma shapes the quality of care that vulnerable patients receive and reinforces their social exclusion. The assumption that patients with schizophrenia were not interested in their own health, because bodily denial was construed as a symptom, illustrates how stigma becomes embedded in clinical reasoning in ways that actively block appropriate care: *"We realized that some professionals may have assumed […] that these patients might not be interested in their own health because denial of the body is considered one of the symptoms of the illness. In*

fact, that's not true at all" (LADAPT, Researcher-2). These patients have the same motivational structures as anyone, but their expressed needs are not taken seriously.

The persistent framing of mental illness as incompatible with competent self-management reflects a cultural refusal to extend ordinary social dignity to the vulnerable population. Stigma manifests not only as explicit discrimination but as a pervasive cultural assumption that people with severe mental illness cannot meaningfully participate in decisions about their own care or lives. The professional evolution toward empowerment-based approaches is therefore not merely a clinical preference but a response to a documented pattern of stigma-driven disempowerment: *"The professional approach must evolve towards empowerment; this requires reflection on practices and positioning"* (LADAPT, Researcher-2). Civil society describes the same need in terms of recovery as the rebuilding of agency: *"This is what happens with mental illness: people lose confidence in their ability to make choices, to take initiative, to work, or to resume their studies"* (LADAPT, Civil Society-2). The most effective destigmatisation initiatives, in turn, are those that mobilise lived experience and reclaim agency: *"The most interesting initiatives are those that empower people to reclaim their agency and say, 'I have a say; I'm not just a victim of stigma'"* (LADAPT, Researcher-1).

Systematic and cultural distrust

Beyond stigma as a social phenomenon, the LADAPT interviews identify a deeper pattern of distrust between the vulnerable population and the healthcare system: a distrust that is often grounded in concrete negative experiences and structural failures rather than unfounded prejudice. The system's historical tendency to overprotect, institutionalise, and manage rather than support, empower, and reintegrate has generated a well-founded wariness among those who have experienced it. Civil society notes that this fear is now often less about the institutions themselves than about the social consequences of being seen using them: *"It's the fear of the social repercussions of being in treatment. The way mental health is discussed in society can contribute to fueling this fear, even just by mentioning involuntary hospitalizations. From this perspective, we can talk about mistrust"* (LADAPT, Civil Society-2).

The dominance of neuroscience-based psychiatry has come at the cost of social and community-based approaches that better reflect the realities of patients' lives: *"a whole branch of psychiatry has developed along the lines of neuroscience, seeking to explain illnesses through genetics. So far, we've come up empty-handed: significant resources have been invested in this research, but ultimately, very few conclusive advances have been made with this approach"* (LADAPT, Researcher-2). This professional trajectory has shaped a service model that often feels alien to the lived experience of those it is meant to serve, and is reinforced by what the academic respondent describes

as a historically closed sector: *"Not only because general practitioners don't have the time to learn how it works, but also because for years there was a very opaque sector within psychiatry that didn't open its doors or communicate about its operations. These are extremely complex organizations. The training is very poor"* (LADAPT, Policymaker).

The cultural norms and expectations embedded in the current psychiatric system further undermine acceptability. Large psychiatric centres that absorb patients because there are no downstream solutions model a form of care that is experienced as containment rather than support. The old model, characterised by institutionalisation, limited exit, and absence of community integration, remains prevalent in some facilities and generates distrust that must be actively deconstructed at the level of professional practice: *"There's a huge amount of work to be done on changing professional practices regarding the individual's goals, wishes, and feelings"* (LADAPT, Civil Society-1). The acceptability of care is thus tied to the system's willingness to transform itself. Civil society further notes that even hospitals themselves carry an image problem that deters engagement: *"Yes, it's difficult to imagine oneself in a space with all the preconceived notions one might have about psychiatric hospitals. Hospitals suffer from this caricature"* (LADAPT, Civil Society-2).

COVID-19 accelerated public recognition of psychological distress while also risking the over-medicalisation of experiences that are better understood as social or existential rather than clinical. The risk of pathologizing normal distress, particularly in institutional contexts such as workplaces, is identified as a concern that complicates the acceptability of mental health services, as it blurs the distinction between support for general wellbeing and care for serious illness: *"Distress is one thing; sometimes these are simply conflict situations that can be explained, and there isn't necessarily a need for pathologizing"* (LADAPT, Researcher-2). Calibrating this distinction is essential to maintaining trust in what the mental health system offers. At the same time, COVID is identified as having created the conditions for a more open public conversation: *"I think the major recent factor is the Covid crisis and the feeling of vulnerability experienced by society as a whole. This has opened up discussion on the subject and allowed people to express themselves"* (LADAPT, Researcher-1).

Availability

Workforce shortages and the appeal of psychiatry

The availability of mental health services for the vulnerable population in France is severely constrained by a structural workforce crisis that affects both the quantity and continuity of care. Psychiatry has become one of the least attractive medical specialties, with significant numbers of residency positions going unfilled each year in major university hospital cities: *"The problem is that the sector suffers greatly from a lack of appeal. There are a huge number of vacancies. Every year in Tours, psychiatry residency positions go unfilled"* (LADAPT, Researcher-2). This is not a temporary aberration but a structural trend with long-term implications for service capacity. The downstream

effect is felt by every part of the system: *"Today, I'm stating the obvious, but no matter which door you knock on, you either can't get an appointment or there's a six-month wait. This timeframe is completely unsuitable for mental health needs. It's like telling someone with a tumor, 'We can't see you for another six months'"* (LADAPT, Researcher-1). Civil society reports the same experience from a service-user perspective: *"the supply is limited simply due to a lack of staff in the teams"* (LADAPT, Civil Society-2).

The workforce deficit raises fundamental questions about whether psychiatric training and specialisation are the only or even the most appropriate response to the scale of their need. From a public health perspective, the current model, which places psychiatrists at the centre of care, is insufficient given the numbers available. There is therefore a strong argument for developing intermediate professions analogous to Advanced Practice Nurses in general healthcare, capable of bridging the gap between specialist psychiatric care and community-based support: *"there's certainly a lack of professionals, intermediate professions, who can bridge the gap and support these patients"* (LADAPT, Researcher-2). Peer support workers with formal qualifications are identified as a particularly promising intermediate profession, combining lived experience with professional accountability. The same shift is articulated by another researcher in terms of underused frontline staff: *"Nurses or specialized educators could go to people's homes, especially for young people, to establish an initial connection and implement strategies"* (LADAPT, Researcher-1).

Sectorisation is viewed positively as a structural principle that supports community-based care and appropriate referrals. It represents a sound public health logic: *"I think sectorization is actually a good approach ; as a public health professional, I approve of this organization. It's a structure that allows patients to receive the best possible care, not institutionally or in hospitals, but in the community"* (LADAPT, Researcher-2). However, sectorisation as a principle is consistently undermined by the practical reality of under-staffing and under-resourcing, which prevents it from functioning as intended. The academic respondent locates a parallel availability problem in inconsistent service hours, which produces real disparities across the territory: "*There's a major disparity between services : some mental health centers (CMP) are open until 7 p.m., others until 4:30 p.m., some on Saturday mornings, others not"* (LADAPT, Policymaker), with the conclusion that *"A CMP that opens at 9 a.m. and closes at 4 p.m. is indeed a huge obstacle to accessing care"* (LADAPT, Policymaker).

The geographical dimension of availability is also significant: access to community mental health services varies substantially across regions, with rural and semi-rural areas being particularly poorly served. The concentration of services in major urban centres means that sectorisation has not yet achieved the geographic equity it was designed to produce. Intermediate professions and outreach services are therefore not merely supplements to the existing system but structural necessities for extending availability to those currently unreached. The academic respondent frames this in terms of

professional distribution: *"Territorial inequalities in healthcare stem from the distribution of professionals across the country"* (LADAPT, Academic). Civil society describes the experiential consequence in equally direct terms: *"if you're in an area where there are no healthcare professionals or psychiatrists, the waiting times at the CMP (Mental Health Center) are significant. Access is complicated and therefore unequal"* (LADAPT, Civil Society-2). Outreach efforts are beginning to respond to this: *"All hospitals are starting to expand their reach within their local areas, precisely to go to populations who have difficulty getting to healthcare facilities"* (LADAPT, Civil Society-2).

Service organisation, continuity, and coordination

Beyond raw workforce numbers, the organisation and coordination of services present persistent availability challenges for the vulnerable population. The downstream community infrastructure required to support patients beyond initial care does not exist at adequate scale, and specialist scarcity is identified as a major constraint: *"The other thing that limits access to care is the number of available specialists. Today, I think that if you want access to mental health care, beyond simply finding information, the challenge is having people available to see you. I'm thinking in particular of the problem of the shortage of psychiatrists"* (LADAPT, Civil Society-1). This represents a fundamental failure of service coordination that perpetuates institutional dependence. Civil society in interview 4 identifies the same problem from the angle of sectoral fragmentation: *"Practices are compartmentalized between sectors. The healthcare sector has a culture that isn't necessarily aligned with administrative or social culture"* (LADAPT, Civil Society-2).

The continuity of care required for a population whose needs are long-term, complex, and highly sensitive to relational discontinuity is further undermined by the annual contract model that governs professional employment in the public psychiatric sector. Staff employed on annual contracts cannot provide sustained therapeutic relationships that effective care for this population requires (LADAPT, Researcher-2). Institutional precarity thus translates directly into care precarity for those most in need of consistency. The point that everyday continuity is built primarily through frontline staff is made directly: *"Patients say it themselves: the strongest bonds are formed with nurses, occupational therapists… The doctor is a valuable partner, but they don't address the everyday"* (LADAPT, Researcher-1).

The coordination between mental health, somatic, and social services is identified across multiple interviews as a fundamental gap. Psychiatric services do not systematically address somatic health and general medicine does not effectively absorb mental health needs. The result is a comprehensive under-treatment that has direct mortality consequences: the vulnerable population lives 15 to 20 years less than the general population, largely due to inadequately treated somatic conditions: *"Inadequate care means 15 to 20 years less life expectancy for this population. And I'm giving you these figures, linked in particular to cardiovascular disorders being treated too late"* (LADAPT, Researcher-2). Civil

society notes some recent improvement on inter-sectoral cooperation: *"we are starting to move beyond these sectoral and disciplinary silos that made dialogue very difficult"* (LADAPT, Civil Society-2).

Structuring an integrated care pathway, one that crosses the boundaries between psychiatry, general medicine, and social support, is identified as the most important systemic response to availability failures. This requires long-term planning, investment in intermediate professions, and an organisational culture that prioritises coordination over specialisation: *"We're trying to break down the silos: an environment in which the patient can navigate the system, potentially helped by the intermediary professionals we've mentioned. This organization needs to be planned for the long term"* (LADAPT, Researcher-2). Hospital-centric models, in particular, are increasingly viewed as inadequate for long-term and recovery-oriented care: *"They can manage the crisis, certainly, but they aren't the place for long-term care, and they're definitely not the place for recovery"* (LADAPT, Researcher-1).

Affordability

Administrative burden and indirect costs of access

For the vulnerable population in France, financial barriers to mental health care are rarely expressed as direct out-of-pocket costs for treatment, which is largely covered within the statutory system. The most significant affordability challenges are indirect: the administrative burden of navigating the rights and benefits system, the digital exclusion produced by computerised procedures, and the exploitation of vulnerable individuals by an unscrupulous healthcare marketplace. The academic respondent is explicit on this point: *"But it's not the cost of care that is the problem, because the healthcare system actually covers everyone"* (LADAPT, Policymaker), and *"It's not the cost that hinders access, but rather how people access it and the quality of the services offered"* (LADAPT, Policymaker).

Administrative complexity is identified across all five interviews as a major indirect barrier, particularly at the moment of transition from hospital to community. At precisely the point when individuals have the least capacity to manage complex administrative demands (immediately post-hospitalisation) the system requires them to navigate multiple separate bureaucratic processes, each with its own authentication codes and procedures: *"Accessing one's rights today requires having a computer and knowing all the codes (one code for Social Security, one for the Family Allowance Fund, etc.). It's very complex"* (LADAPT, Researcher-2). The computerisation of administrative procedures, intended as a simplification, has in practice introduced new forms of exclusion for those without digital literacy or consistent internet access. Civil society describes the same effect plainly: *"There are administrative complications that can hinder the drive towards care"* (LADAPT, Civil Society-2).

The vulnerability of this population to exploitation by healthcare-adjacent commercial actors is a significant but underexamined affordability dimension. The absence of guidance and support in navigating healthcare choices exposes individuals to what one respondent describes as a whole business built around healthcare: *"Vulnerable people are easy prey because there's a whole 'business' built around healthcare"* (LADAPT, Researcher-2). Without informed support throughout the care pathway, individuals are at risk of directing their limited resources toward ineffective or exploitative services. Another researcher highlights a parallel financial inequality: free crisis care exists, but ongoing prevention is not affordable: *"inequalities are exploding when it comes to prevention or early intervention"* (LADAPT, Researcher-1), and *"seeing a psychologist allows a great many people to continue their lives, prevents their situation from deteriorating, and provides real benefits in terms of well-being. Yet, in 90% of cases, it's not covered by insurance, and people have to pay out of pocket"* (LADAPT, Researcher-1).

The indirect economic burden of inadequate care falls ultimately on individuals with severe and persistent mental illnesses through the health consequences of under-treatment, the 15 to 20 year life expectancy gap, and on families and informal carers who bear the financial and practical cost of care that the system fails to provide. Breaking this chain requires not only better care but better protection and navigation support throughout the healthcare journey: *"These patients need help, support, and probably protection throughout their healthcare journey and in accessing their rights. It's a comprehensive package; there isn't just one solution that works on its own"* (LADAPT, Researcher-2).

Support mechanisms

Across all five LADAPT interviews, a consistent finding is that housing is not simply one need among many but the foundational prerequisite for any meaningful engagement with mental healthcare. The conditional logic of care access, one must first be housed, then begin social reintegration, and only then can healthcare become a priority and possibility, represents a profound structural affordability challenge that is not reducible to the cost of services. Civil society echoes this when describing the structural inequality between those with and without resources: *"People without the resources have no choice: they simply have to make an appointment at their local mental health center and wait for the required time"* (LADAPT, Civil Society-2).

The relationship between housing and healthcare engagement is articulated most directly in terms of what patients themselves identify as their primary need: *"the most important thing (and this is what all patients say as soon as they are able to leave the hospital to get better) is having an apartment. Because behind an apartment lies the possibility of regaining privacy and rebuilding a social life"* (LADAPT, Researcher-2). Without housing, the social conditions that enable self-care, motivation, and care engagement cannot be established.

This finding reframes affordability as a question that extends far beyond the pricing of clinical services. Financial hardship, housing insecurity, and the inability to navigate welfare systems are not merely background conditions to mental health care; they are determinative of whether care engagement is possible at all: *"Once again, it goes beyond medical care: it's about housing, it's about support; the medical care itself comes later"* (LADAPT, Researcher-2). Affordability in this context must therefore encompass housing security, income support, and social reintegration, not merely the cost of clinical interventions. The academic respondent reinforces that the public system itself is theoretically inclusive but practically uneven: *"In France, we have an exemplary healthcare system. Everyone is covered and can turn to their local sector: consultations with their general practitioner are covered, and a certain number of sessions with a psychologist are covered for those accredited by Monsoutienpsy"* (LADAPT, Policymaker), even though *"What's expensive is having a public service that isn't functioning properly, without timely access to care, and without a general practitioner within a certain radius of your home"* (LADAPT, Policymaker).

The financing mechanisms currently available, social insurance, housing benefits, disability allowances, are in practice insufficient for the needs of this population, and their administration is itself a barrier. The emphasis on community-based care and de-institutionalisation as policy goals is appropriate in principle, but it requires that the downstream social infrastructure (housing, income, community support) is actually in place. As civil society notes, even ostensibly free care can fail to deliver because indirect costs and the affordability of well-being are themselves barriers: *"This issue of cost also arises with vision and dental care: not everything that's free is necessarily of high quality, and I think this potentially hinders the healthcare process"* (LADAPT, Civil Society-1), and *"People who work might decide to allocate a budget to these alternative approaches, but for people living on the AAH (Disability Allowance for Adults), it's clearly not possible"* (LADAPT, Civil Society-1). Without adequate downstream infrastructure, de-institutionalisation risks simply transferring individuals from institutional inadequacy to community precarity. Local intermediary structures help to fill this gap: *"Mutual Support Groups (GEMs) are, in this respect, real intermediaries closer to the ground, and they deserve credit for existing"* (LADAPT, Researcher-1).

Appropriateness

Fit and usefulness of care

The appropriateness of mental health care for the vulnerable population is described as one of the central challenges of contemporary French psychiatry, requiring a fundamental transformation of the service model from institutional management to community-based empowerment. The key finding is not that individual professionals lack commitment, but that the system within which they work was designed around a logic of containment rather than reintegration, and that this design still shapes practice in ways that make care inappropriate for significant numbers of patients. The academic

respondent observes that even basic evaluation of appropriateness is currently absent: *"Currently, services aren't evaluated based on this. We don't have a list of indicators to assess the effectiveness of services, their quality, or how well they meet people's needs. Each service organizes itself as it sees fit"* (LADAPT, Policymaker).

The language of "transformation of services" is identified as the emerging national alternative to the term "de-institutionalisation", a shift that signals not merely a change of setting but a change of purpose and design, aimed at responding to the needs and desires for empowerment of people with a mental illness. Civil society frames this as a broader cultural shift away from a purely psychopathological framing of mental illness: *"There are movements that are even questioning the purely psychopathological interpretation"* (LADAPT, Civil Society-1), and *"considering all the possibilities of people living with mental health conditions is a real revolution for healthcare professionals. It radically changes their professional approach"* (LADAPT, Civil Society-1). The person must be back at the centre, a principle that has significant implications for how services are structured, how professionals are trained, and how success is measured. Civil society in interview 4 frames the same shift in terms of recovery: *"Recovery means putting the person's life plan back at the heart of the conversation: how they want, or don't want, to be cared for and participate in this process"* (LADAPT, Civil Society-2).

Peer learning and relational care are identified as central to appropriate care. The variability between supportive, trusting relationships and rigid, paternalistic ones is striking: *"I see people who have flexible interlocutors, in a relationship of trust and a genuine therapeutic alliance: there's an exchange, an adaptation. And I see others who remain trapped in treatment methods where their free will and their ability to initiate change don't exist"* (LADAPT, Civil Society-1). Peer trainers and people who have themselves moved through the system are positioned as a uniquely valuable resource: *"These are people trained in empowerment; they know what it's about, but for themselves, there are moments of doubt"* (LADAPT, Civil Society-1).

Integrating patient perspectives and recovery-oriented frameworks into initial professional training is identified as a currently missing element that would significantly improve the appropriateness of care over time. Civil society is unsparing on the state of training: "*However, the way we still train people is problematic. We take on interns, and these topics are barely touched upon"* (LADAPT, Civil Society-1). Without this integration, professional training produces clinicians who are equipped to understand illness diagnostically but not to understand the experience of those living with it. The consequence is felt directly by patients: *"Raising awareness among professionals is crucial: many patients tell me they try to discuss things, but the care teams tell them, 'Yes, we'll adjust the treatment if you can't tolerate it,' only to ultimately impose the same treatment despite side effects"* (LADAPT, Civil Society-1). Civil society in interview 4 reinforces the importance of functional, rehabilitation-oriented care: *"It's*

a functional approach that helps people regain certain social skills that may have been impaired. We work specifically on cognitive skills: memory, organization, and planning, precisely to help them get back on their feet in their daily lives and move forward in the most fulfilling way possible" (LADAPT, Civil Society-2).

Quality of interaction and respect

The quality of provider-patient relationships in the LADAPT context is shaped by a set of structural conditions that systematically undermine the relational foundation necessary for effective care. Stigma persists at the professional level, professional training is oriented toward neuroscientific and diagnostic frameworks that prioritise the disorder over the person, and the compartmentalisation of specialties prevents the integrated view of a patient's life that appropriate care requires. These are not failures of individual professionals but structural conditions that good professionals must work against rather than with. Civil society makes the link between staffing pressure and relational breakdown explicit: *"Following a conversation with a member of the team, she realized that it was ultimately the extremely strained work organization, in terms of staffing levels, that had generated these misunderstandings and misinterpretations*" (LADAPT, Civil Society-2).

The dominance of neuroscience-based psychiatric training is identified as a specific obstacle to relational quality, not because neuroscience is inherently irrelevant but because it has come at the expense of social and community-oriented approaches that better reflect the determinants of mental health outcomes: *"if psychiatry were taught differently, it would allow for more significant progress. I think there's also a huge link to be made with general medicine. Mental illness and distress are also part of general medicine"* (LADAPT, Researcher-2). The compartmentalisation of psychiatry from general medicine creates relational failures at a systemic level. Another researcher points to the workload reality this creates for psychiatrists: *"Psychiatrists find themselves overwhelmed by countless questions when their priority is the therapeutic strategy*" (LADAPT, Researcher-1).

A particularly significant finding regarding interaction quality concerns the problem of patients whose expressions of need are not taken seriously by healthcare professionals. The recurring patient experience: *"I have trouble expressing my problems; they aren't taken seriously"* (LADAPT, Researcher-2), is not simply a relational failure but a structural one, produced when time pressures, professional distance, and stigma-driven assumptions converge to prevent genuine listening. Civil society offers a concrete illustration of how a service can fail to deliver on its own stated recovery values: *"one person told us that the facility treating her advertised itself in its documents as a place of compassion with recovery-oriented practices. But, in reality, she didn't experience that at all in her interactions with the professionals"* (LADAPT, Civil Society-2). These shortcomings in the quality of somatic care interactions contribute directly to the mortality gap experienced by this population.

The empowerment idea which repositions the patient as an active participant in their own care rather than a passive recipient of professional decisions, is identified as the necessary evolution of the professional-patient relationship. This requires not only individual practitioners to reflect on their practices and positioning, but a systemic shift in training, supervision, and organisational culture: *"The professional approach must evolve towards empowerment; this requires reflection on practices and positioning"* (LADAPT, Researcher-2). Another researcher describes the same orientation in terms of how mental health care is intrinsically activated by the person, not delivered to them: *"It is not a form of care that is administered; it is a form of care that is activated within the individual, that is stimulated"* (LADAPT, Researcher-1). The quality of interaction is ultimately a function of the system within which interactions take place, not only of the individuals engaged in them.

Community-based empowerment approaches, such as user-led discussion groups that mobilise within the city to approach social and healthcare professionals, represent both an alternative model of service delivery and a mechanism for improving the quality of professional-patient relationships at a systemic level. When professionals are required to respond to organised patient communities rather than individual isolated patients, the power dynamics of the interaction shift in ways that make mutual respect more structurally achievable. Civil society describes the relational baseline this aims to restore: "*This raises the question of the quality of human relationships, quite simply: respect for the individual, the establishment of routines, allowing people to maintain their dignity, even in a healthcare setting"* (LADAPT, Civil Society-2). This represents one of the most concrete pathways toward improving appropriateness of care for the vulnerable population in France.

4.7 Bulgaria

4.7.1 Quantitative results

The sample included 201 respondents across three groups: General (n = 66), Roma community (n = 68), and ethnic and religious minorities (n = 67). Group sizes are presented in Table xx. Descriptive characteristics by group are shown in Table yy. Mean ages were similar across groups: 46.8 years (SD 13.3) in the General group, 43.9 years (SD 12.7) in the Roma community, and 43.5 years (SD 12.7) among ethnic and religious minorities. The mode of questionnaire completion differed between groups. In the General group, most respondents completed the questionnaire independently (80.6%). In the Roma community, both self-completion (63.2%) and assisted completion (22.1%) were common. Among ethnic and religious minorities, fewer respondents completed the questionnaire independently (37.9%), while larger proportions completed it with assistance (42.4%) or through someone else (19.7%). Sex at birth distributions were broadly similar across groups, with women accounting for 62.7% of the General group, 58.8% of the Roma community, and 57.6% of ethnic and religious minorities; men made up most of the remaining respondents, with a small number of Roma respondents preferring not to say. Gender identity corresponded with sex assigned at birth for almost all participants, although a few respondents in the ethnic and religious minority group preferred not to report their gender. Sexual orientation was predominantly heterosexual in all three groups: 97.0% in the General group, 98.5% in the Roma community, and 92.4% among ethnic and religious minorities. Only a few responses fell into other categories (bisexual or “prefer not to say”), and none identified as gay or lesbian. Nearly all respondents lived in Bulgaria and were also born there. This applied to all participants in the General and Roma groups and to almost all respondents in the ethnic and religious minority group. Citizenship followed a similar pattern: all respondents in the General and Roma groups, and the large majority in the ethnic and religious minority group, held Bulgarian citizenship, with only a very small number reporting citizenship of another EU or non-EU country. Reported duration of residence in Bulgaria broadly reflected age, with group means of approximately four to five decades. Educational attainment (ISCED) differed notably between groups. In the General group, education levels were skewed toward higher attainment, with more than half reporting a Master’s degree (ISCED 7) and many others holding a Bachelor’s degree (ISCED 6). In contrast, among Roma respondents and ethnic and religious minorities, upper secondary education (ISCED 3) was the most common level, followed by lower secondary education (ISCED 2), while tertiary qualifications were uncommon. A small number of respondents reported only primary education (ISCED 1). Use of mental health services in the previous 12 months was relatively low across groups. It was reported by 10.4% of respondents in the General group, 26.5% in the Roma

community, and 10.6% among ethnic and religious minorities, with most respondents in each group indicating no use of services during this period. These figures are descriptive only.

Table 122: Distribution of participants across the included groups in Bulgaria

General group	Roma community	Ethnic and religious minorities
N = 66	N = 68	N = 67

Table 123: Descriptive statistics of the different included groups in Bulgaria

Demographic variable	General group	Roma community	Ethnic and religious minorities	Overall
Age, *mean (sd)*	46.8 (13.3)	43.9 (12.7)	43.5 (12.7)	44.7 (12.9)
Questionnaire completed by, *n (%)*				
Respondent alone	54 (80.6%)	43 (63.2%)	25 (37.9%)	122 (60.7%)
Respondent with help	4 (6.0%)	15 (22.1%)	28 (42.4%)	47 (23.4%)
Someone else	9 (13.4%)	10 (14.7%)	13 (19.7%)	32 (15.9%)
Sex at birth, *n (%)*				
Female	42 (62.7%)	40 (58.8%)	38 (57.6%)	120 (59.7%)
Male	25 (37.3%)	26 (38.2%)	28 (42.4%)	79 (39.3%)
Non-binary	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prefer not to say	0 (0%)	2 (2.9%)	0 (0%)	2 (1.0%)
Gender the same as assigned at birth, *n (%)*				
Yes	67 (100%)	68 (100%)	63 (95.5%)	198 (98.5%)
No	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prefer not to say	0 (0%)	0 (0%)	3 (4.5%)	3 (1.5%)
Sexual orientation, *n (%)*				
Heterosexual	65 (97.0%)	67 (98.5%)	61 (92.4%)	193 (96.0%)
Gay	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Lesbian	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Bisexual	1 (1.5%)	0 (0%)	0 (0%)	1 (0.5)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prefer not to say	1 (1.5%)	1 (1.5%)	5 (7.6%)	7 (3.5%)
Country of residence, *n (%)*				

Bulgaria	67 (100%)	68 (100%)	66 (100%)	201 (100%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Country of birth, *n (%)*				
Born in the country of residence	67 (100%)	68 (100%)	64 (97.0%)	199 (99.0%)
In another country in the EU	0 (0%)	0 (0%)	1 (1.5%)	1 (0.5%)
Born in another country outside the EU	0 (0%)	0 (0%)	1 (1.5%)	1 (0.5%)
Citizen of country, *n (%)*				
Citizen of the country of residence	67 (100%)	68 (100%)	64 (97.0%)	199 (99.0%)
No citizenship of the country of residence but that of another EU member state	0 (0%)	0 (0%)	1 (1.5%)	1 (0.5%)
No citizenship of the country of residence but that of a country outside the EU	0 (0%)	0 (0%)	1 (1.5%)	1 (0.5%)
Duration of stay in the country of residence, *mean years (SD)*	46.0 (14.5)	42.4 (13.6)	43.7 (14.1)	43.7 (14.1)
Highest level of education completed (ISCED), *n (%)*				
Early childhood education (ages 3 and above), including pre-primary education	0 (0%)	0 (0%)	0 (0%)	0 (0%)

and early childhood educational development (under 3). (ISCED 0)				
Primary education (also known as elementary or basic education). (ISCED 1)	1 (1.5%)	1 (1.5%)	2 (3.0%)	4 (2.0%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	3 (4.5%)	12 (17.6%)	26 (39.4%)	41 (20.4%)
Upper secondary education (also known as senior high or high school). (ISCED 3)	16 (23.9%)	42 (61.8%)	33 (50.0%)	91 (45.3%)
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	1 (1.5%)	7 (10.3%)	2 (3.0%)	10 (5.0%)
Short-cycle third level education (programs typically lasting 2-3 years and	0 (0%)	0 (0%)	0 (0%)	0 (0%)

leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)				
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	7 (10.4%)	2 (2.9%)	0 (0%)	9 (4.5%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	38 (56.7%)	1 (1.5%)	1 (1.5%)	40 (19.9%)
Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	1 (1.5%)	0 (0%)	0 (0%)	1 (0.5%)
Missing	0 (0%)	3 (4.4%)	2 (3%)	5 (2.5%)
Use of mental health care in the previous 12 months, *n (%)*				
Yes	7 (10.4%)	18 (26.5%)	7 (10.6%)	32 (15.9%)
No	60 (89.6%)	50 (73.5%)	59 (89.4%)	169 (84.1%)

Availability and accommodation

Within the Availability and Accommodation dimension, several indicators did not demonstrate statistically significant differences between population groups. Specifically, no differences were observed regarding the time required to travel to mental health service locations or the time required

to obtain an appointment when mental healthcare was needed (Figure 126; all p-values > 0.05).

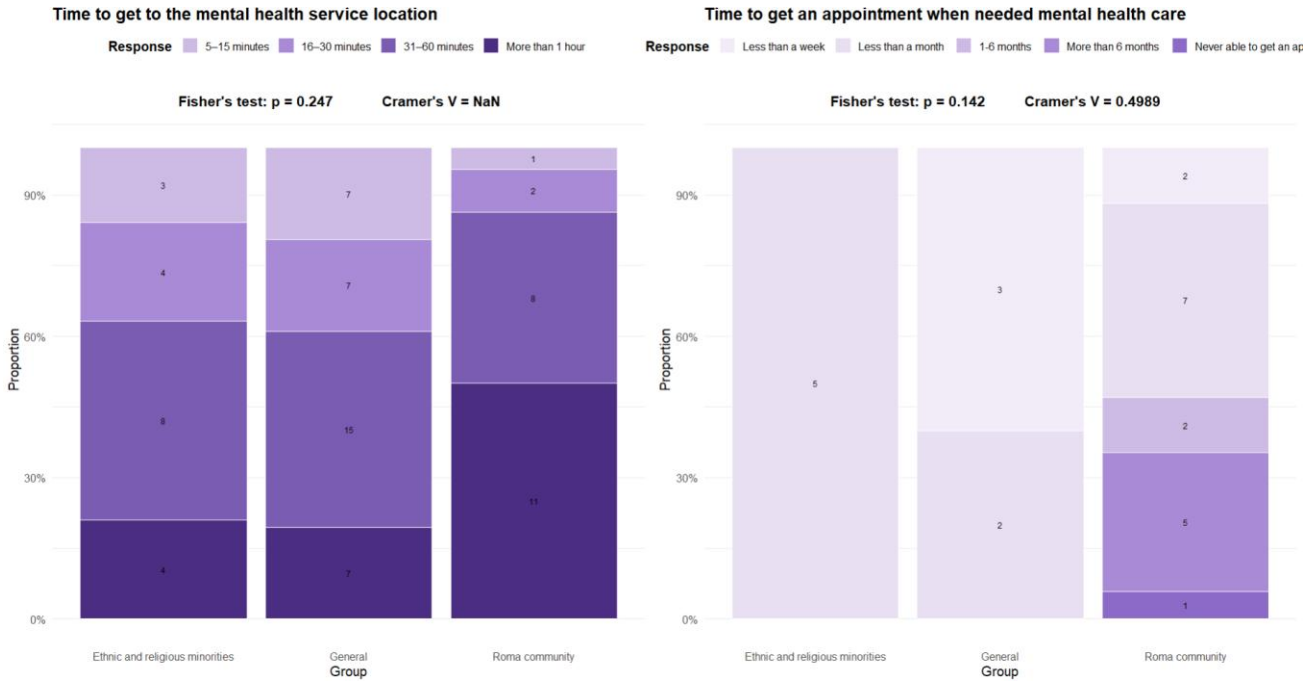

Figure 124: Non-significant differences across groups for the Availability & Accommodation dimension in Bulgaria

In contrast, differences between groups were identified regarding awareness of mental health services in the local area. Pairwise comparisons indicated statistically significant differences between ethnic and religious minorities and the general population (p = 0.045, Cramer's V = 0.249), as well as borderline differences between the general population and the Roma community (p = 0.050, Cramer's V = 0.222). Descriptive findings indicated that respondents from ethnic and religious minority groups reported lower levels of awareness of available mental health services compared with the general population. The corresponding Cramer's V values indicate small to moderate associations, suggesting meaningful variation in awareness between groups (Figure 127;

Table 124).

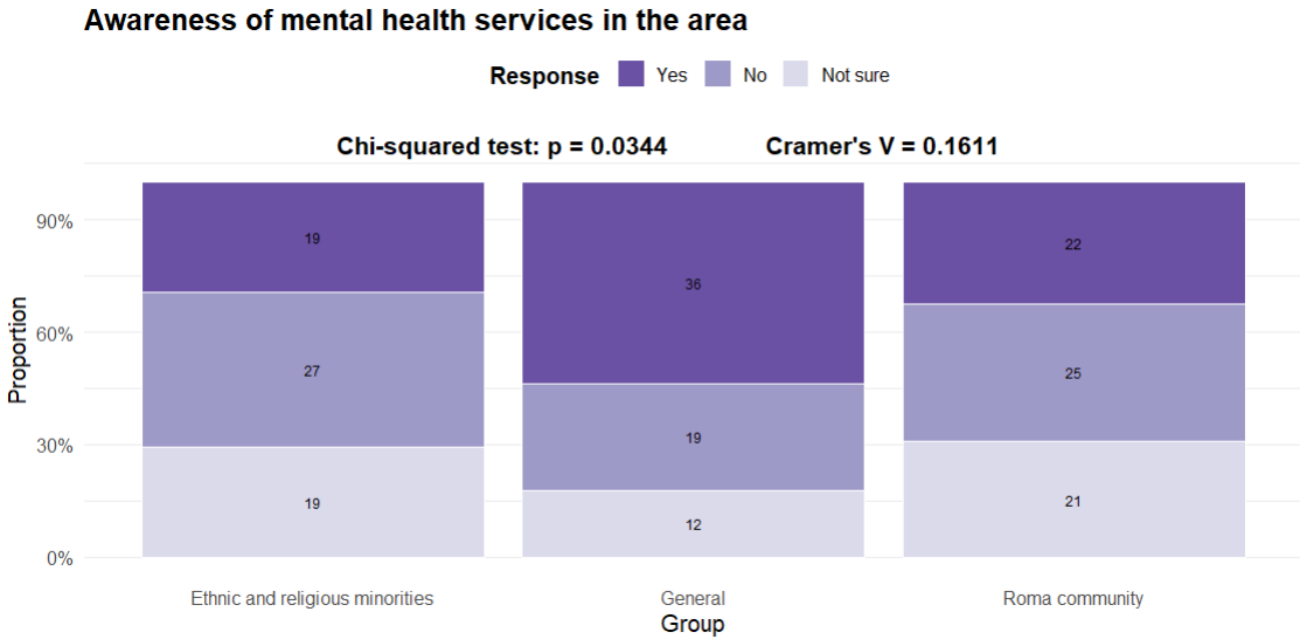

Figure 125: Chi-squared test of the awareness of mental health services in the area item in Bulgaria

Table 124: Pairwise comparison test of the awareness of mental health services in the area item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.045	0.249
Ethnic and religious minorities: Roma community	0.888	0.050
General group : Roma community	0.050	0.222

Differences were also observed for knowledge of where to seek immediate help during a mental health crisis. Statistically significant differences were identified between ethnic and religious minorities and the general population (p = 0.003, Cramer's V = 0.325). Descriptive findings indicated that respondents from ethnic and religious minority groups reported lower levels of knowledge regarding emergency mental health service pathways compared with the general population. The corresponding effect size suggests a moderate association, indicating a notable difference between these groups (Figure 128; Table 125).

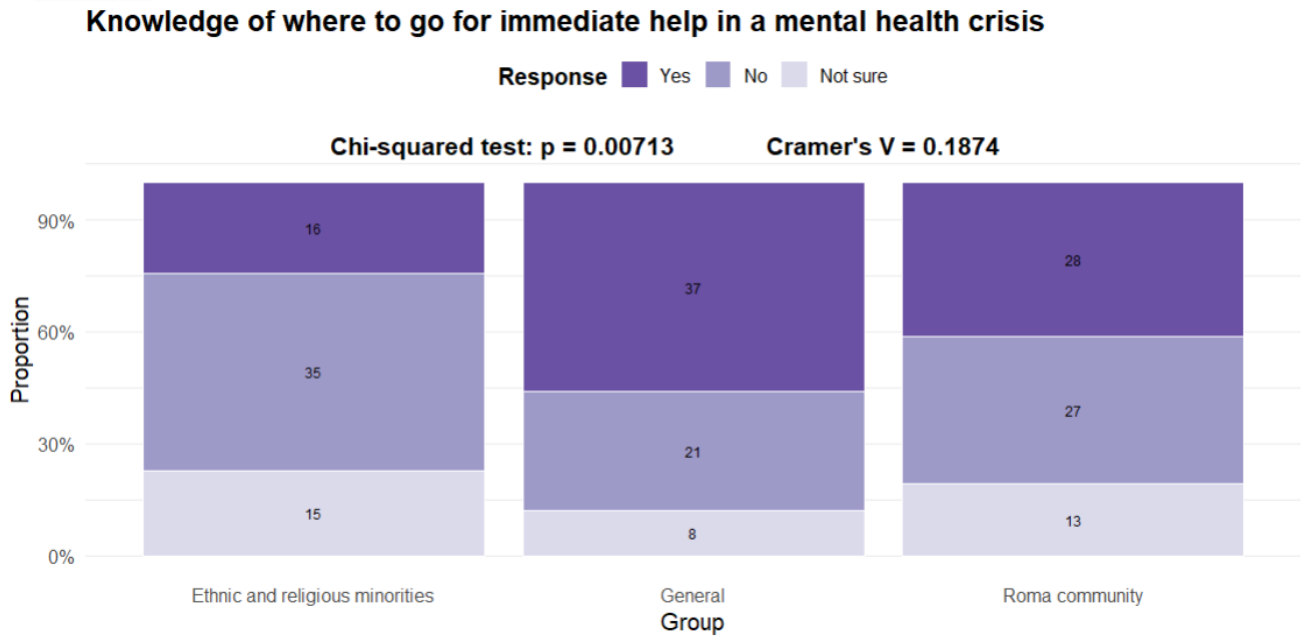

Figure 126: Chi-squared test of the knowledge of where to go for immediate help in a mental health crisis in Bulgaria

Table 125: Pairwise comparison test of the knowledge of where to for immediate help in a mental health crisis in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.003	0.325
Ethnic and religious minorities: Roma community	0.171	0.182
Group with both a physical and intellectual disability : Group with a physical disability	0.207	0.154

Approachability

Within the Approachability dimension, several indicators did not demonstrate statistically significant differences between population groups. Specifically, no differences were observed regarding whether participants had encountered information on accessing mental health support, come across outreach programs, or had been invited to participate in research related to mental health (Figure

129; all p-values > 0.05).

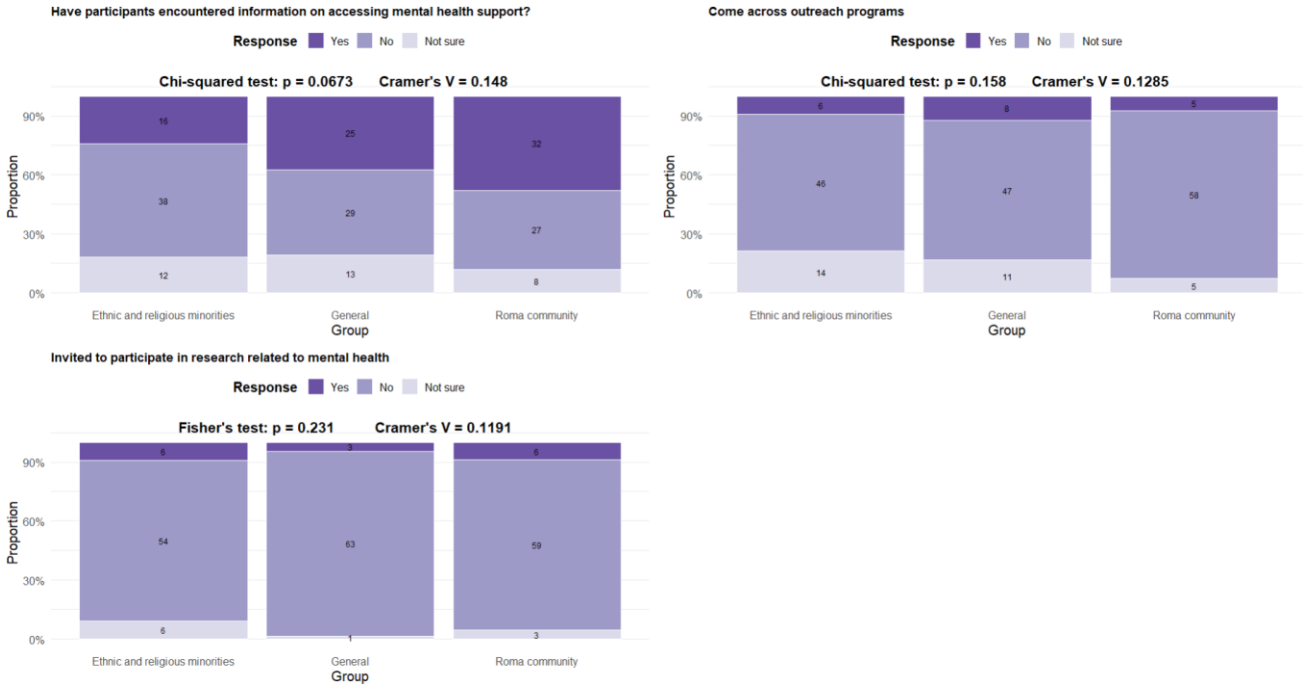

Figure 127: Non-significant differences across groups for the Approachability dimension in Bulgaria

On the contrary, statistically significant differences were observed regarding the ease of understanding information about mental health services. Pairwise comparisons indicated significant differences between ethnic and religious minorities and the general population ($p < 0.001$, Cramer's $V = 0.399$), between ethnic and religious minorities and the Roma community ($p < 0.001$, Cramer's $V = 0.491$), and between the general population and the Roma community ($p = 0.012$, Cramer's $V = 0.308$). Descriptive findings indicated that understanding information was reported as easiest within the general population, followed by the Roma community, while respondents from ethnic and religious minority groups reported the greatest difficulty. The corresponding effect sizes indicate moderate to large associations, suggesting substantial variation in perceived information

comprehension between groups (Figure 130 and Table 126).

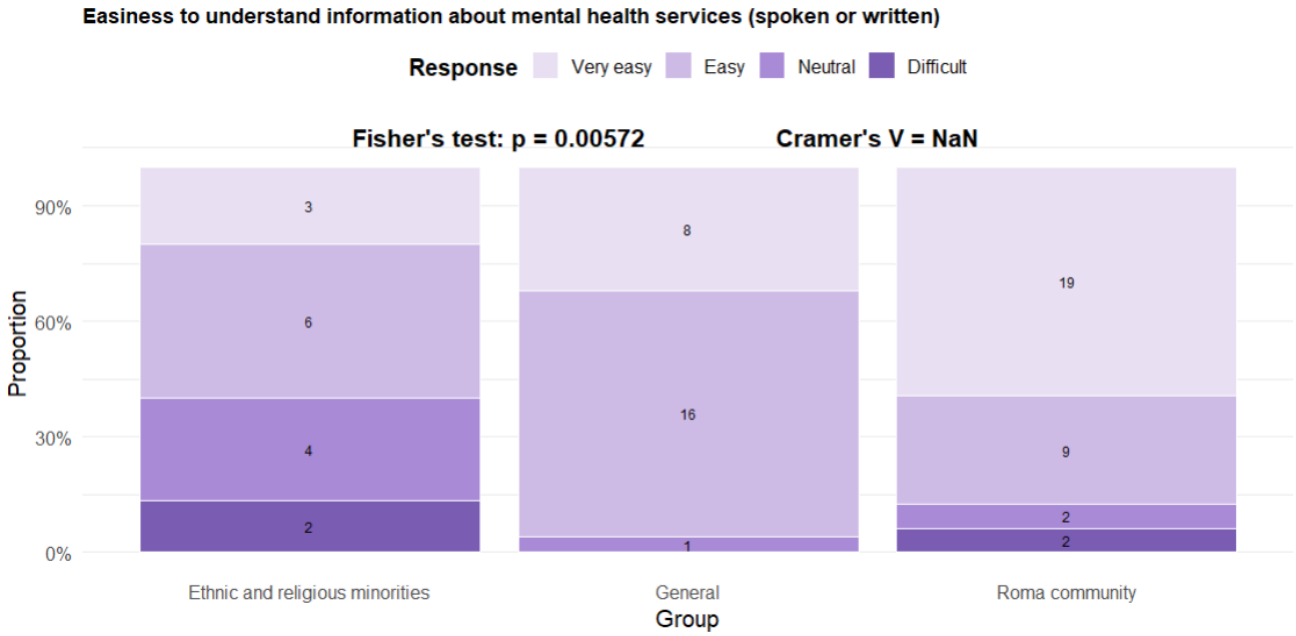

Figure 128: Fisher's exact test of the easiness to understand information about mental health services (spoken or written) item in Bulgaria

Table 126: Pairwise comparison test of the easiness to understand information about mental health services (spoken or written) item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.000	0.399
Ethnic and religious minorities: Roma community	0.000	0.491
General group : Roma community	0.012	0.308

Differences were also identified regarding whether participants had been asked about their mental well-being during encounters with healthcare or support professionals (Figure 131; Table 127). Although the overall test indicated variation between groups, pairwise comparisons did not identify statistically significant differences between specific group combinations after adjustment (all adjusted p-values = 0.157). The corresponding Cramer's V values suggest small associations,

indicating that differences between individual group pairs were limited.

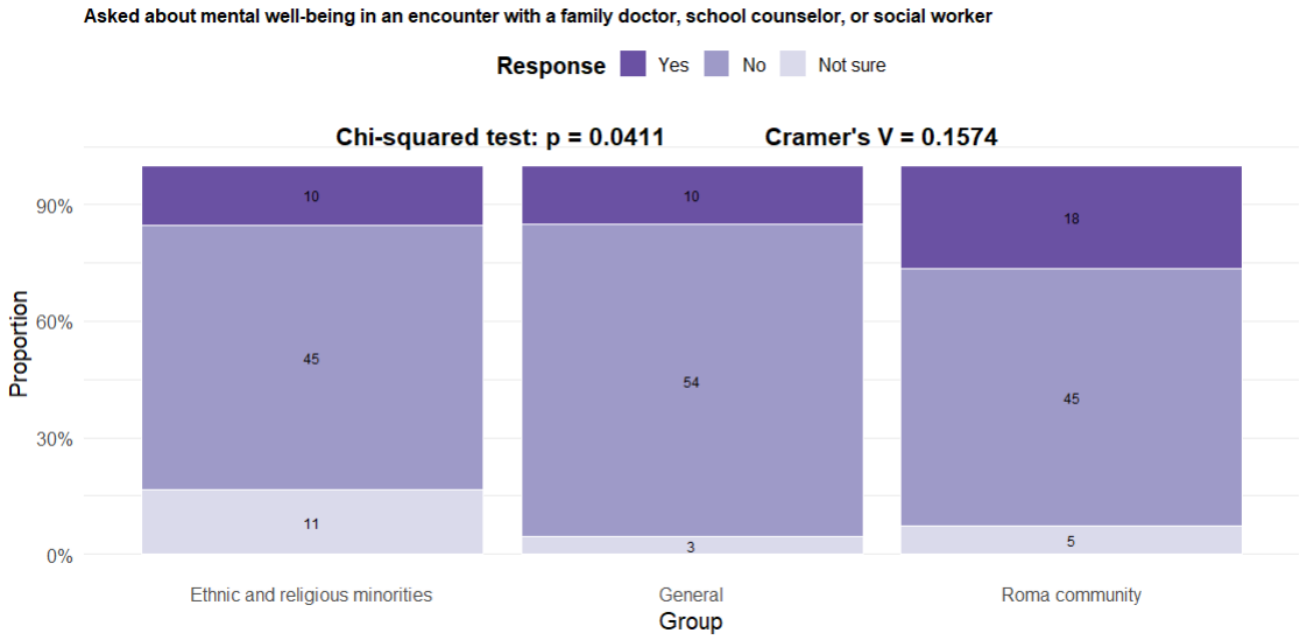

Figure 129: Chi-squared test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Bulgaria

Table 127: Pairwise comparison test of the asked about mental well-being in an encounter with a family doctor, school counsellor, or social worker item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.157	0.201
Ethnic and religious minorities: Roma community	0.157	0.183
General group : Roma community	0.157	0.163

Furthermore, statistically significant differences were observed regarding whether participants had heard about experiences of other patients related to mental health services. Pairwise comparisons indicated a significant difference between ethnic and religious minorities and the Roma community ($p = 0.005$, Cramer's $V = 0.305$). Descriptive findings suggested variation in awareness of patient experiences between these groups. The corresponding effect size indicates a moderate

association, suggesting meaningful differences in peer-related information exposure.

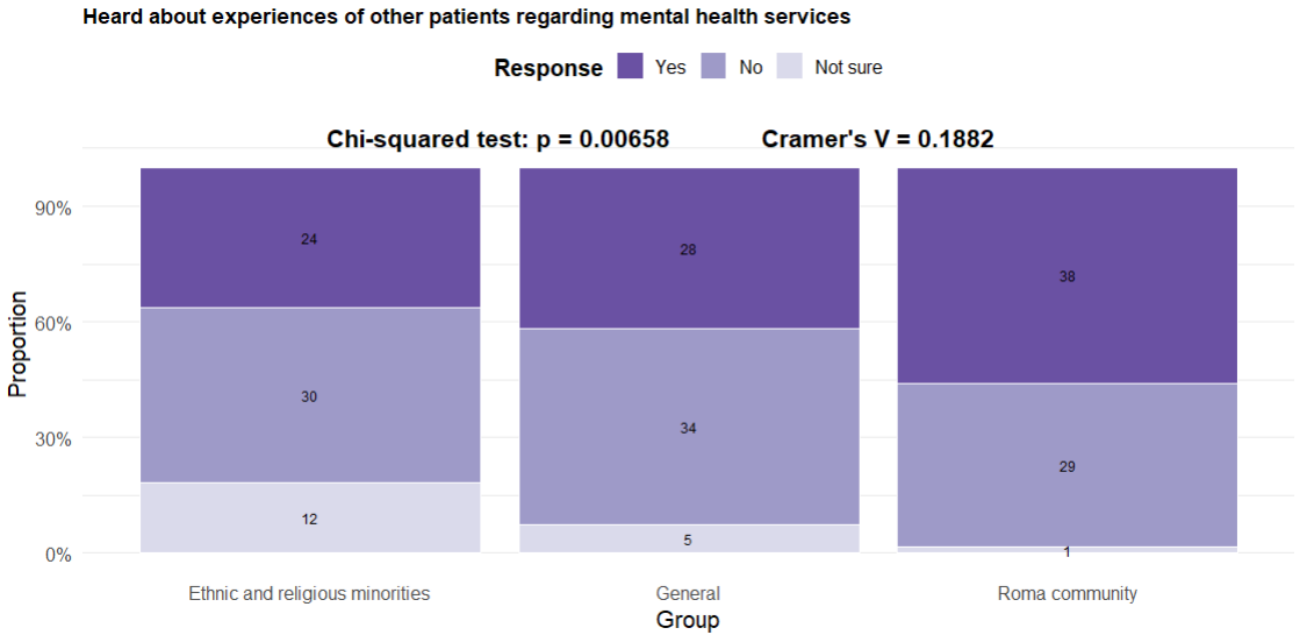

Figure 130: Chi-squared test of the heard about experiences of other patients regarding mental health services item in Bulgaria

Table 128: Pairwise comparison test of the heard about experiences of other patients regarding mental health services item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.207	0.161
Ethnic and religious minorities: Roma community	0.005	0.305
General group : Roma community	0.137	0.184

Acceptability

Within the Acceptability dimension, several indicators did not demonstrate statistically significant differences between population groups. These included the option to communicate with a mental health provider in a preferred language, the possibility to choose one's own doctor or therapist, and perceptions that mental health professionals communicated respectfully with patients (Figure 133; all p-values > 0.05). These findings suggest that communication-related aspects of care and

respectful interaction were perceived similarly across the general population, ethnic and religious minority groups, and Roma communities.

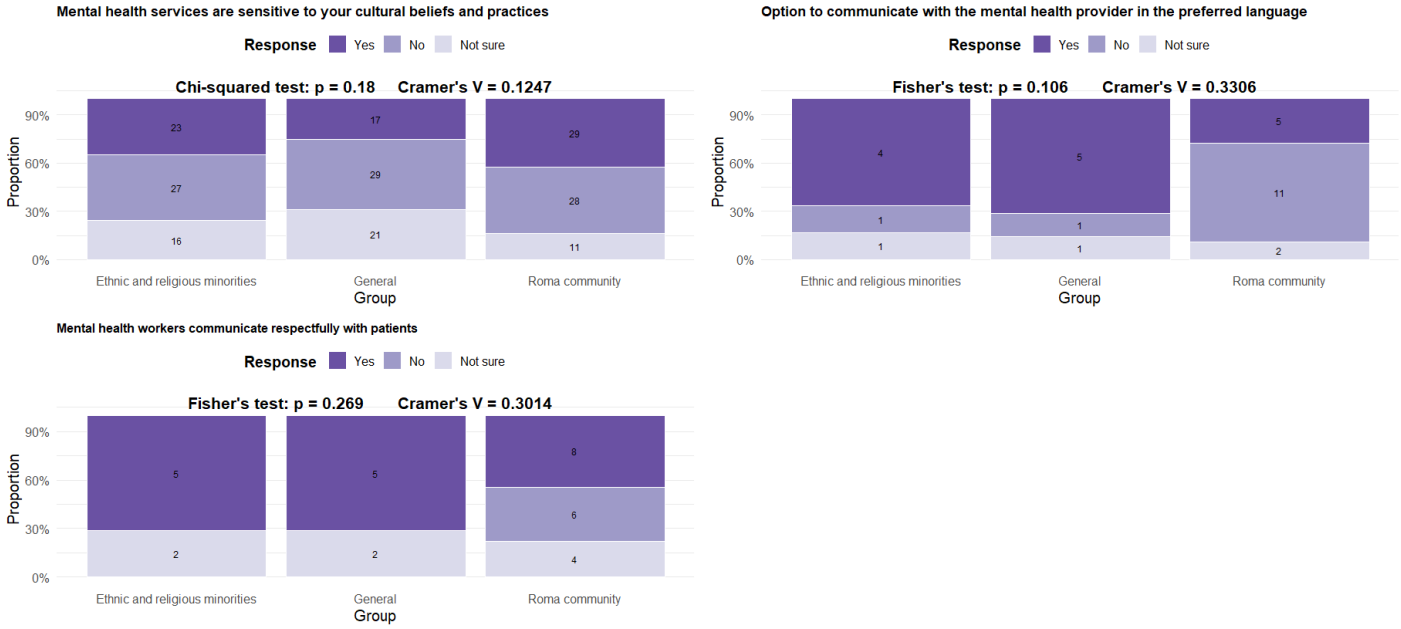

Figure 131: Non-significant differences across groups for the Acceptability dimension in Bulgaria

Differences were observed, however, regarding perceptions that patients' rights are protected against mistreatment or abuse. Pairwise comparisons indicated a statistically significant difference between ethnic and religious minorities and the Roma community (p = 0.005, Cramer's V = 0.305). Descriptive findings suggested variation between these groups in perceived protection of patient rights. The corresponding effect size indicates a moderate association, suggesting meaningful

differences between these two population groups (Figure 134 and Table 129).

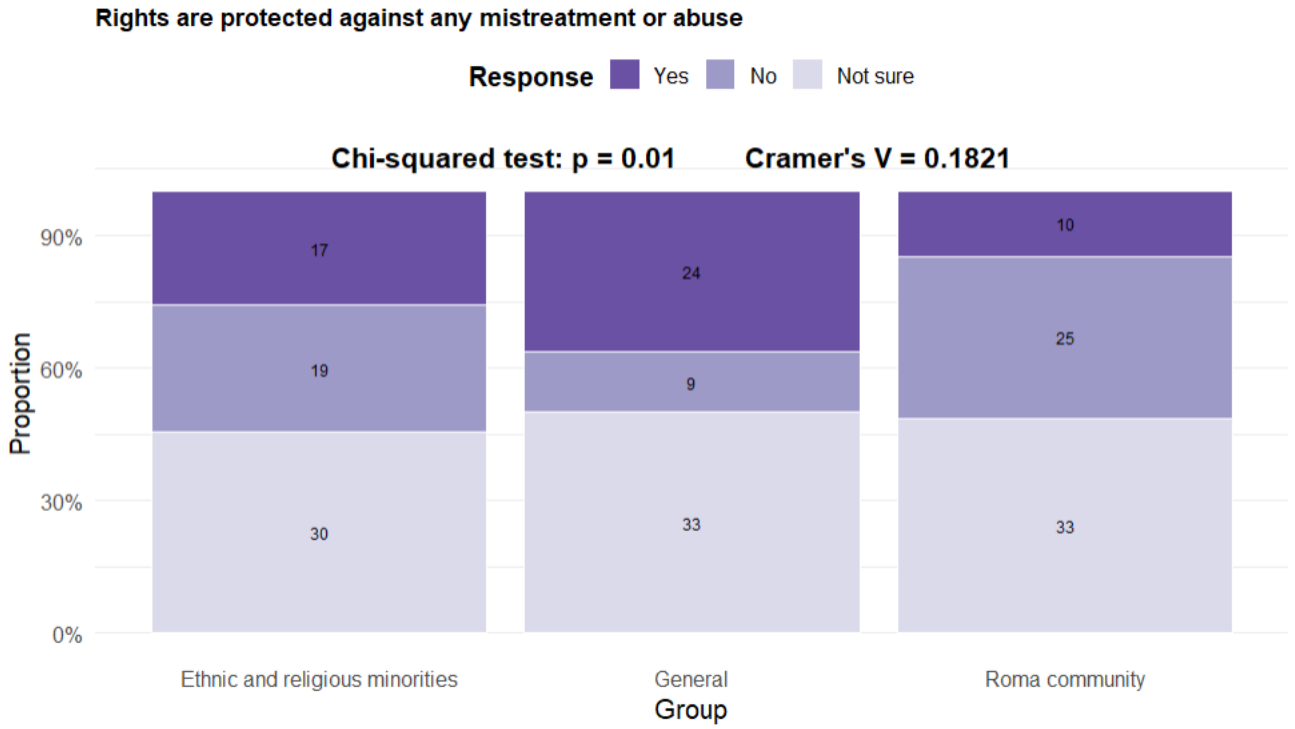

Figure 132: Chi-squared test of the rights are protected against any mistreatment or abuse item in Bulgaria

Table 129: Chi-squared test of the rights are protected against any mistreatment or abuse item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.207	0.161
Ethnic and religious minorities: Roma community	0.005	0.305
General group : Roma community	0.137	0.184

In addition, perceptions regarding whether mental health services are trustworthy differed in the overall group comparison. However, subsequent pairwise comparisons did not identify statistically significant differences between specific group combinations after adjustment (all adjusted p-values = 0.116). The corresponding Cramer's V values indicate small associations, suggesting limited variation between individual groups (Figure 135 and Table 130).

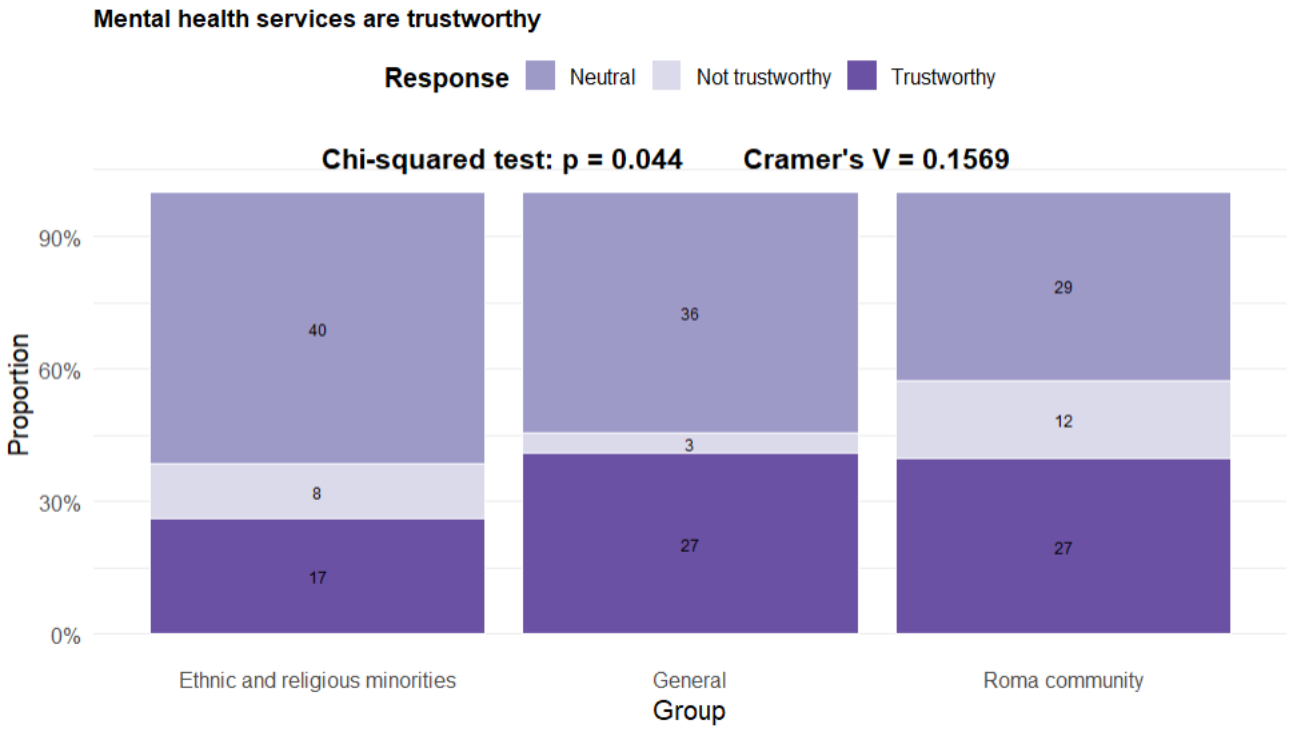

Figure 133: Chi-squared test of the mental health services are trustworthy item in Bulgaria

Table 130: Pairwise comparison test of the mental health services are trustworthy item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.116	0.190
Ethnic and religious minorities: Roma community	0.116	0.189
General group : Roma community	0.116	0.214

Affordability

Within the Affordability dimension, several indicators did not demonstrate statistically significant differences between population groups. These included the possibility of accessing mental health services through public programs or services free of charge or at low cost, the presence of health insurance coverage for mental health services, and whether respondents reported receiving support

from services regarding payment options, insurance questions, or financial assistance (Figure 136; all p-values > 0.05).

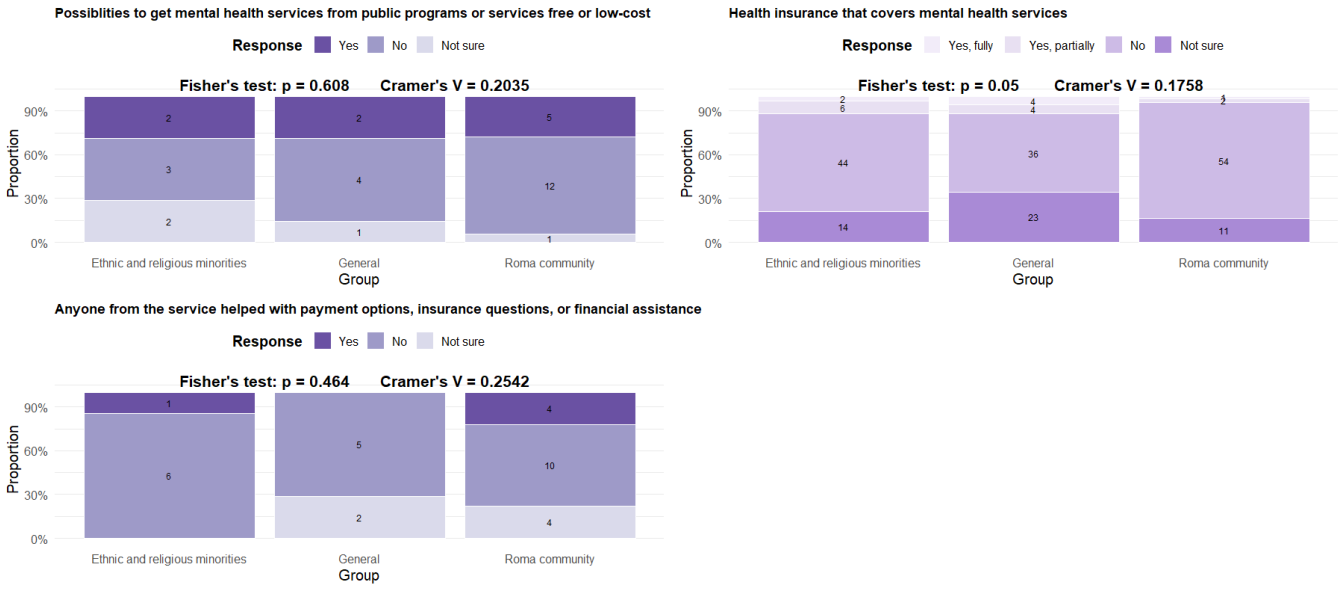

Figure 134: Non-significant differences across groups for the Affordability dimension in Bulgaria

Differences between groups were observed regarding not taking prescribed medication due to cost. Pairwise comparisons indicated statistically significant differences between ethnic and religious minorities and the general population (p = 0.021, Cramer's V = 0.275), between ethnic and religious minorities and the Roma community (p = 0.003, Cramer's V = 0.357), and between the general population and the Roma community (p = 0.008, Cramer's V = 0.312). Descriptive findings indicated that financial barriers affecting medication adherence were reported more frequently among respondents from the Roma community. The corresponding effect sizes indicate moderate associations, suggesting meaningful differences between groups (Table 131 and Figure 137).

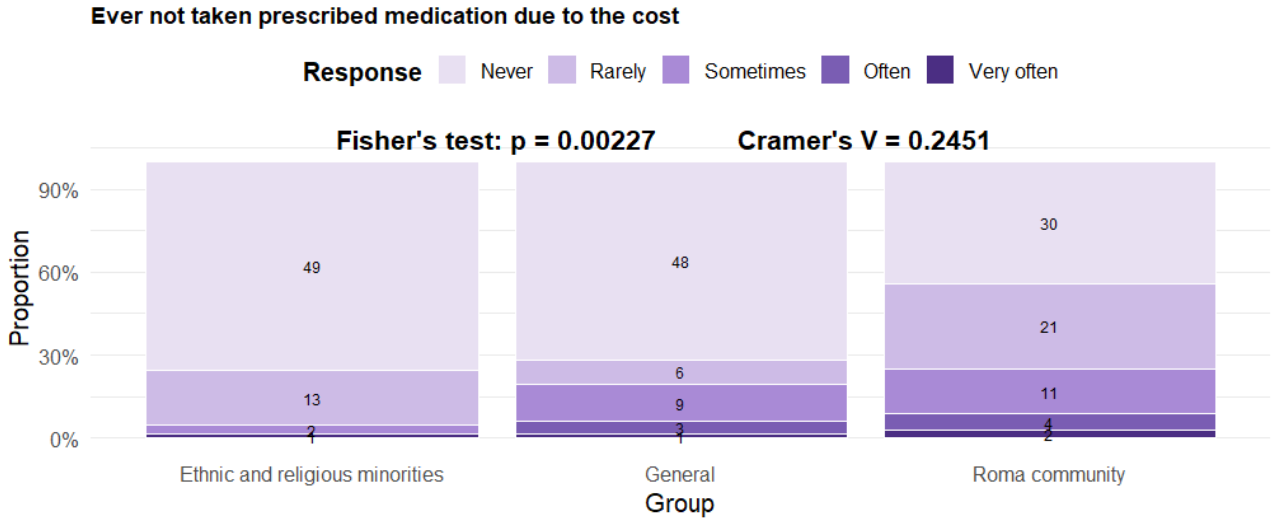

Figure 135: Fisher's test of the ever not taken prescribed medication due to the cost item in Bulgaria

Table 131: Pairwise comparison test of the ever not taken prescribed medication due to the cost item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.021	0.275
Ethnic and religious minorities: Roma community	0.003	0.357
General group : Roma community	0.008	0.312

Additional variation was identified regarding delayed or avoided mental healthcare due to cost within the past 12 months (Figure 138; Table 132). After pairwise comparison, a statistically significant difference was identified between the general population and the Roma community (p = 0.002, Cramer's V = 0.304). Descriptive findings indicated that respondents from the Roma community more frequently reported delaying or avoiding care due to financial reasons compared with the general population. The effect size indicates a moderate association, suggesting a notable difference between these groups.

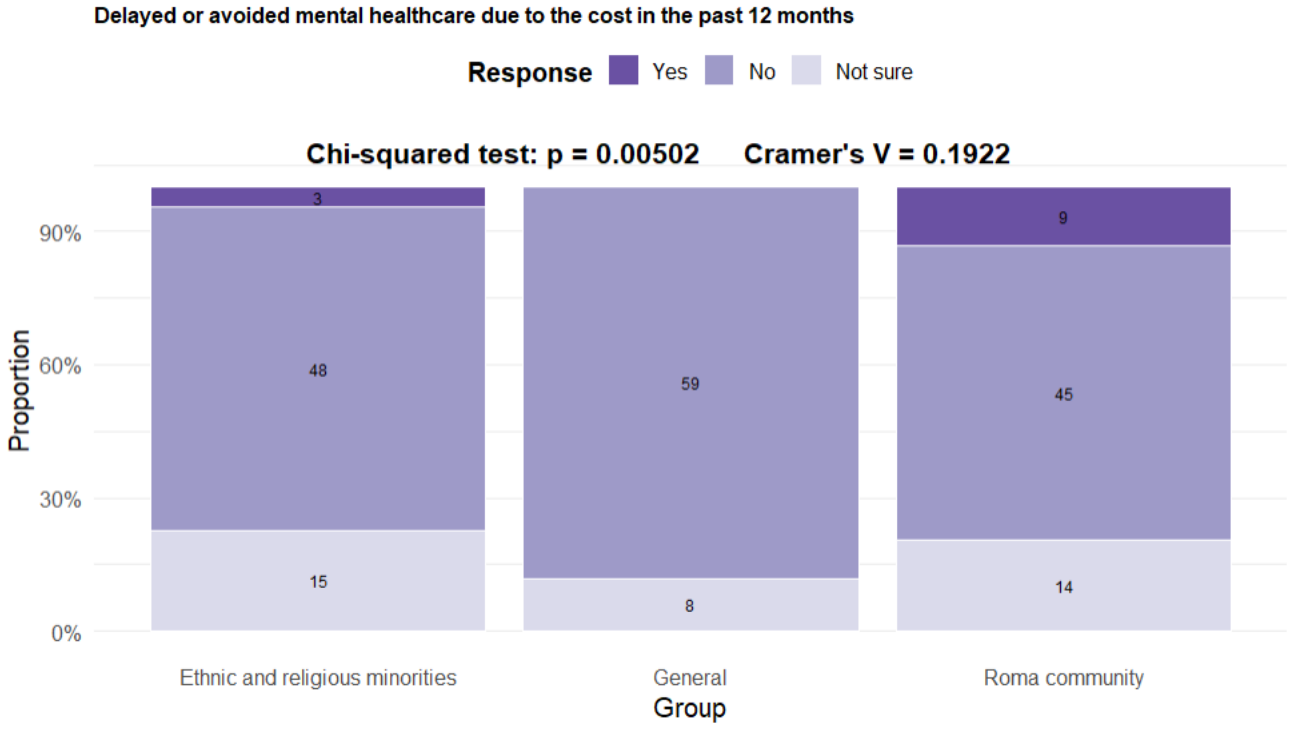

Figure 136: Chi-squared test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Bulgaria

Table 132: Chi-squared test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Bulgaria

Comparison	P Value adjusted	Cramer's V

	Chi-squared test	
Ethnic and religious minorities : General group	0.056	0.217
Ethnic and religious minorities: Roma community	0.255	0.152
General group : Roma community	0.002	0.304

Differences were also observed for difficulty accessing mental healthcare due to loss of income. Statistically significant differences were identified between ethnic and religious minorities and the Roma community (p = 0.017, Cramer's V = 0.304), as well as between the general population and the Roma community (p = 0.006, Cramer's V = 0.351). Descriptive findings indicated that respondents from the Roma community more frequently reported experiencing income-related barriers to accessing mental healthcare. The corresponding effect sizes suggest moderate associations, indicating meaningful disparities between groups (Figure 139 and Table 133).

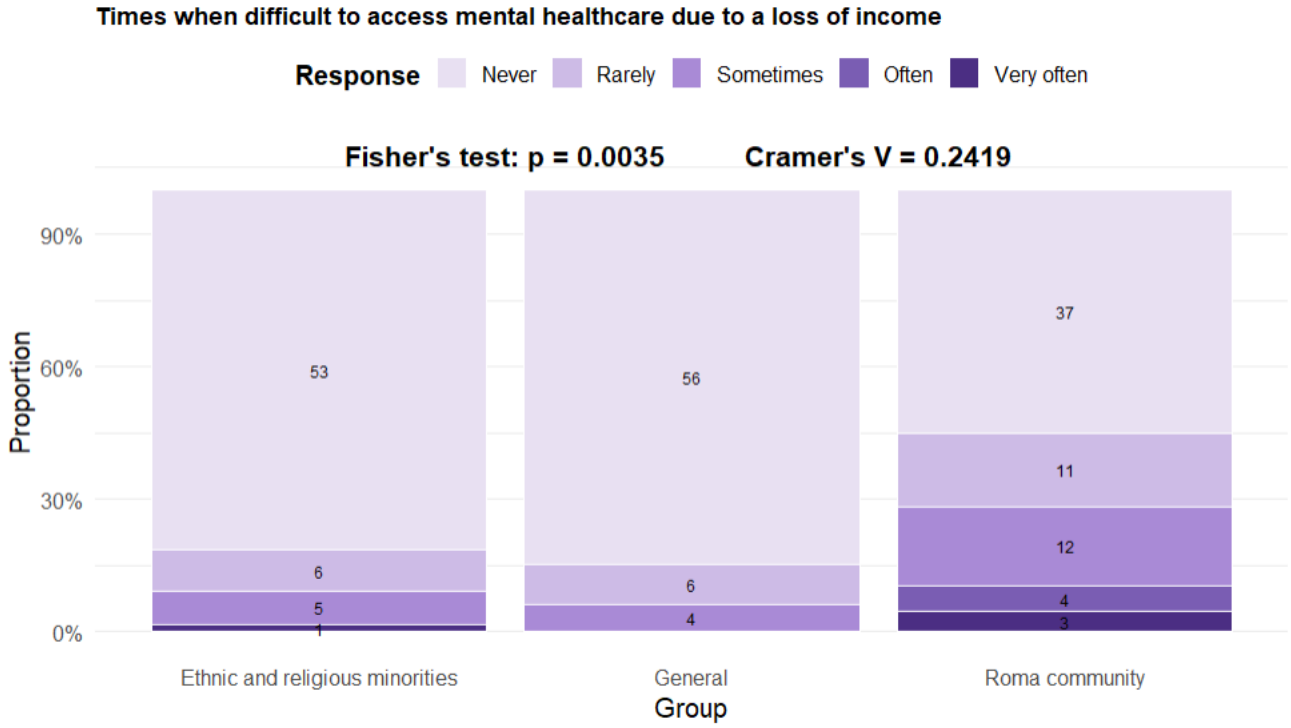

Figure 137: Fisher's exact test of the times when difficult to access mental healthcare due to a loss of income in Bulgaria

Table 133: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.913	NC
Ethnic and religious minorities: Roma community	0.017	0.304
General group : Roma community	0.006	0.351

Similarly, statistically significant differences were identified regarding difficulty accessing mental healthcare due to additional costs. Pairwise comparisons showed significant differences between ethnic and religious minorities and the Roma community (p = 0.014, Cramer's V = 0.304), as well as between the general population and the Roma community (p = 0.008, Cramer's V = 0.346). Descriptive findings again indicated higher levels of cost-related access barriers among respondents from the Roma community. The observed effect sizes indicate moderate associations, reinforcing the presence of financial access challenges within this group (Figure 140 and Table 134).

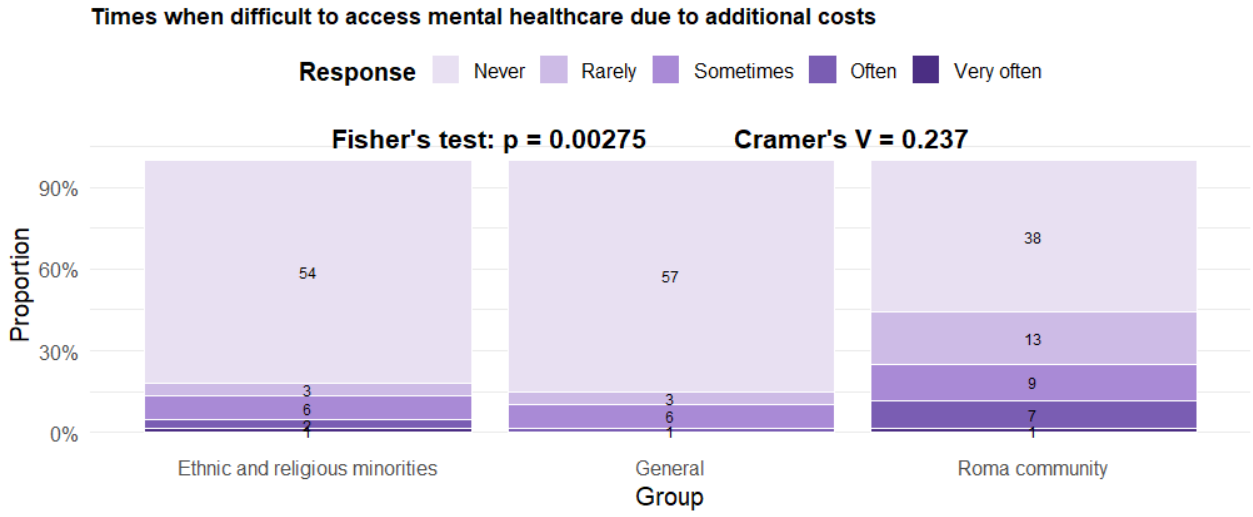

Figure 138: Fisher's test of the times when difficult to access mental healthcare due to additional costs item in Bulgaria

Table 134: Fisher's test of the times when difficult to access mental healthcare due to additional costs item in Bulgaria

Comparison	P Value adjusted Chi-squared test	Cramer's V
Ethnic and religious minorities : General group	0.954	0.103

Ethnic and religious minorities: Roma community	0.014	0.304
General group : Roma community	0.008	0.346

Appropriateness

Within the Appropriateness dimension, several indicators did not demonstrate statistically significant differences between population groups. These included whether mental health services were perceived as helpful or relevant, the ease of scheduling follow-up appointments, the possibility of consistently seeing the same doctor or therapist, and whether support was offered to caregivers or family members (Figure 141; all p-values > 0.05). These findings indicate that several aspects related to continuity and perceived usefulness of care were broadly comparable across the general population, ethnic and religious minority groups, and Roma communities.

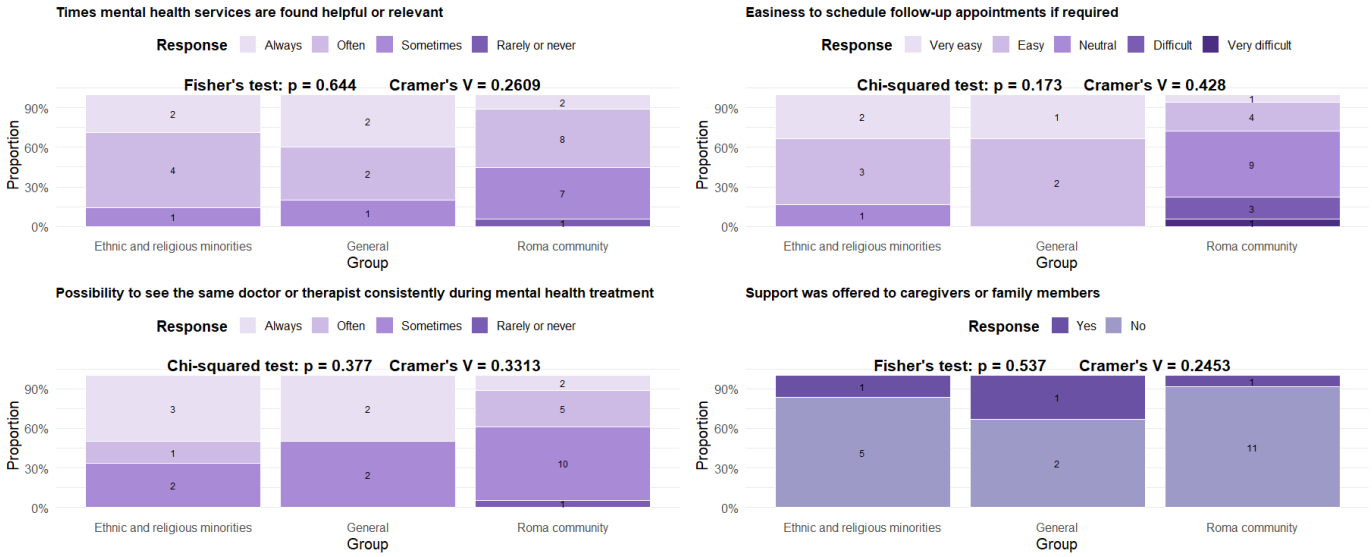

Figure 139: Non-significant differences across groups for the Appropriateness dimension in Bulgaria

Statistically significant differences were identified regarding whether mental health professionals treated clients with courtesy and respect. Pairwise comparisons showed significant differences between ethnic and religious minorities and the Roma community (p = 0.023, Cramer's V = 0.639), as well as between the general population and the Roma community (p = 0.011, Cramer's V = 0.754). Descriptive findings indicated that respondents from the Roma community reported fewer instances of respectful treatment compared with other groups. The corresponding Cramer's V values indicate large associations, suggesting substantial differences between groups (Figure 142;

Table 135)

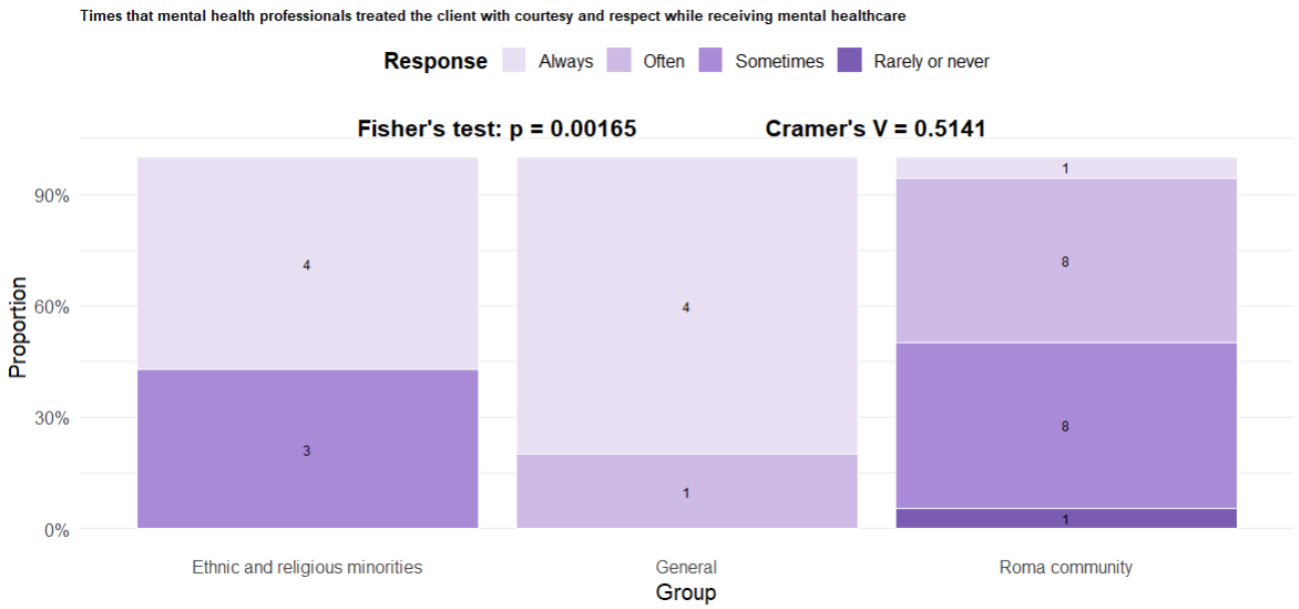

Figure 140: Fisher's exact test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare in Bulgaria

Table 135: Fisher's exact test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.196	NC
Ethnic and religious minorities: Roma community	0.023	0.639
General group : Roma community	0.011	0.754

Differences were also observed regarding whether providers explained information in a way that was easy to understand (Figure 143; Table 136). Pairwise comparisons indicated a statistically significant difference between the general population and the Roma community (p = 0.002, Cramer's V = 0.887). Descriptive findings indicated that respondents from the Roma community reported greater difficulty understanding provider explanations compared with the general population. The corresponding effect size indicates a very large association, suggesting a

pronounced difference between these groups.

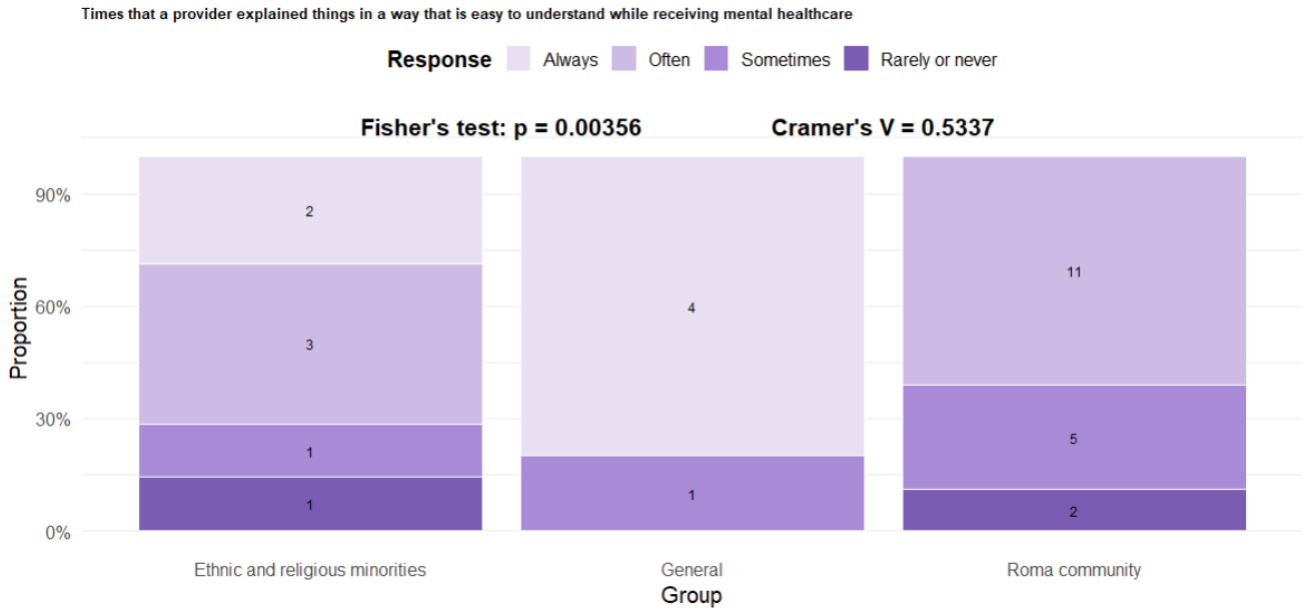

Figure 141: Fisher's exact test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Bulgaria

Table 136: Pairwise comparison test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.203	0.609
Ethnic and religious minorities: Roma community	0.203	0.484
General group : Roma community	0.002	0.887

Although variation was identified regarding whether providers spent enough time during consultations, pairwise comparisons did not identify statistically significant differences between individual groups after adjustment (all adjusted p-values > 0.05). The corresponding effect sizes varied but should be interpreted cautiously given the absence of statistically significant pairwise

results (Figure144; Table 137).

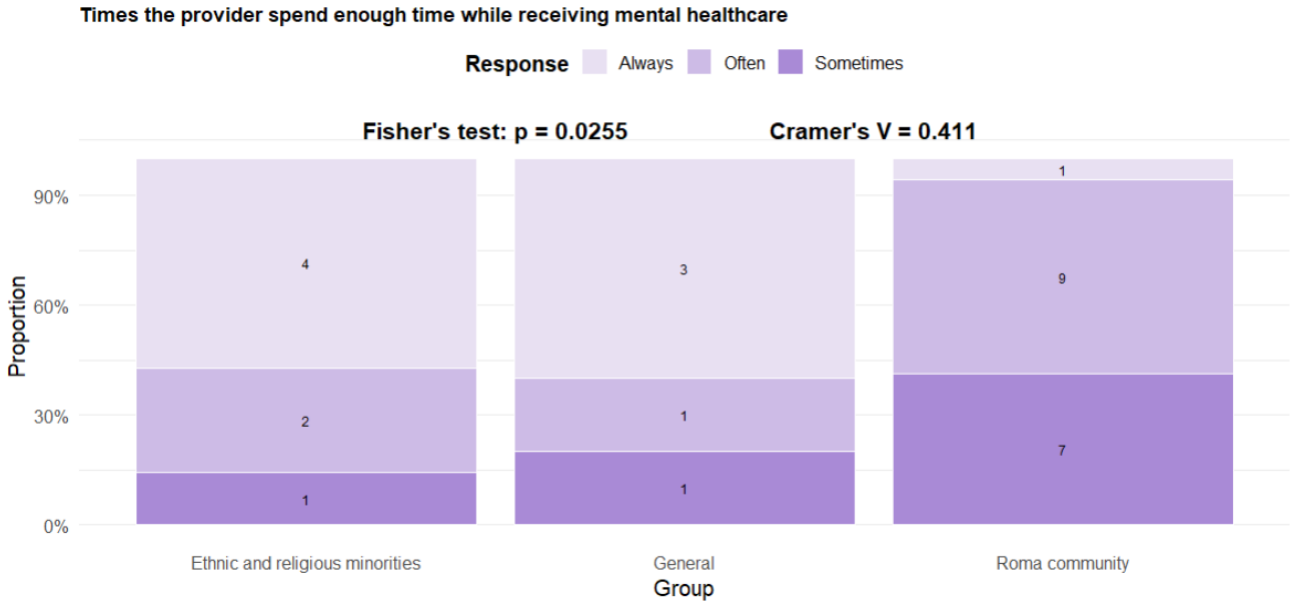

Figure 142: Fisher's exact test of the times the provider spend enough time while receiving mental healthcare item in Bulgaria

Table 137: Pairwise comparison test of the times the provider spend enough time while receiving mental healthcare item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	1.000	0.111
Ethnic and religious minorities: Roma community	0.053	0.576
General group : Roma community	0.068	0.589

Further differences were identified regarding whether cultural beliefs and practices were taken into account during mental healthcare. Pairwise comparisons indicated a statistically significant difference between the general population and the Roma community (p = 0.0495, Cramer's V = 0.695). Descriptive findings suggested that respondents from the Roma community reported fewer instances where cultural considerations were addressed during care. The corresponding effect size indicates a large association, suggesting meaningful differences between groups (Figure 145 and

Table 138).

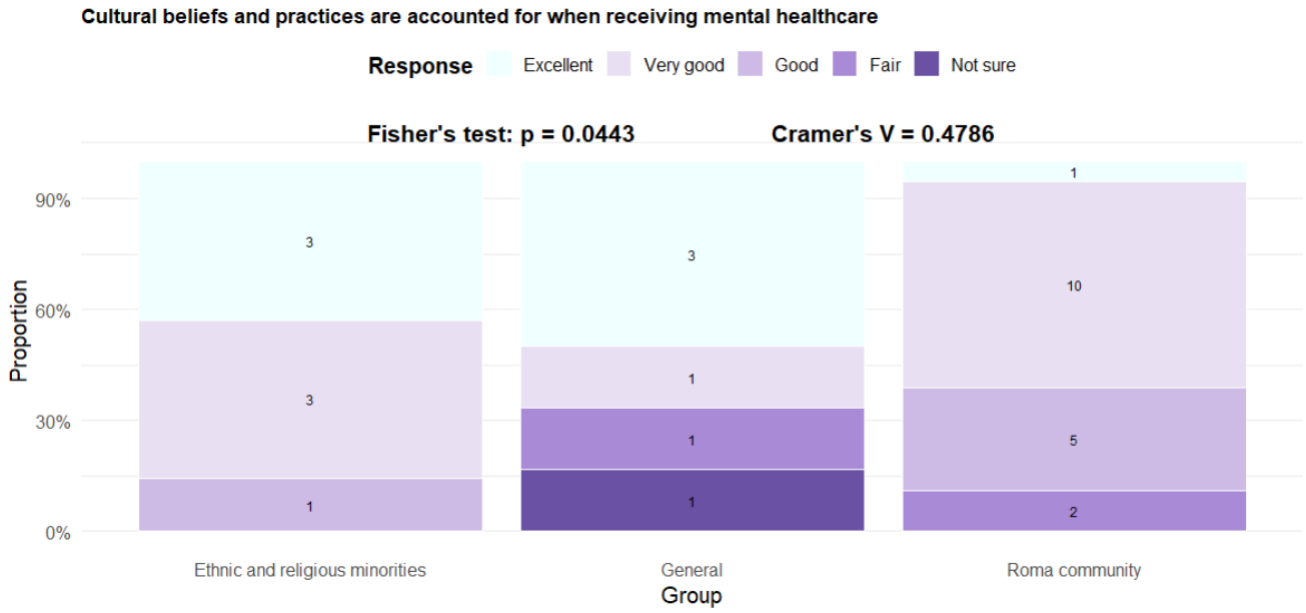

Figure 143: Fisher's exact test of the cultural beliefs and practices are accounted for when receiving mental healthcare in Bulgaria

Table 138: Pairwise comparison test of the cultural beliefs and practices are accounted for when receiving mental healthcare in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.578	0.551
Ethnic and religious minorities: Roma community	0.296	NC
General group : Roma community	0.0495	0.695

Similarly, overall variation was observed regarding whether mental health providers considered other aspects of patients' life experiences, although no statistically significant pairwise differences were identified following adjustment. These findings suggest that while variation may exist at the group level, differences between specific groups were not clearly attributable (Table 139 and Figure

146).

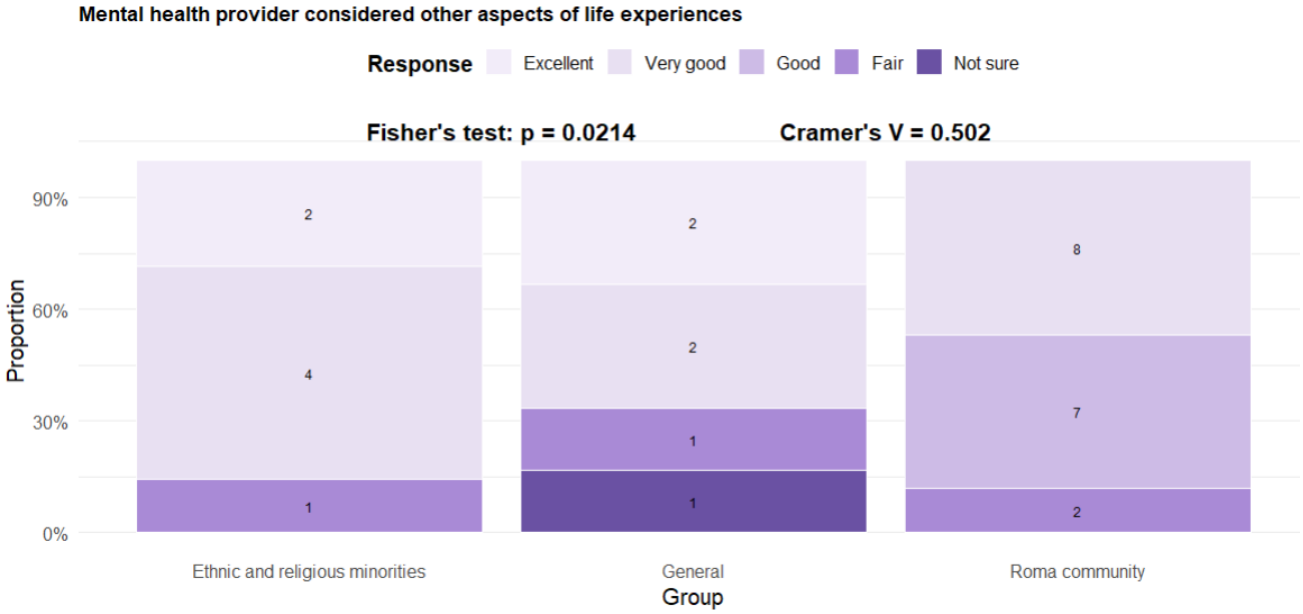

Figure 144: Fisher's exact test of the mental health provider considered other aspects of life experiences item in Bulgaria

Table 139: Pairwise comparison test of the mental health provider considered other aspects of life experiences item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.865	NC
Ethnic and religious minorities: Roma community	0.062	NC
General group : Roma community	0.053	0.699

Differences were also identified regarding smooth referral between services or professionals without needing to repeat information. Pairwise comparisons indicated a statistically significant difference between ethnic and religious minorities and the Roma community (p = 0.017, Cramer's V = 0.624). Descriptive findings indicated that respondents from the Roma community reported fewer experiences of smooth referral processes compared with ethnic and religious minority groups. The corresponding effect size indicates a large association, suggesting notable variation between

groups (Figure 147 and Table 140).

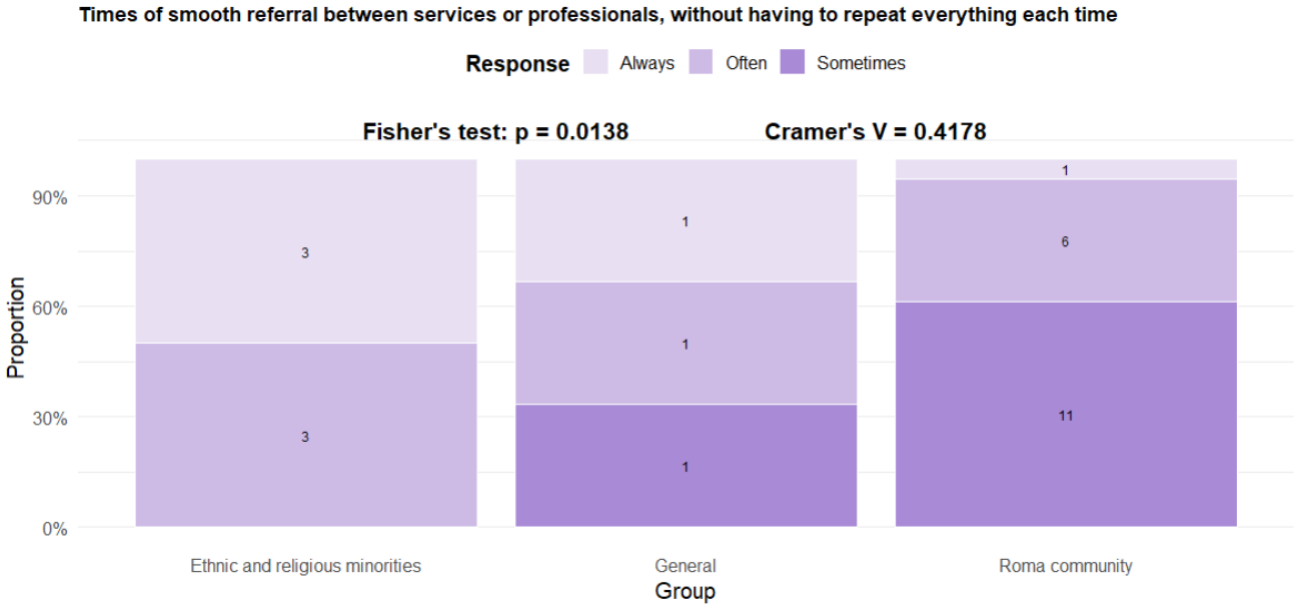

Figure 145: Fisher's exact test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Bulgaria

Table 140: Pairwise comparison test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.421	0.500
Ethnic and religious minorities: Roma community	0.017	0.624
General group : Roma community	0.421	0.340

Finally, variation was observed regarding whether mental health users received invitations to provide feedback regarding their treatment. However, pairwise comparisons did not identify statistically significant differences between individual groups after adjustment. These findings suggest that although variation was observed at the overall level, specific group-level differences could not be confirmed (Table 141 and Figure 148).

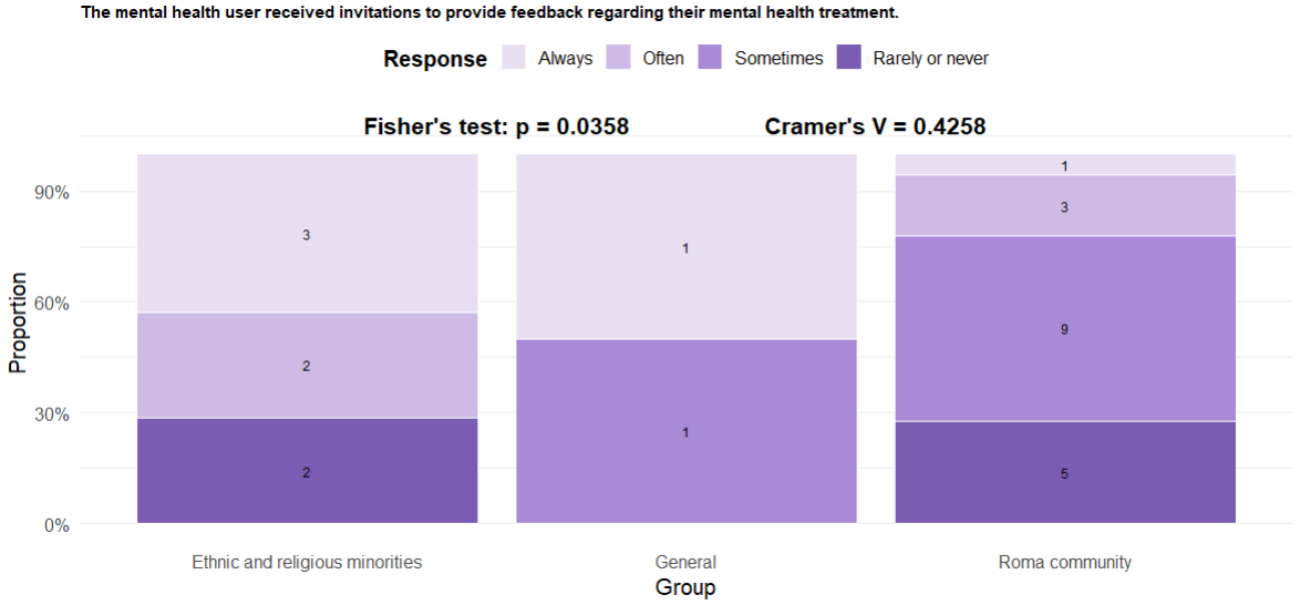

Figure 146: Fisher's exact test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Bulgaria

Table 141: Pairwise comparison test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Bulgaria

Comparison	P Value adjusted Fisher test	Cramer's V
Ethnic and religious minorities : General group	0.381	0.720
Ethnic and religious minorities: Roma community	0.071	0.574
General group : Roma community	0.381	0.471

Participant-reported health, unmet need for care, and triangulation

Health-related quality of life

Health-related quality of life, assessed using the EQ-5D-5L, showed relatively high utility values across all population groups. The overall mean utility score in the present dataset was 0.952 (SD = 0.083). Group-specific means were 0.944 (SD = 0.107) for the general group, 0.943 (SD = 0.066) for the Roma community, and 0.943 (SD = 0.066) for ethnic and religious minority groups. For comparison, national reference values derived from Bulgarian population data using the Polish EQ-5D value set, as reported by Encheva et al. (2020)[19] indicated a mean utility value of 0.967. When compared with this reference value, mean utility scores observed in the present dataset were descriptively slightly lower, although overall levels remained relatively high across groups.

Self-perceived health

Self-perceived health was assessed using items aligned with those included in EU-SILC Bulgaria, enabling comparison with national distributions reported through Eurostat EU-SILC Bulgaria datasets[12]. As subgroup-specific data for Roma communities and ethnic minorities were not available within EU-SILC Bulgaria, comparisons were conducted at the overall country level, primarily using values from the general group. Within the present dataset, the majority of respondents reported good or very good health, particularly among ethnic and religious minority groups and Roma communities (Table 142). In the general group, 44.8% reported good health and 26.9% reported very good health, which is broadly comparable to national distributions reported in EU-SILC Bulgaria, where 47.8% reported good health and 16.9% reported very good health (Table 143). Across all study groups, relatively small proportions reported bad or very bad health, aligning with patterns observed in national EU-SILC Bulgaria data.

Table 142: Self-perceived health in the dataset of Bulgaria

	General group	Ethnic and religious minorities	Roma community
Very bad, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)
Bad, *n (%)*	3 (4.5)	0 (0.0)	1 (1.5)
Fair (neither good nor bad), *n (%)*	16 (23.9)	9 (13.6)	12 (17.6)
Good, *n (%)*	30 (44.8)	37 (56.1)	31 (45.6)
Very good, *n (%)*	18 (26.9)	19 (28.8)	24 (35.3)
Missing, *n (%)*	0 (0.0)	1 (1.5)	0 (0.0)

Table 143: Self-perceived health in the dataset of EU-SILC Bulgaria

	Total country
Very bad, %	1.2
Bad, %	6.6
Fair (neither good nor bad), %	27.5
Good, %	47.8
	16.9

Activity limitations

Functional limitations were assessed using indicators corresponding to those included in EU-SILC Bulgaria[13], enabling comparison with national activity limitation data. Within the present dataset, most respondents reported no limitations in daily activities, particularly among ethnic and religious minority groups (92.4% not limited) and the general group (71.6% not limited). Among the Roma community, 70.6% reported no limitations, although a somewhat higher proportion (8.8%) reported being severely limited compared with other groups (Table 144). National reference values from EU-SILC Bulgaria indicated that 86.7% of respondents reported no activity limitations, 10.8% reported limitations, and 2.5% reported severe limitations (Table 145).

Table 144: Activity limitations in the dataset of Bulgaria

	General group	Ethnic and religious minorities	Roma community
Severely limited %	2 (3.0)	0 (0.0)	6 (8.8)
Limited %	17 (25.4)	4 (6.1)	14 (20.6)
Not limited, %	48 (71.6)	61 (92.4)	48 (70.6)
Missing, %	0 (0.0)	1 (1.5)	0 (0.0)

Table 145: Activity limitations in the EU-SILC dataset of Bulgaria

	Total country
Severely limited, %	2.5
Limited, %	10.8
Not limited, %	86.7

Unmet need for care

Information on unmet need for healthcare was collected using indicators aligned with those included in EU-SILC Bulgaria, enabling comparison with national-level estimates reported through Eurostat EU-SILC Bulgaria datasets[14]. Within the present dataset, several reasons for unmet need were reported across groups, with cost-related barriers among the most frequently reported. Specifically, 14.9% of the general group, 6.1% of ethnic and religious minority respondents, and 14.7% of Roma respondents reported unmet need due to services being too expensive. Additional reasons included waiting lists, travel distance, and uncertainty regarding suitable providers (Table 146). In contrast,

EU-SILC Bulgaria national data indicated that a large majority of respondents (95.1%) reported no unmet healthcare needs, with only a small proportion reporting specific barriers (Table 147).

Table 146: Unmet need for care in the dataset of Bulgaria

	General group	Ethnic and religious minorities	Roma community
Too expensive, *n (%)*	10 (14.9)	4 (6.1)	10 (14.7)
Too far to travel, *n (%)*	3 (4.5)	0 (0.0)	2 (2.9)
No time, *n (%)*	1 (1.5)	1 (1.5)	0 (0.0)
Didn't know any good doctor or specialist, *n (%)*	5 (7.5)	0 (0.0)	0 (0.0)
Waiting list, *n (%)*	8 (11.9)	6 (9.1)	8 (11.8)
Fear of doctor, hospital examination or treatment, *n (%)*	0 (0.0)	1 (1.5)	0 (0.0)
Wanted to wait and see if problem got better on its own, *n (%)*	5 (7.5)	0 (0.0)	4 (5.9)
Other reason, *n (%)*			
No unmet needs to declare, *n (%)*	41 (61.2)	54 (81.8)	47 (69.1)
Missing, *n (%)*	0 (0.0)	0 (0.0)	0 (0.0)

Table 147: Unmet need for care in the EU-SILC dataset of Bulgaria

	Total country
Too expensive, %	0.0
Too far to travel, %	0.0

No time, %	0.0
Didn't know any good doctor or specialist, %	0.0
Waiting list, %	0.0
Fear of doctor, hospital examination or treatment, %	0.0
Wanted to wait and see if problem got better on its own, %	0.0
Other reason, %	4.9
	95.1

Depression severity

Depressive symptom severity was assessed using items corresponding to those included in EHIS Bulgaria, allowing comparison with national mental health distributions reported through Eurostat EHIS Bulgaria datasets[15]. Across all groups in the present dataset, the majority of respondents reported none or minimal depressive symptoms, particularly among ethnic and religious minority groups (75.8%) and the general group (65.7%). However, moderate depressive symptoms were reported more frequently among Roma respondents (17.6%) compared with other groups (Table 148). National reference values from EHIS Bulgaria indicated that 88.6% of respondents reported no or minimal depressive symptoms, while smaller proportions reported moderate or severe symptoms (Table 149).

Table 148: Depression severity in the dataset of Bulgaria

	General group	Ethnic and religious minorities	Roma community
Severe, *n (%)*	1 (1.5)	0 (0.0)	0 (0.0)
Moderately severe, *n (%)*	3 (4.5)	0 (0.0)	1 (1.5)
Moderate, *n (%)*	2 (3.0)	3 (4.5)	12 (17.6)
Mild, *n (%)*	15 (22.4)	13 (19.7)	19 (26.5)
None or minimum, *n (%)*	44 (65.7)	50 (75.8)	36 (52.9)
Missing, *n (%)*	2 (3.0)	0 (0.0)	1 (1.5)

Table 149: Depression severity in the EHIS dataset of Bulgaria

	Total country

Severe, %	0.7
Moderately severe, %	0.8
Moderate, %	2.6
Mild, %	7.4
None or minimum, %	88.6

4.7.2 Qualitative results

Approachability

Information awareness

Mental health information does not reach vulnerable communities through any systematic or coordinated channel. Awareness depends almost entirely on intermediaries, such as mediators, NGOs, GPs, and schools, rather than on a coherent, proactive information infrastructure. Where information does exist, it is unevenly distributed and rarely penetrates the communities that need it most.

Trusted intermediaries are not merely useful additions to the information system but a structurally necessary condition for information to be received at all. Without pre-existing trust, information campaigns are ineffective regardless of their content or reach: *"This trust is often lacking in the work of other structures"* (AMALIPE, Civil Society).

Information channels in use at the municipal level are acknowledged as insufficient, with no dedicated communication strategy in place. The reliance on national campaigns is a structural weakness rather than a solution: *"As a small municipality, we recognize that these measures are not sufficient – we do not have a specialized communication strategy and rely heavily on national information campaigns"* (AMALIPE, Policymaker).

National information campaigns show wide reach and increased awareness in aggregate, but no sustainable effect on actual service demand, pointing to the fundamental inadequacy of broadcast-style strategies for these populations (AMALIPE, Academic).

At the community level, the absence of information is so complete that the question of where and how to seek help does not arise for most people: *"Almost no one is interested in this type of help and, accordingly, the questions of where and how do not arise for the majority of people"* (AMALIPE, User Representative).

Project-based outreach represents the most promising available model for active information dissemination, but its structural fragility undermines its effectiveness: once project funding ends, initiatives cease entirely, making even well-designed efforts unsustainable as a primary information pathway (AMALIPE, Provider).

Barriers to recognising or seeking help

Barriers to help-seeking are multilayered, mutually reinforcing, and cumulative, operating simultaneously at individual, cultural, and structural levels. The most fundamental barrier precedes all others: communities do not recognise that a problem exists. People *"almost never take the initiative to seek support in the field of mental health or even realize that there is a problem"* (AMALIPE, Civil Society).

Low health literacy is a pervasive cross-cutting barrier. The absence of a distinction between psychology and psychiatry means that any form of mental health care is associated with severe mental illness, generating avoidance before help-seeking is consciously considered: *"Many people do not distinguish between psychological counseling and psychiatric treatment. For this reason, any form of mental health care is associated with severe mental illness"* (AMALIPE, Provider).

The GP gatekeeping pathway creates a structural multiplier of barriers. In order to reach a mental health specialist, who is in over 90% of cases located in a large regional city, community members must navigate multiple institutional steps, each requiring time, resources, and motivation that many do not have: *"In order to contact a mental health specialist, a representative of the Roma community must go through their personal doctor and then be referred to a specialist. This costs time, desire and resources"* (AMALIPE, Civil Society).

Geographic isolation, financial constraint, low health literacy, and stigma are compounding rather than independent barriers, forming a cascade in which each level reinforces the others. A vicious circle exists between poverty, social isolation, and poor mental health outcomes, in which barriers are systematically hardest for exactly those who need help most (AMALIPE, Academic).

Acceptability

Cultural and social fit

Cultural and social alignment is a central condition of service acceptability. A consistent finding across all interviews is that barriers to acceptability are concentrated at the point of engagement rather than in the quality of care once received which is an asymmetry with significant implications for how access interventions should be designed.

Mental health problems are not accepted as normal health problems within family and community frameworks. Seeking help risks being labelled "crazy," which within close-knit minority communities

carries the severe social consequence of community exclusion: *"'Stigmatizing' or 'labeling' someone would exclude them from the community and significantly limit their social interactions"* (AMALIPE, Civil Society). The family functions as a gatekeeper whose attitudes determine whether individual engagement with services is possible at all. Parents fear that a child's contact with psychological services will stigmatise the entire family unit: *"They fear that their family will be stigmatized or that the child will be labeled as mentally ill"* (AMALIPE, Provider).

The Bulgarian mental health system's highly institutional and medically oriented model structurally limits the perception of services as personalised or supportive. Roma communities, migrants, and people in poverty frequently perceive services as foreign, difficult to understand, or hostile when cultural sensitivity or mediation is absent, leading to later help-seeking, treatment interruption, or complete avoidance (AMALIPE, Academic).

National strategies formally commit to culturally appropriate care and fund health mediation at the national level. However, implementation at the municipal level is incomplete: the regional mental health centre has no Roma mediators, and no ethnically diverse specialists are employed: *"The actual implementation of the national strategies at the municipal level is incomplete – we do not have the resources to hire specialists of different ethnic backgrounds, and the Center for Mental Health does not have Roma mediators"* (AMALIPE, Policymaker).

Notably, once individuals do access services, feedback is predominantly positive, with specialists described as approaching users with understanding and tolerance regarding education level, cultural differences, and family values (AMALIPE, Civil Society). This confirms that cultural barriers are concentrated at entry rather than within the care encounter itself.

Stigma

Stigma is the single most powerful barrier to mental health care access, operating at multiple simultaneous levels such as the individual, family, community, and institutional level. It is described unambiguously as *"the big problem in Bulgaria regarding professional mental health care"* (AMALIPE, User Representative).

At the community level, stigma operates through social exposure risk. In close-knit settlement communities, knowledge of someone seeking help can circulate quickly, and fear of others finding out is one of the most powerful deterrents to help-seeking: *"People definitely hide. They do not want anyone to know about their problems, and accordingly they do not share them with loved ones, and even more so with professionals"* (AMALIPE, User Representative).

Internalized stigma creates a self-reinforcing dynamic in which stigma directly worsens the conditions it prevents from being treated. Self-stigma is associated with lower self-esteem, higher symptom

severity, and a lower likelihood of seeking support. For vulnerable groups, a "stacking" effect occurs in which mental health stigma compounds with ethnic, economic, and migration-related stigmatisation, producing a stronger institutional distrust than either form would generate alone (AMALIPE, Academic).

Religious beliefs add a further cultural layer to stigma that mainstream anti-stigma campaigns are unlikely to address. For more religious community members, like evangelical Christians or Muslims, seeking mental health care can conflict directly with faith frameworks: *"Sometimes this conflicts with their religious beliefs, especially for those who are more religious – evangelical Christians or Muslims"* (AMALIPE, Civil Society).

Stigma reduction efforts exist but are fragmented and of limited reach. The training of Roma mediators to recognise mental health problems represents the most promising initiative, positioning peer-based, trust-centred mediation as the most effective available approach (AMALIPE, Civil Society). National campaigns do not reach the most marginalised: *"The campaigns do not reach the most marginalized groups, the Roma communities in small villages, people with low media literacy and the older population"* (AMALIPE, Policymaker). Evidence confirms that broadcast-style anti-stigma initiatives show increased awareness in general populations but no sustainable effect on help-seeking behaviour (AMALIPE, Academic).

Availability

Distribution and sufficiency of services

Mental health services are structurally under-provided, with geographic concentration in urban centres leaving rural and remote communities, precisely where Roma and minority populations are disproportionately located, effectively without local access. This is one of the most consistent findings across all five interviews: *"The short answer is no! In general, people who live in remote places – the elderly, Roma, minorities and other vulnerable geographically and financially have more limited access to healthcare and mental health in particular"* (AMALIPE, Civil Society).

Service distribution does not follow patterns of need. There is no stable relationship between the number of specialists and the degree of social vulnerability of the population and the most vulnerable regions have the fewest resources. Depopulation and socioeconomic decline in northern and rural Bulgaria further reduce service availability precisely where vulnerability is highest (AMALIPE, Academic).

At the local level, the specific contours of this shortage are stark. In Pavlikeni municipality, 27 settlements, most small and remote, are served by a single referral pathway to a centre approximately 30 kilometres away, with no on-site psychiatric or psychological service available (AMALIPE, Policymaker).

A specific age-related availability gap exists: after the age of 18, when young people exit the school system and its associated support structures, the already limited services in small settlements become even more restricted. Interdisciplinary coordination, necessary for complex cases, is significantly harder to achieve outside the school system, leaving vulnerable young adults in a structural service vacuum (AMALIPE, Provider).

Mobile mental health teams are identified as a potential solution to geographic inaccessibility, but this service is not yet operational in the relevant region: *"At the national level, the development of mobile mental health teams is planned, but in our region this service is not yet fully functioning. We believe that mobile services would significantly solve the problem of geographical remoteness"* (AMALIPE, Policymaker). This represents a future facilitator that currently remains unrealised.

Timing, format, and accesibility of delivery

Service hours are significantly misaligned with the daily realities of working people and those living in remote areas. Standard weekday schedules make specialist visits practically impossible for people in employment: *"People from remote areas, especially working people, have almost no opportunity to visit a specialist during working hours on weekdays. There is a clear need for specialists to work outside standard working hours, as well as on weekends"* (AMALIPE, Civil Society).

No unified national mechanism for flexible access has been introduced. Services operate with standard working hours, creating hardship for working people and those with caregiving commitments: *"Currently, the Child and Family Care Center – Veliko Tarnovo operates with standard working hours, which is a hardship for working people or those with caregiving commitments"* (AMALIPE, Policymaker).

Crisis support for adults is particularly weak at the local level. No specialised local resource exists for adults in crisis. People are redirected to general emergency services, a response that is neither specialised nor designed for mental health needs. A regional crisis line or duty psychologist is identified as a necessary but currently absent provision (AMALIPE, Policymaker).

Project-based outreach, bringing consultations directly to settlements, represents the most promising alternative delivery model, removing scheduling and transport barriers that standard formats impose. However, this model is entirely dependent on project funding and ceases when funding ends: *"After the project is completed, the initiatives usually stop, as there is a lack of funding for transportation and for continuing the work in the settlements themselves"* (AMALIPE, Provider). This makes it structurally unsustainable as a primary access pathway.

Affordability

Direct and indirect costs

Financial barriers are among the most significant obstacles to mental health care access. Mental health care is effectively positioned beyond the reach of communities struggling to meet primary needs: *"Mental health care is much higher up the financial ladder and to get to it, you have to go through all the more basic levels, which in turn have to be satisfactorily met"* (AMALIPE, Civil Society).

Psychological counselling and psychotherapy are largely paid entirely by users, making them practically inaccessible to people with low incomes, the unemployed, and representatives of marginalised communities. Even where health insurance exists, coverage is limited and does not meet needs for long-term support (AMALIPE, Academic).

A significant share of the most vulnerable, particularly Roma and the long-term unemployed, are uninsured and therefore entirely excluded from public coverage: *"The problem in the Municipality of Pavlikeni is the significant share of uninsured persons, especially among the Roma community and the long-term unemployed. The NHIF does not cover the costs for them"* (AMALIPE, Policymaker).

Indirect costs are equally significant but less visible in formal statistics. The cost of travelling 20–25 kilometres to a specialist is a concrete, experienced barrier: *"I live in a small town that is 20 km from the city and I face the obstacle of how to reach a mental health care provider"* (AMALIPE, User Representative). The recurring cost of regular appointments causes people to discontinue treatment even after beginning it, directly undermining continuity of care: *"Many families do not have enough financial resources to pay for consultations, especially if regular appointments are required"* (AMALIPE, Provider).

Support mechanisms

Financial support mechanisms formally exist but are practically inadequate, of restricted reach, and structurally fragile. Mechanisms exist on paper but do not function as effective safeguards for the most vulnerable.

Available mechanisms include: free psychiatric care for insured persons through the NHIF; exemptions for people with disabilities and children under 18; a municipally funded psychologist at the Centre for Social Rehabilitation and Integration; one-time financial assistance under the Social Assistance Act; and project-based funding through the OP Human Resources Development programme. Each mechanism is immediately qualified by a significant limitation: insurance excludes the uninsured, one-time assistance is *"administratively burdensome"* (AMALIPE, Policymaker), project funding is unstable, and municipal emergency funds are not earmarked for mental health.

Efforts to connect vulnerable people with financial support are limited by the scarcity of available options: *"When possible, yes. This is one of the areas we have been trying to develop in recent years, but overall the opportunities are not many and I would say limited"* (AMALIPE, Civil Society).

Financing at the system level does not sufficiently support the development of psychosocial services, leading to the dominance of a medication model that is cheaper to fund but less appropriate for the complex needs of vulnerable populations (AMALIPE, Academic). The collective picture is of a patchwork system with significant coverage gaps, in which the most marginalised fall between available mechanisms and must rely on civil society organisations as de facto intermediaries for a system not designed to reach them.

Appropriateness

Fit and usefulness of care

A distinctive finding across the interviews is the asymmetry between entry barriers and care quality: once people do access services, feedback is predominantly positive. This suggests that the appropriateness problem is primarily one of structural access rather than clinical inadequacy.

Among those who do reach services, most report improvement in their condition and describe services as useful, with specialists noted for approaching users with understanding and tolerance regarding education level, cultural differences, and family values (AMALIPE, Civil Society). Where negative experiences are reported, they are located not in the quality of care itself but in accessibility and administrative burden: *"The negative ones come mainly from the accessibility and administrative burden of the help"* (AMALIPE, User Representative).

Contemporary frameworks assess care appropriateness not only by clinical outcomes but by whether it is accessible, understandable, culturally appropriate, and trust-building. By these standards, Bulgaria's highly institutional and medically oriented system falls significantly short, not because professionals are inadequate but because the structural design prioritises a narrow clinical model over the broader contextual responsiveness that vulnerable populations require (AMALIPE, Academic).

Psychological work currently focuses on individual problems without systematically incorporating the wider cultural and social context of vulnerable groups: *"It is not always clear to what extent they fully correspond to the cultural characteristics and values of different communities. Psychological work focuses mainly on the individual problems of the patient, but does not always fully take into account the wider cultural and social context of vulnerable groups"* (AMALIPE, Provider). This gap between technical professional competence and culturally contextual appropriateness, which remains underdeveloped, is confirmed across multiple interviews.

Person-centred care is formally defined in national legislation and individual plans are legally required. In social services this is being implemented with monitoring by the Agency for the Quality of Social Services. However, in psychiatric services the reality diverges: high patient loads and limited staff make personalised approaches structurally difficult to achieve (AMALIPE, Policymaker).

Quality of interaction and respect

The quality of individual provider–patient interactions is broadly positive at the level of direct clinical encounter. Interactions are described as good and help as “at a level”, with group-based socialization activities noted as particularly beneficial for those with more serious conditions (AMALIPE, Civil Society). Patient rights are formally regulated under the Health Act and Regulation N4, including rights to informed consent and complaints procedures (AMALIPE, Policymaker).

However, the most analytically significant finding on this dimension is one of scale rather than quality: positive interactions within the system are experienced by *“a small number of people with mostly more serious and clearly expressed mental problems”* (AMALIPE, Civil Society). The appropriateness of care for those within the system cannot be assessed independently of the fact that the vast majority of vulnerable community members never reach it. Under-treatment of the broader population is the dominant appropriateness finding.

Structural conditions undermine quality of interaction at the system level. Patients from vulnerable groups rarely exercise their formal rights due to low health literacy and institutional anxiety (AMALIPE, Policymaker). Language barriers are a concrete daily obstacle: the psychologist cannot speak Turkish or Romani, significantly hindering communication with the families most in need of culturally sensitive engagement: *“The psychologist can only speak Bulgarian, and some families mainly use Turkish or Romani. This significantly hinders communication”* (AMALIPE, Provider).

Mediators are identified as the primary tool for bridging communication gaps, and their role is described as indispensable: *“Working with vulnerable communities is very difficult without mediators or people who already have trust in the community”* (AMALIPE, Provider). However, this mediation function is delivered through individual professional commitment and civil society intermediation rather than through systemic design, making it fragile, uneven, and insufficient in scale.

Mandatory staff training in communication with vulnerable groups is explicitly recommended as a necessary systemic response to the current gap: *“We believe that national standards should include mandatory training of staff in communication with vulnerable groups”* (AMALIPE, Policymaker). Without this, the quality of interaction that does exist within the system will remain dependent on individual initiative rather than institutional provision.

4.8 Germany

4.8.1 Quantitative results

The dataset included 367 respondents across three groups: General (n = 221), older adults (65+) without a migration background (n = 130), and older adults (65+) with a migration background (n = 16). Group composition is presented in Table 150.

Table 150: Distribution of participants across the included groups in Germany

General group	Older adults (65+) without migration background	Older adults (65+) with migration background
N = 221	N =130	N = 16

Descriptive statistics by group are shown in Table 151. Mean age differed markedly between groups, reflecting the inclusion of older adults: 41.9 years (SD 14.5) in the General group, 69.4 years (SD 4.43) among older adults without a migration background, and 69.9 years (SD 5.20) among those with a migration background. Questionnaires were mainly self-completed across all groups, although respondents with a migration background were somewhat more likely to complete the questionnaire with assistance (18.8%).

Sex at birth distributions showed a higher proportion of females among older adults with a migration background (100%) than in the General group (58.3%) or among older adults without a migration background (47.7%). Gender identity corresponded with sex assigned at birth for almost all respondents, with only a small number reporting a different gender or preferring not to say.

Across groups, most respondents identified as heterosexual: 72.9% in the General group, 87.7% among older adults without a migration background, and 87.5% among those with a migration background. Other orientations; including gay, lesbian, bisexual, and “prefer not to say”, were reported less frequently (see Table 151).

Nearly all respondents reported Germany as their country of residence, although a larger proportion of older adults with a migration background lived outside Germany (25%). Birthplace reflected migration status: 94.6% of the General group and all respondents without a migration background were born in Germany, compared with 31.3% of those with a migration background. Citizenship followed a similar pattern, with German citizenship reported by 95% of the General group and all respondents without a migration background, compared with 81.3% among those with a migration background.

Parental birthplace further highlighted these differences. Both parents were born in Germany for 78.3% of the General group and all respondents without a migration background, compared with 6.3% among those with a migration background.

Mean duration of residence in Germany was longest among older adults without a migration background (56.2 years, SD 21.9), followed by older adults with a migration background (49.4 years, SD 17.7) and the General group (36.3 years, SD 17.5).

Educational attainment (ISCED) differed across groups. Lower secondary education (ISCED 2) was most common among older adults without a migration background (33.8%), while upper secondary education (ISCED 3) was most frequent in the General group (26.2%). Among older adults with a migration background, tertiary education was relatively common, with 31.3% holding a Master's degree (ISCED 7) and 12.5% a Doctoral degree (ISCED 8).

Use of mental health services in the previous 12 months was reported by 82.8% of the General group, 86.2% of older adults without a migration background, and 68.8% of those with a migration background. Non-use was more common among respondents with a migration background (31.3%) than in the other groups.

Table 151: Descriptive statistics of the different included groups in Germany

Demographic variable	General group	Older adults (65+) without migration background	Older adults (65+) with migration background	Overall
Age, *mean (sd)*	41.9 (14.5)	69.4 (4.43)	69.9 (5.20)	52.8 (17.8)
Questionnaire completed by, *n (%)*				
Respondent alone	218 (98.6%)	127 (97.7%)	13 (81.3%)	358 (97.5%)
Respondent with help	3 (1.4%)	2 (1.5%)	3 (18.8%)	8 (2.2%)
Someone else	0 (0%)	1 (0.8%)	0 (0%)	1 (0.3%)
Sex at birth, *n (%)*				
Female	129 (58.3%)	62 (47.7%)	16 (100%)	203 (55.3%)
Male	84 (38.0%)	67 (51.5%)	0 (0%)	155 (42.2%)
Non-binary	8 (3.6%)	1 (0.8%)	0 (0%)	9 (2.5%)

Gender the same as assigned at birth, *n (%)*				
Yes	209 (94.6%)	130 (100%)	132 (100%)	355 (96.7%)
No	11 (5.0%)	0 (0%)	0 (0%)	11 (3.0%)
Prefer not to say	1 (0.5%)	0 (0%)	0 (0%)	1 (0.3%)
Sexual orientation, *n (%)*				
Heterosexual	161 (72.9%)	114 (87.7%)	14 (87.5%)	289 (78.7%)
Gay	12 (5.4%)	5 (3.8%)	0 (0%)	17 (4.6%)
Lesbian	5 (2.3%)	1 (0.8%)	0 (0%)	6 (1.6%)
Bisexual	32 (14.5%)	6 (4.6%)	1 (6.3%)	39 (10.6%)
Other	7 (3.2%)	2 (1.5%)	1 (6.3%)	10 (2.7%)
Prefer not to say	4 (1.8%)	2 (1.5%)	0 (0%)	6 (1.6%)
Country of residence, *n (%)*				
Germany	219 (99.1%)	127 (97.7%)	12 (75.0%)	358 (97.5%)
Other	2 (0.9%)	3 (2.3%)	4 (25.0%)	9 (2.5%)
Country of birth, *n (%)*				
Born in the country of residence	209 (94.6%)	130 (100%)	5 (31.3%)	344 (93.7%)
In another country in the EU	7 (3.2%)	0 (0%)	6 (37.5%)	13 (2.6%)
Born in another country outside the EU	5 (2.3%)	0 (0%)	5 (31.3%)	10 (2.7%)
Citizen of country, *n (%)*				
Citizen of the country of residence	210 (95.0%)	130 (100%)	13 (81.3%)	353 (96.2%)
No citizenship of the country of residence but that of another EU member state	8 (3.6%)	0 (0%)	2 (12.5%)	10 (2.7%)
No citizenship of the country of residence but that	3 (1.4%)	0 (0%)	1 (6.3%)	4 (1.1%)

of a country outside the EU				
Both parents born in Germany, *n (%)*				
Yes	173 (78.3%)	130 (100%)	1 (6.3%)	304 (82.8%)
No	48 (21.7%)	0 (0%)	15 (93.8%)	63 (17.2%)
Duration of stay in the country of residence, *mean years (SD)*	36.3 (17.5)	56.2 (21.9)	49.4 (17.7)	44.0 (21.3)
Highest level of education completed (ISCED), *n (%)*				
Early childhood education (ages 3 and above), including pre-primary education and early childhood educational development (under 3). (ISCED 0)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Primary education (also known as elementary or basic education). (ISCED 1)	12 (5.4%)	12 (9.2%)	1 (6.3%)	25 (6.8%)
Lower secondary education (also known as middle or junior high). (ISCED 2)	53 (24.0%)	44 (33.8%)	3 (18.8%)	103 (27.2%)
Upper secondary education (also known as senior	58 (26.2%)	21 (16.2%)	0 (0%)	79 (21.5%)

high or high school). (ISCED 3)				
Post-secondary non-third level education (education between secondary and tertiary levels). (ISCED 4)	13 (5.9%)	7 (5.4%)	0 (0%)	20 (5.5%)
Short-cycle third level education (programs typically lasting 2-3 years and leading to qualifications at a lower level than a bachelor's degree). (ISCED 5)	21 (9.5%)	12 (9.2%)	4 (25%)	37 (10.1%)
Bachelor's or equivalent level (first degree or equivalent in higher education). (ISCED 6)	43 (19.5%)	13 (10.0%)	1 (6.3%)	57 (15.5%)
Master's or equivalent level (second degree or equivalent in higher education). (ISCED 7)	18 (8.1%)	16 (12.3%)	5 (31.3%)	39 (10.7%)

Doctoral or equivalent level (highest level of higher education, typically leading to a PhD (ISCED 8)	2 (0.9%)	5 (3.8%)	2 (12.5%)	9 (2.5%)
Missing	1 (0.5%)	0 (0%)	0 (0%)	1 (0.3%)
Use of mental health care in the previous 12 months, *n (%)*				
Yes	183 (82.8%)	112 (86.2%)	11 (68.8%)	306 (83.4%)
No	38 (17.2%)	18 (13.8%)	5 (31.3%)	61 (16.6%)

Comparison of the Levesque dimensions between the groups

Availability and accommodation

Figure 149 presents the results for items related to the Availability and Accommodation dimension of access to mental health services. No statistically significant differences were observed between population groups for several items within this dimension. Specifically, no group differences were identified in reported awareness of mental health services in the local area, time required to travel to the location of mental health services, availability of private space for receiving care and discussing concerns openly, or knowledge of where to seek immediate help during a mental health crisis (all p-values > 0.05). These findings suggest that, across groups, respondents reported broadly similar experiences in relation to these aspects of service availability and physical accessibility.

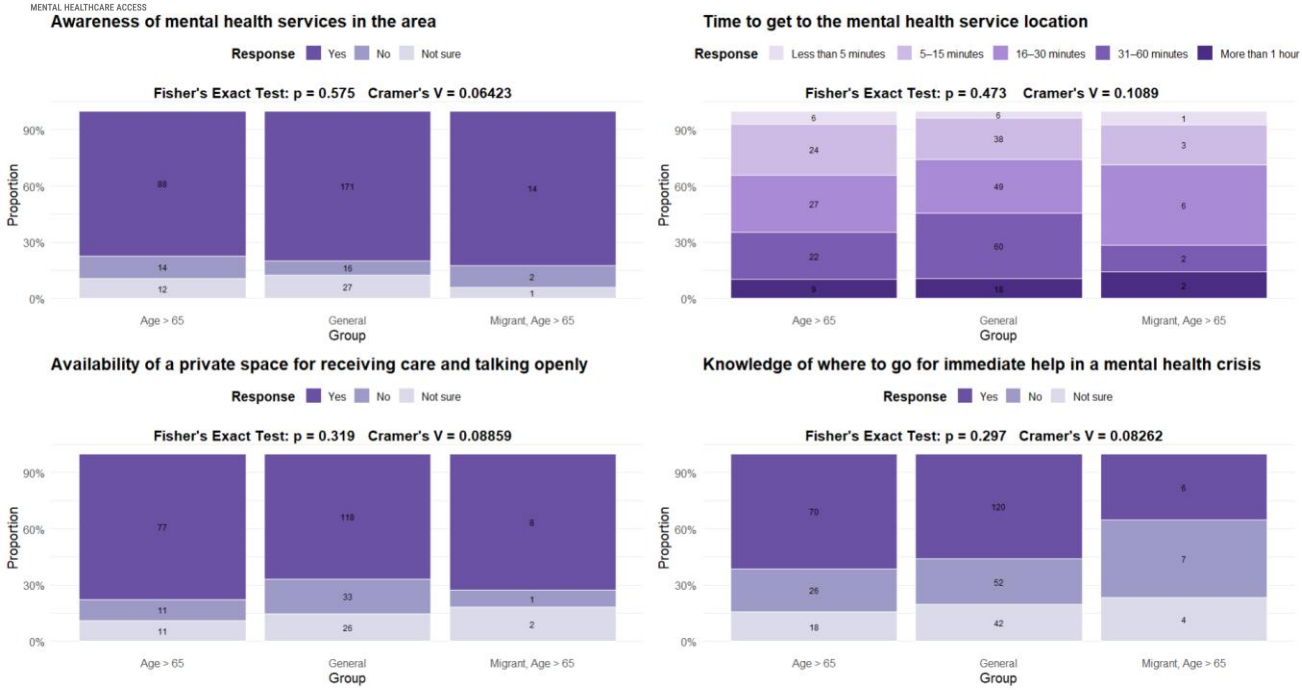

Figure 147: Non-significant differences across groups for the Availability & Accommodation dimension in Germany

In contrast, a statistically significant association was observed for the item concerning time required to obtain an appointment when mental health care was needed (Figure 150; Table 142), with a p-value below the significance threshold of 0.05. Pairwise comparisons indicated that this difference was primarily driven by variation between the general population group and the elderly group. However, the corresponding Cramer's V value indicated a small effect size, suggesting that although the difference between groups was statistically significant, the practical magnitude of the association was limited. This implies that while elderly respondents reported somewhat different experiences regarding appointment waiting times compared to the general population, the overall strength of this relationship was relatively small.

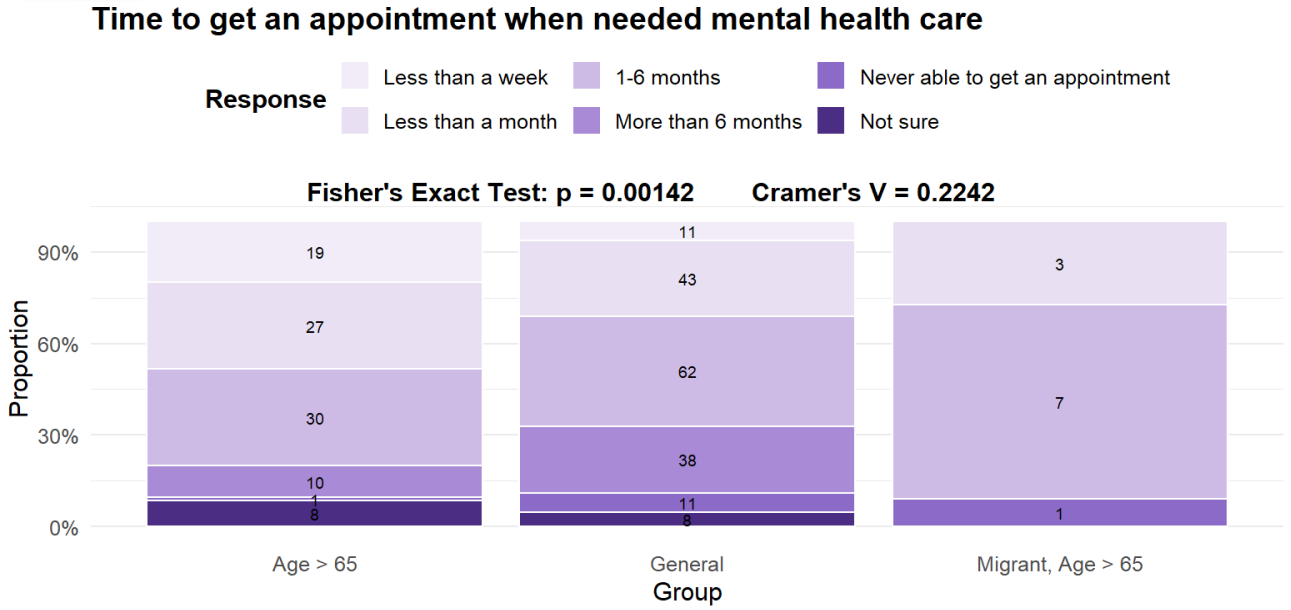

Figure 148: Fisher's exact test of the time to get an appointment when needed mental health care item in Germany

Table 152: Pairwise comparison test of the time to get an appointment when needed mental health care item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.006	0.277
Age > 65 : Migrant, Age > 65	0.121	0.316
General Group : Migrant, Age > 65	0.303	0.179

Approachability

Within the Approachability dimension, none of the analysed items showed statistically significant differences between population groups, as presented in Figure 151 and Figure 152 (all p-values > 0.05). This indicates that reported experiences related to the availability and accessibility of information about mental health services were comparable across the studied groups. Specifically, no significant differences were observed between groups regarding whether respondents had encountered information about accessing mental health support, found information about mental health services easy to understand, or experienced difficulties in locating reliable information. Similarly, responses did not differ significantly between groups with respect to being asked about mental wellbeing during encounters with family doctors, school counsellors, or social workers. No group differences were identified in exposure to outreach programs, awareness of experiences shared by other patients, or invitations to participate in research related to mental health.

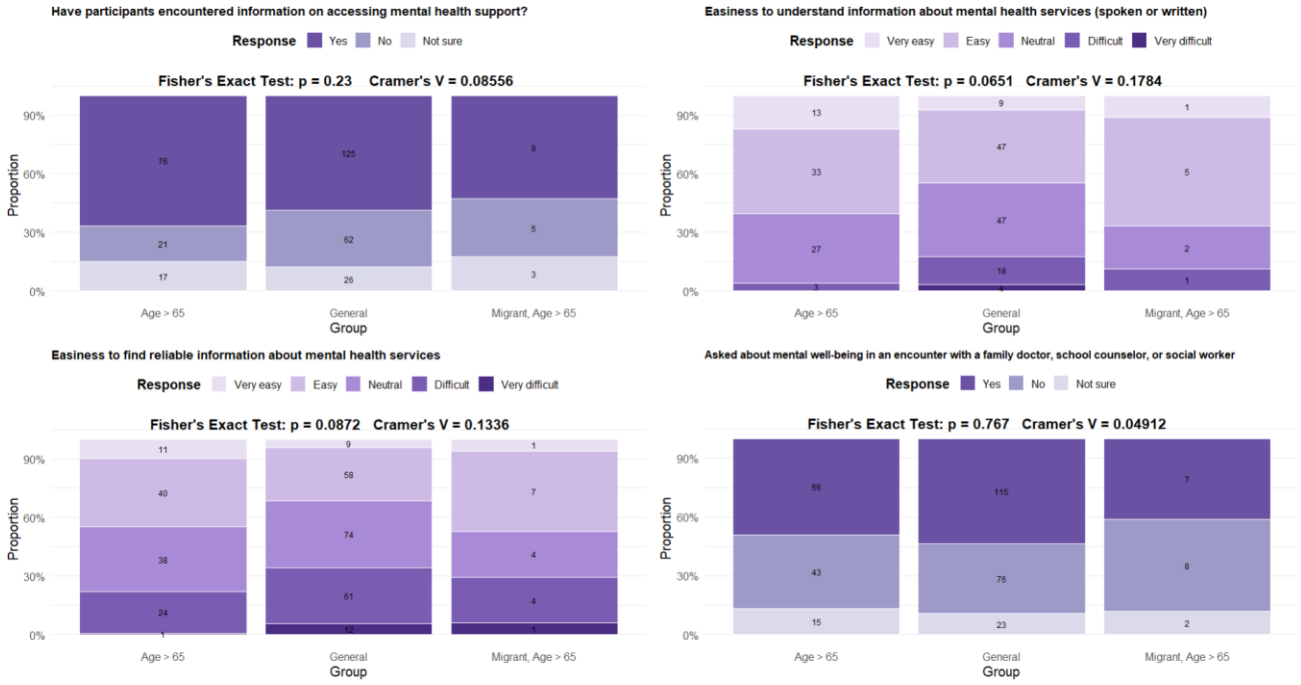

Figure 149: Non-significant differences across groups for the Approachability dimension in Germany (1)

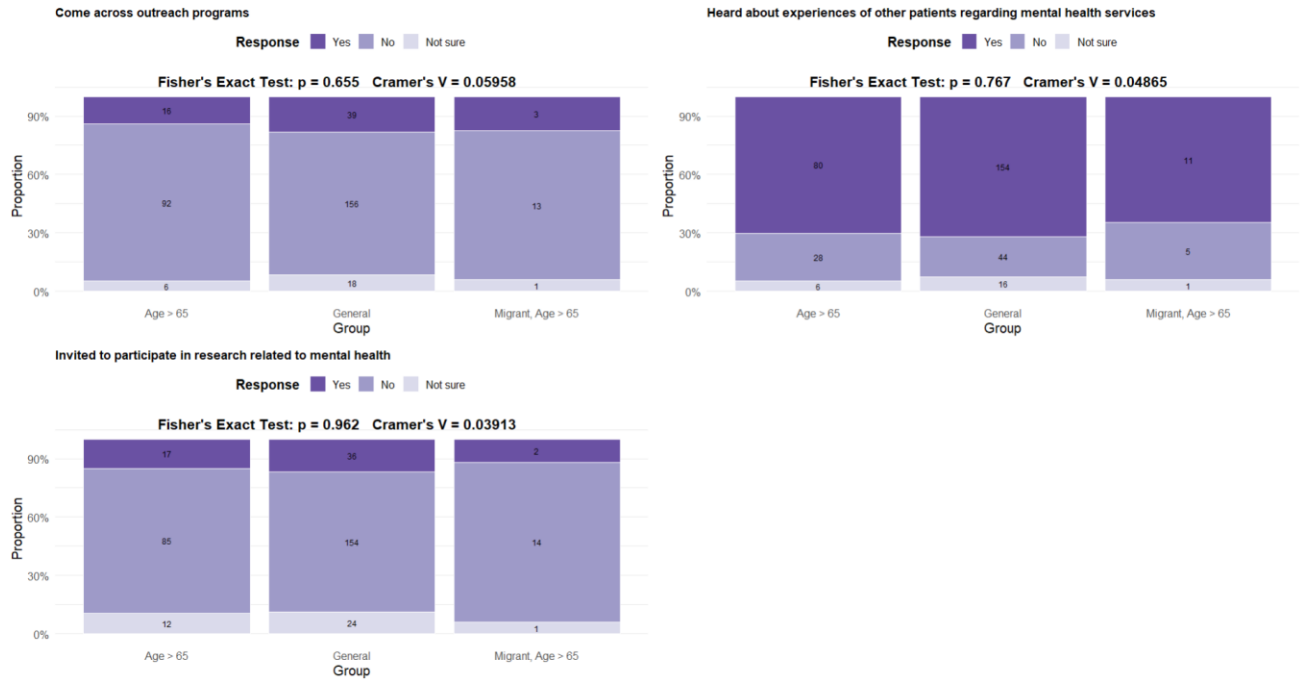

Figure 150: Non-significant differences across groups for the Approachability dimension in Germany (2)

Acceptability

Within the Acceptability dimension, most items did not show statistically significant differences between population groups (Figure 152). Specifically, no significant group differences were observed regarding perceptions that mental health services are sensitive to cultural beliefs and

practices, the availability of communication in a preferred language, the possibility to choose one's own doctor or therapist, or whether mental health professionals communicate respectfully with specific population groups (all p-values > 0.05). These findings indicate broadly similar perceptions across groups with respect to cultural sensitivity, communication, and provider interaction.

However, statistically significant differences were observed for two items within this dimension.

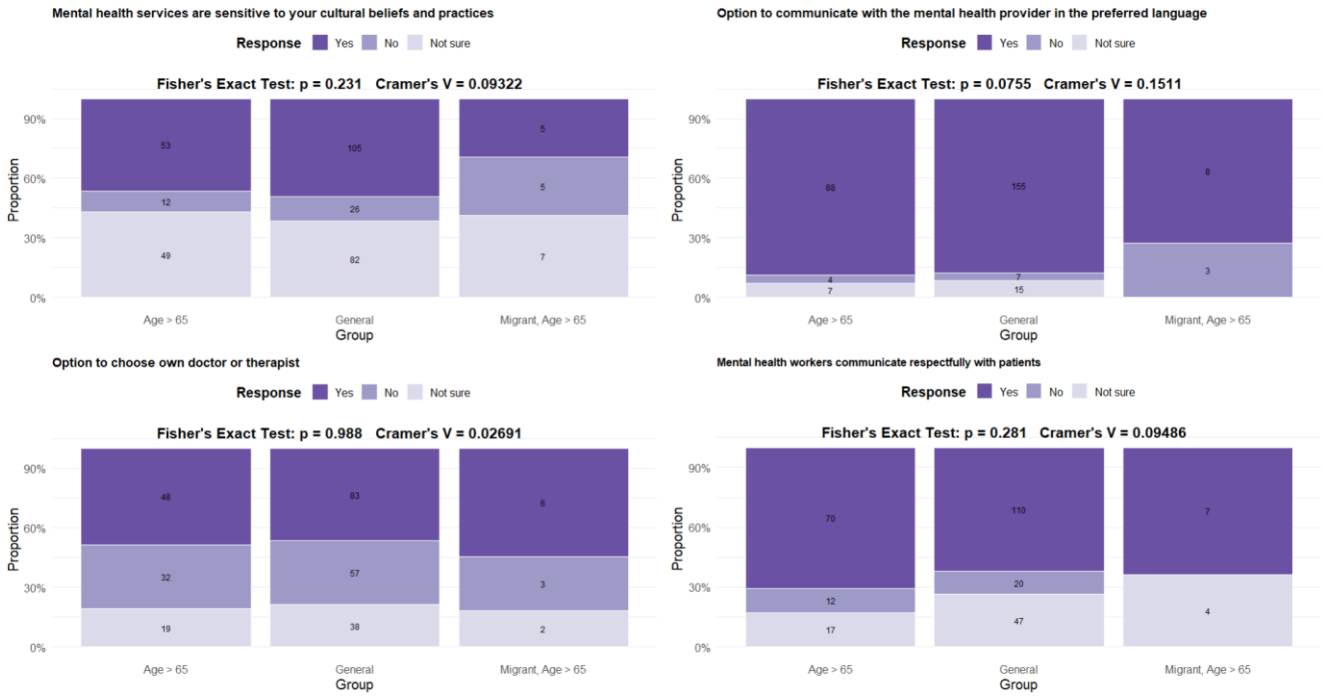

Figure 151: Non-significant differences across groups for the Acceptability dimension in Germany

First, a significant association was identified for the perception that patients' rights are protected against mistreatment or abuse (Table 153; p = 0.012, Cramer's V = 0.172). Pairwise comparisons indicated that this difference was primarily driven by variation between the elderly group without migrant status and the general population group. Descriptive results (Figure 153) showed that a higher proportion of respondents in the elderly group without migrant status reported that patient rights were adequately protected compared to the general population. The effect size was small, indicating that although the difference was statistically significant, its magnitude was limited.

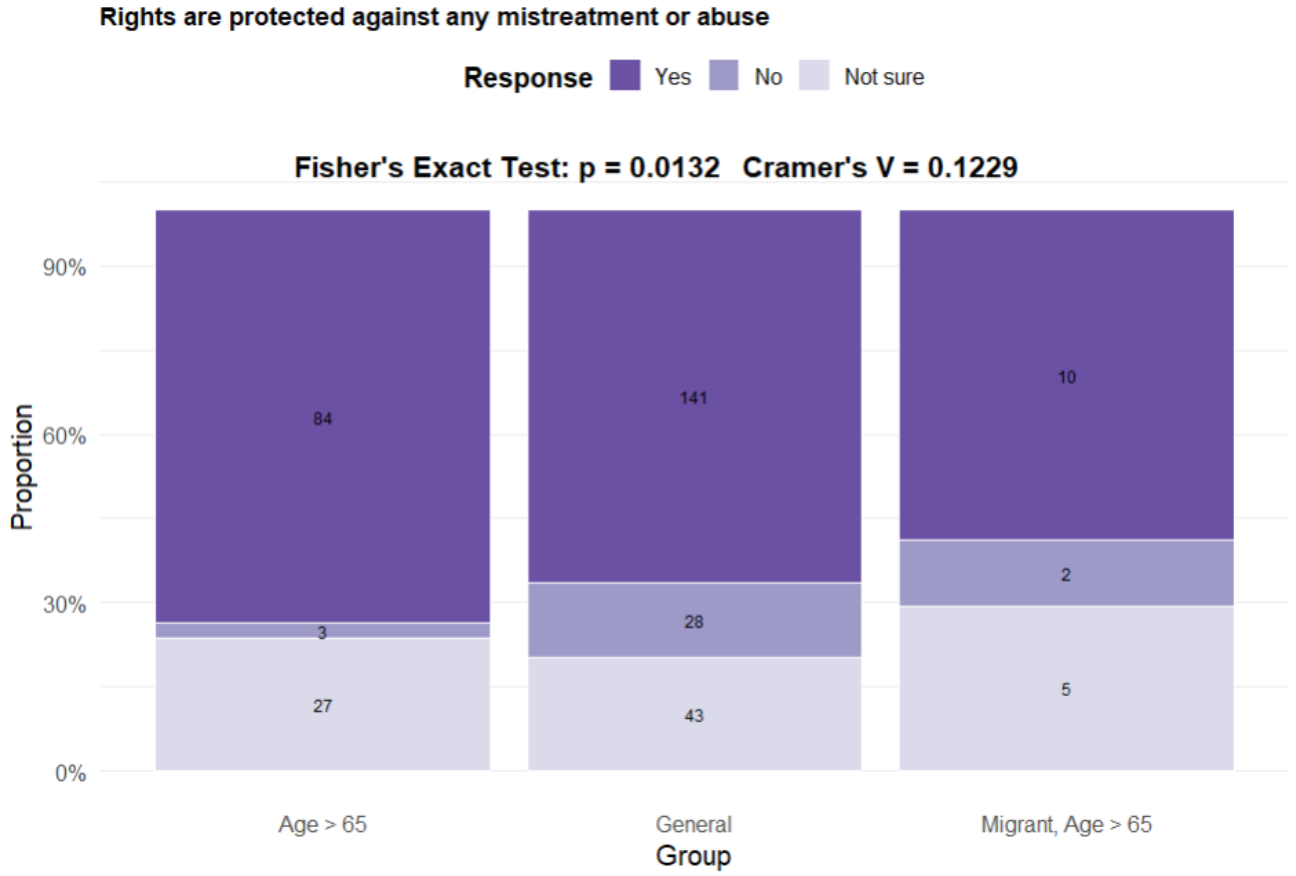

Figure 152: Fisher's exact test of the rights are protected against any mistreatment or abuse item in Germany

Table 153: Pairwise comparison of the rights are protected against any mistreatment or abuse item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.012	0.172
Age > 65 : Migrant, Age > 65	0.228	0.172
General Group : Migrant, Age > 65	0.611	0.059

Second, statistically significant differences were found regarding perceptions that mental health services are trustworthy. These differences were primarily observed between the general population group and the elderly group with migrant status (p = 0.038, Cramer's V = 0.244), as well as between the elderly group without migrant status and the elderly group with migrant status (p = 0.0021, Cramer's V = 0.279) (Table 154). In both cases, respondents belonging to the elderly group with migrant status reported lower levels of trust in mental health services compared to the other groups (Figure 155). The corresponding effect sizes indicate small to moderate associations, suggesting that while differences were present, they were not large in magnitude.

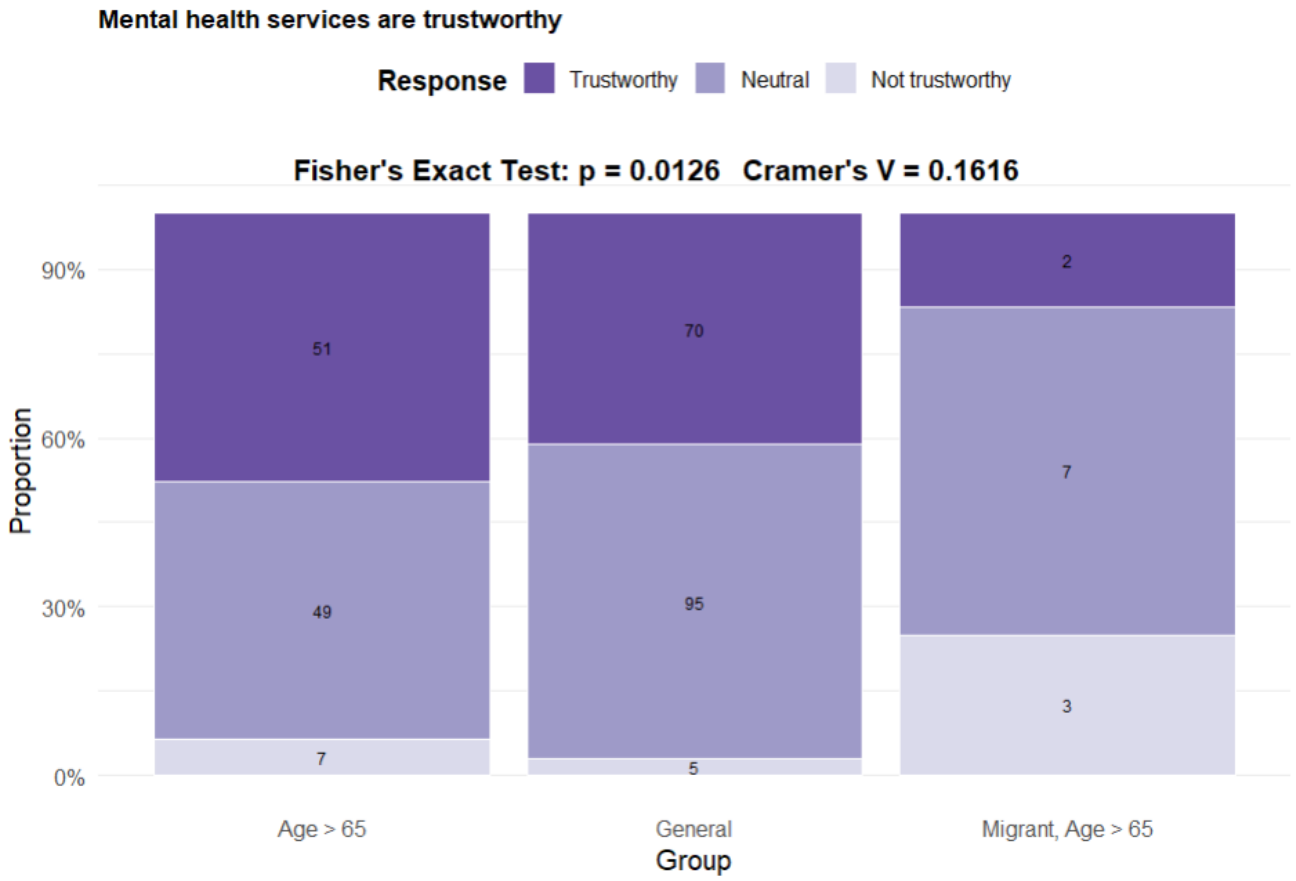

Figure 153: Fisher's exact test of the mental health services are trustworthy item in Germany

Table 154: Pairwise comparison test of the mental health services are trustworthy item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.155	0.188
Age > 65 : Migrant, Age > 65	0.038	0.244
General Group : Migrant, Age > 65	0.021	0.279

Affordability

Within the Affordability dimension, most items did not show statistically significant differences between population groups. Specifically, no significant differences were observed regarding the ability to obtain mental health services through public programs or low-cost services, health insurance coverage for mental health services, instances of not taking prescribed medication due to costs, being offered financial support or discounts to reduce the costs of care, or receiving

assistance with payment options, insurance-related questions, or financial support (Figure 155 and Figure 156; all p-values > 0.05). These findings indicate broadly comparable experiences across groups regarding general financial support structures and insurance coverage.

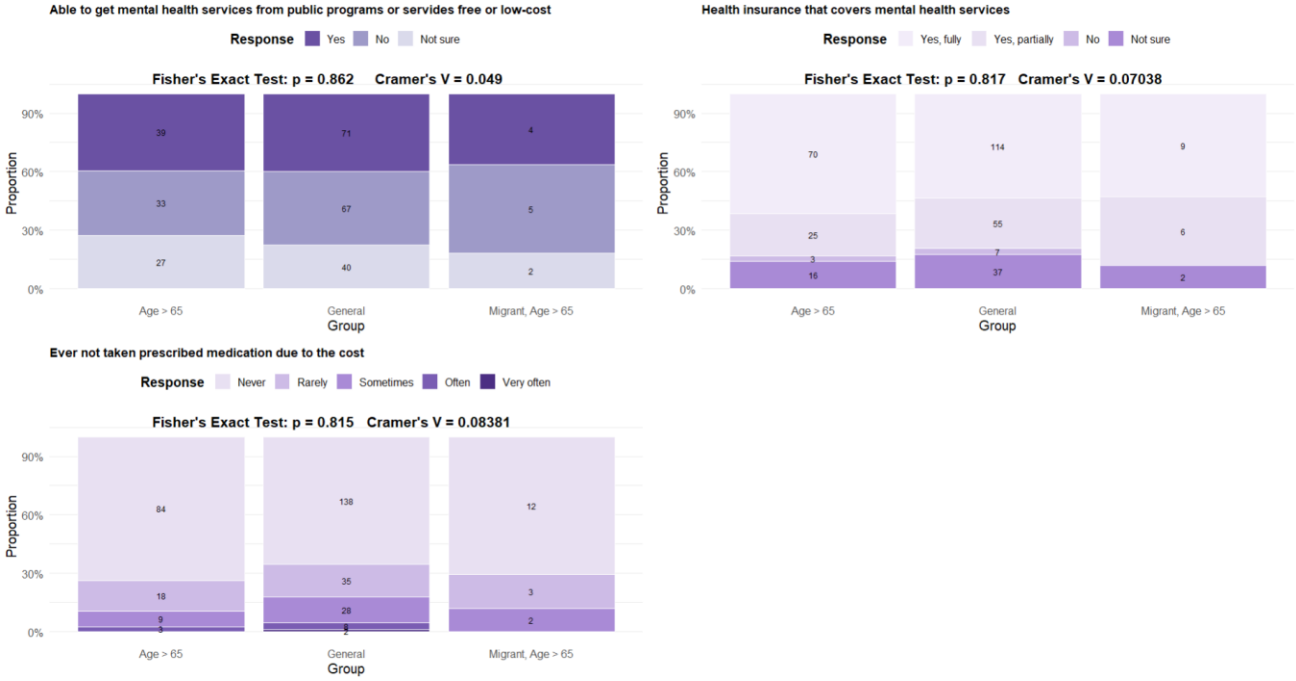

Figure 154: Non-significant differences across groups for the Affordability dimension in Germany (1)

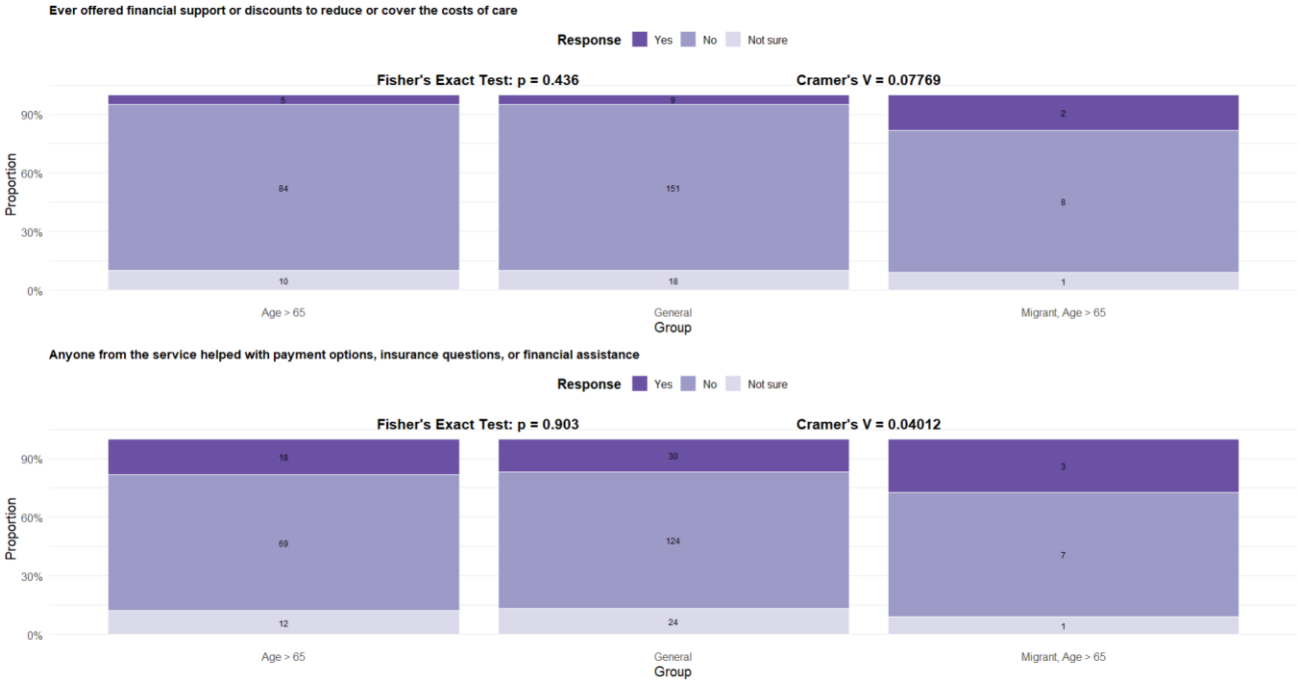

Figure 155: Non-significant differences across groups for the Affordability dimension in Germany (2)

However, statistically significant differences were observed for several cost-related barriers. First, a significant association was identified for delayed or avoided mental health care due to costs in the past 12 months (Table 155; p = 0.011, Cramer's V = 0.163). Pairwise comparisons indicated that this difference was primarily driven by variation between the elderly group without migrant status and the general population group. Descriptive results showed that a higher proportion of respondents in the general population reported delaying or avoiding mental health care due to financial constraints compared to the elderly group (Figure 158). The effect size was small, indicating that although statistically significant, the magnitude of the association was limited.

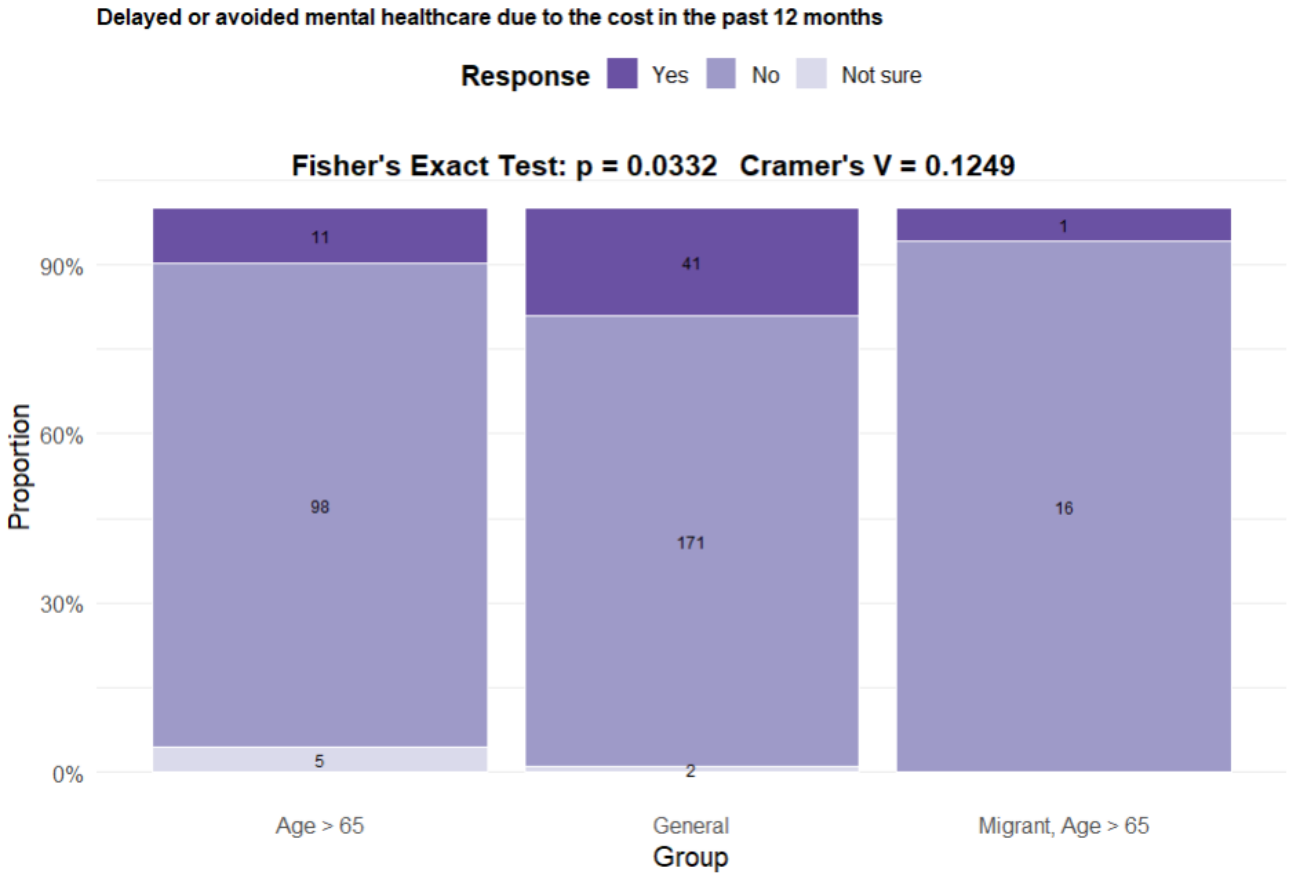

Figure 156: Fisher's exact test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Germany

Table 155: Pairwise comparison test of the delayed or avoided mental healthcare due to the cost in the past 12 months item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.011	0.163
Age > 65 : Migrant, Age > 65	1.000	0.091
General Group : Migrant, Age > 65	0.395	0.095

Second, statistically significant differences were found regarding difficulties accessing mental health care due to additional costs (Table 156; p = 0.015, Cramer's V = 0.215). This difference was again primarily observed between the elderly group without migrant status and the general population group, with a higher proportion of elderly respondents reporting difficulties related to additional costs (Figure 159). The corresponding effect size indicates a small association.

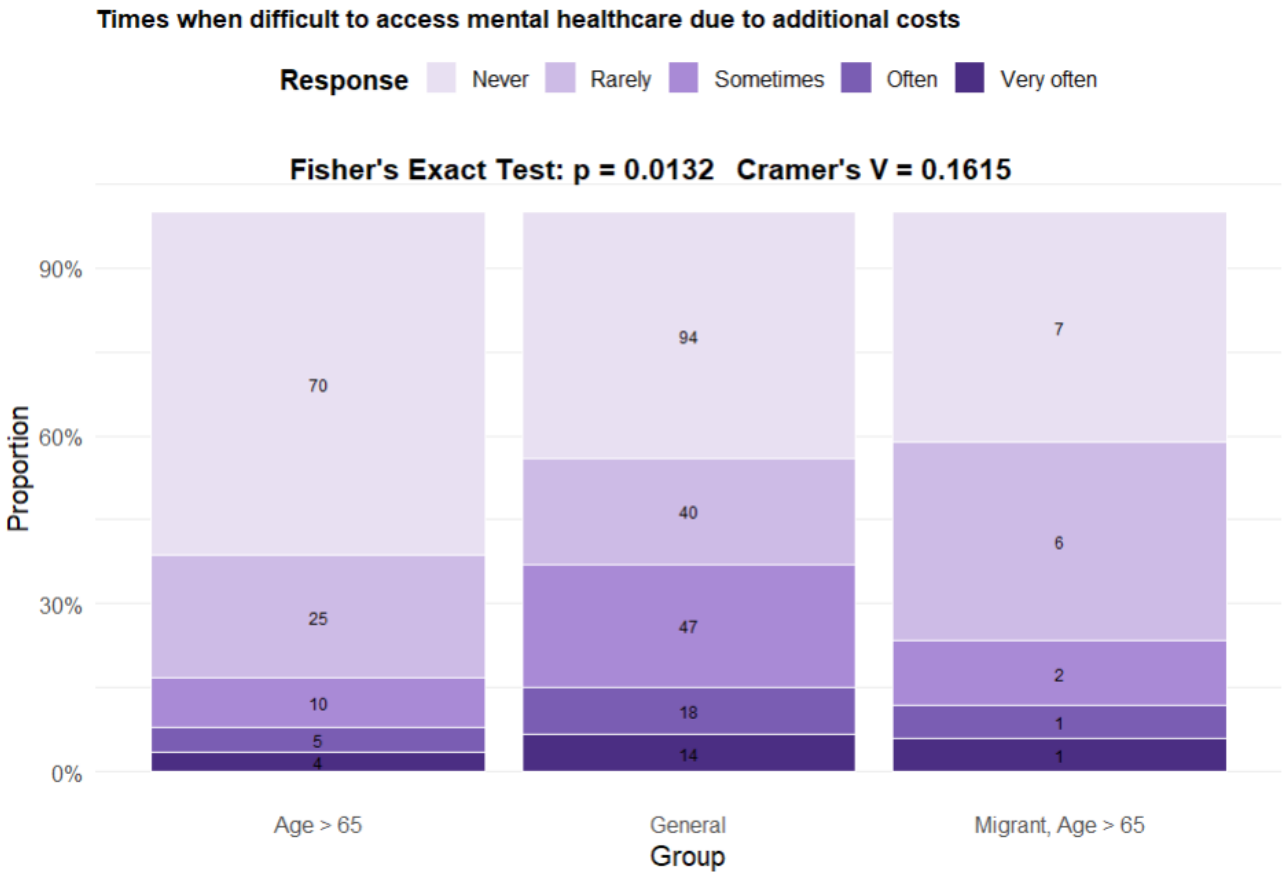

Figure 157: Fisher's exact test of the times when difficult to access mental healthcare due to additional costs item in Germany

Table 156: Pairwise comparison test of the times when difficult to access mental healthcare due to additional costs item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.015	0.215
Age > 65 : Migrant, Age > 65	0.544	0.140

General Group : Migrant, Age > 65	0.563	0.116

Third, a significant difference was identified for difficulties accessing mental health care due to loss of income (Table 157; p = 0.011, Cramer's V = 0.204). This difference was also primarily observed between the elderly group without migrant status and the general population group, with elderly respondents reporting more frequent financial barriers related to income loss (Figure 160). The effect size was small, suggesting limited but meaningful differences between groups.

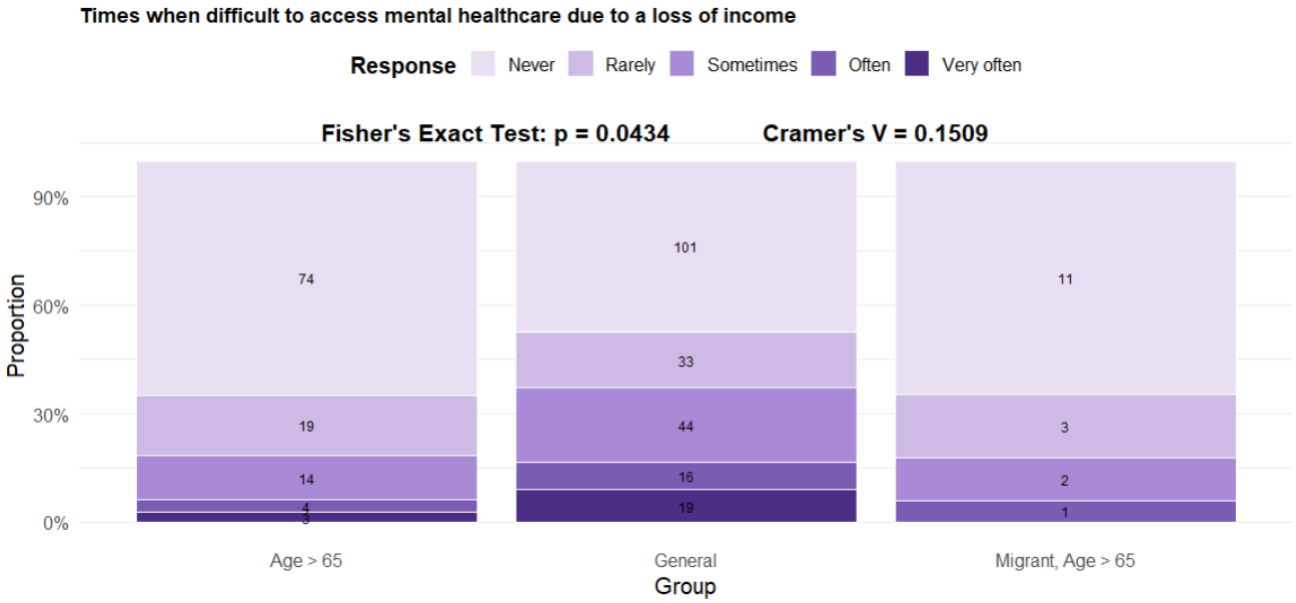

Figure 158: Fisher's exact test of the times when difficult to access mental healthcare due to a loss of income item in Germany

Table 157: Pairwise comparison test of the times when difficult to access mental healthcare due to a loss of income item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.011	0.204
Age > 65 : Migrant, Age > 65	0.948	0.072
General Group : Migrant, Age > 65	0.624	0.118

Appropriateness

Across the Appropriateness dimension, most items did not demonstrate statistically significant differences between population groups. This included items related to whether providers spent

sufficient time during consultations, whether services were perceived as helpful or relevant, and whether cultural beliefs and practices were taken into account during treatment. Similarly, no differences were identified in relation to providers considering broader life circumstances, involvement in treatment planning, ease of arranging follow-up appointments, the possibility to consistently see the same provider, or perceptions that user feedback contributed to service improvement (Figures 161, 162, and 163; all p-values > 0.05). Together, these findings suggest that perceptions of care relevance, continuity, and patient involvement were largely consistent across groups.

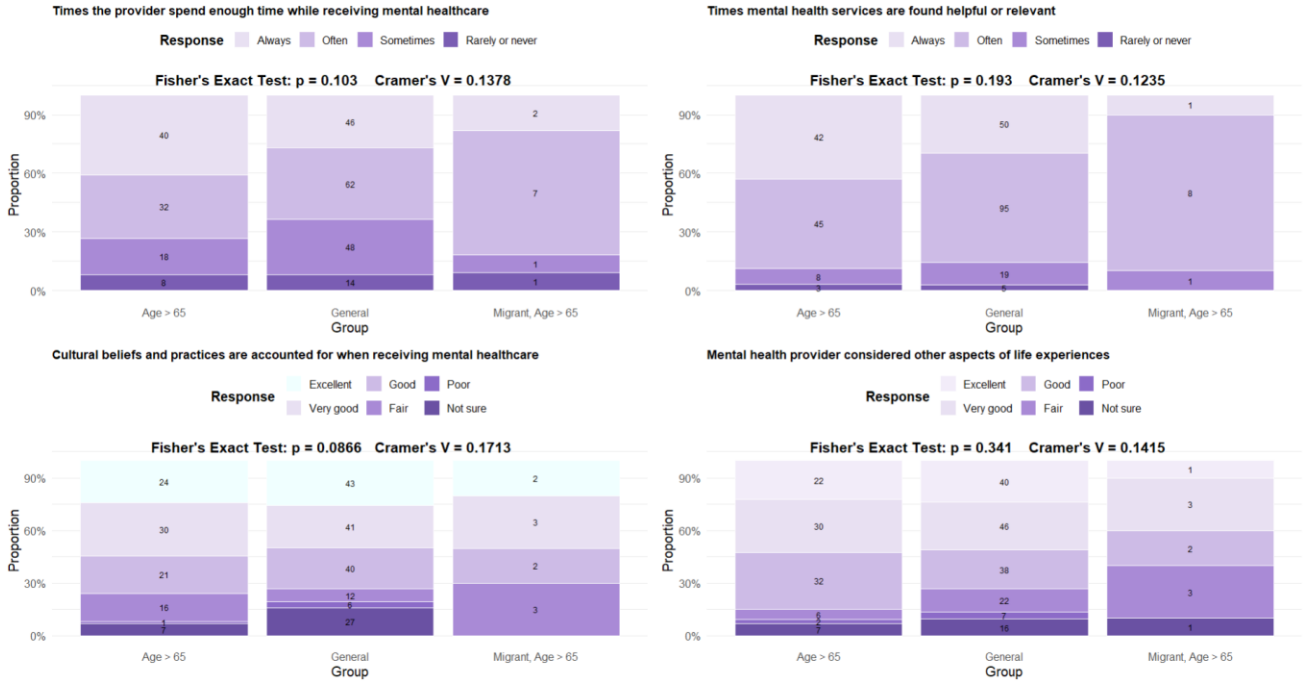

Figure 159: Non-significant differences across groups for the Appropriateness dimension in Germany (1)

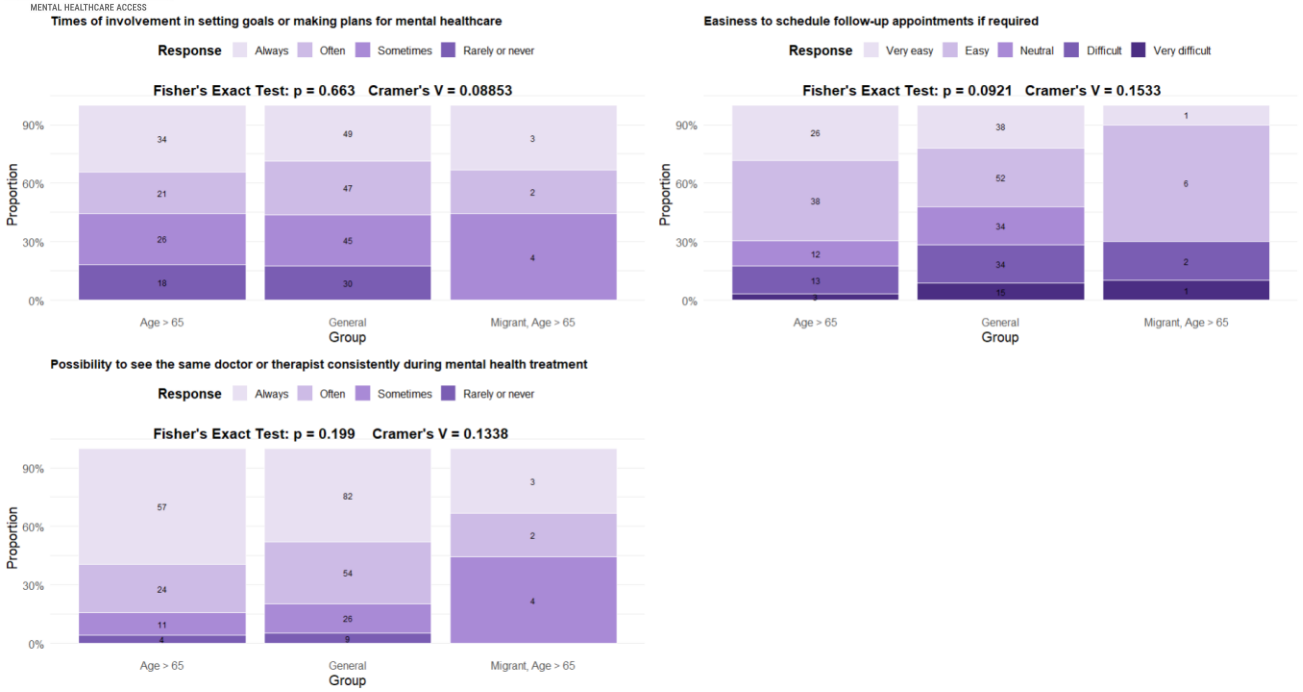

Figure 160: Non-significant differences across groups for the Appropriateness dimension in Germany (2)

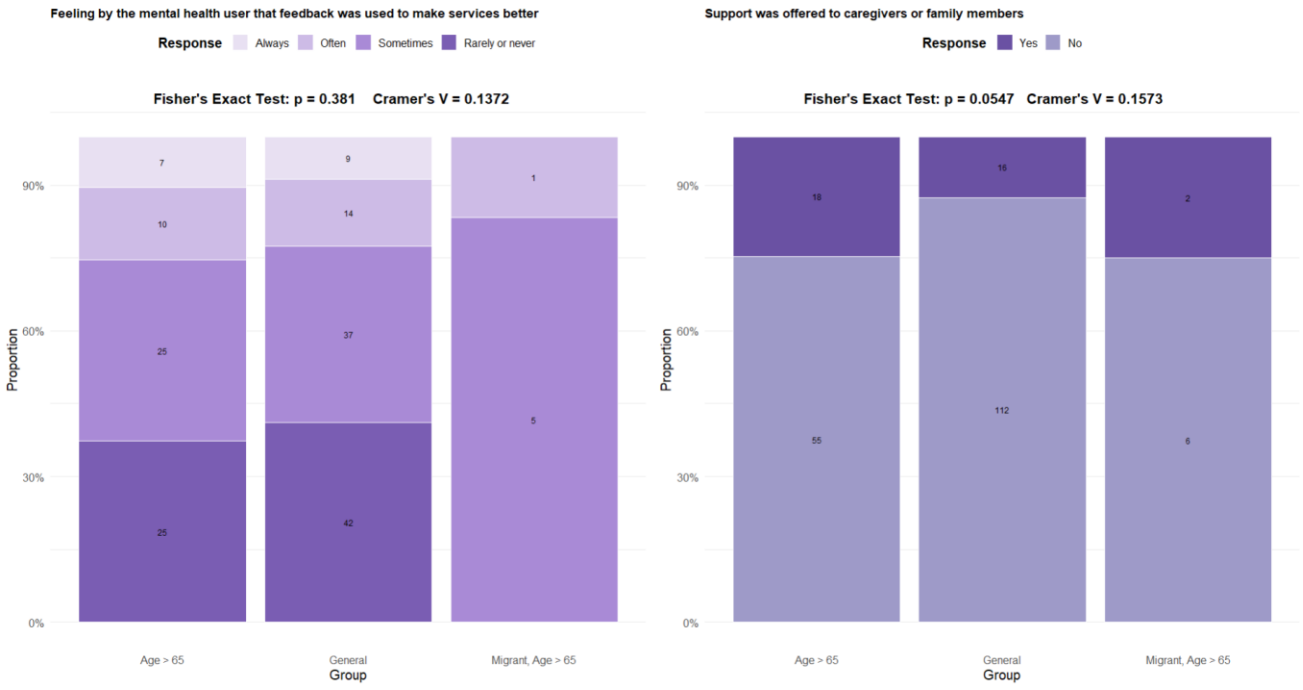

Figure 161: Non-significant differences across groups for the Appropriateness dimension in Germany (3)

Nevertheless, several aspects of communication and service coordination showed statistically significant differences between groups. A significant difference was observed for the item assessing whether mental health professionals treated clients with courtesy and respect during care (p = 0.035, Cramer's V = 0.192; Table 158). This difference was mainly observed between the general population group and the elderly group without migrant status, with elderly respondents more frequently reporting respectful treatment (Figure 164). Although statistically significant, the corresponding effect size indicates that the strength of this association was modest.

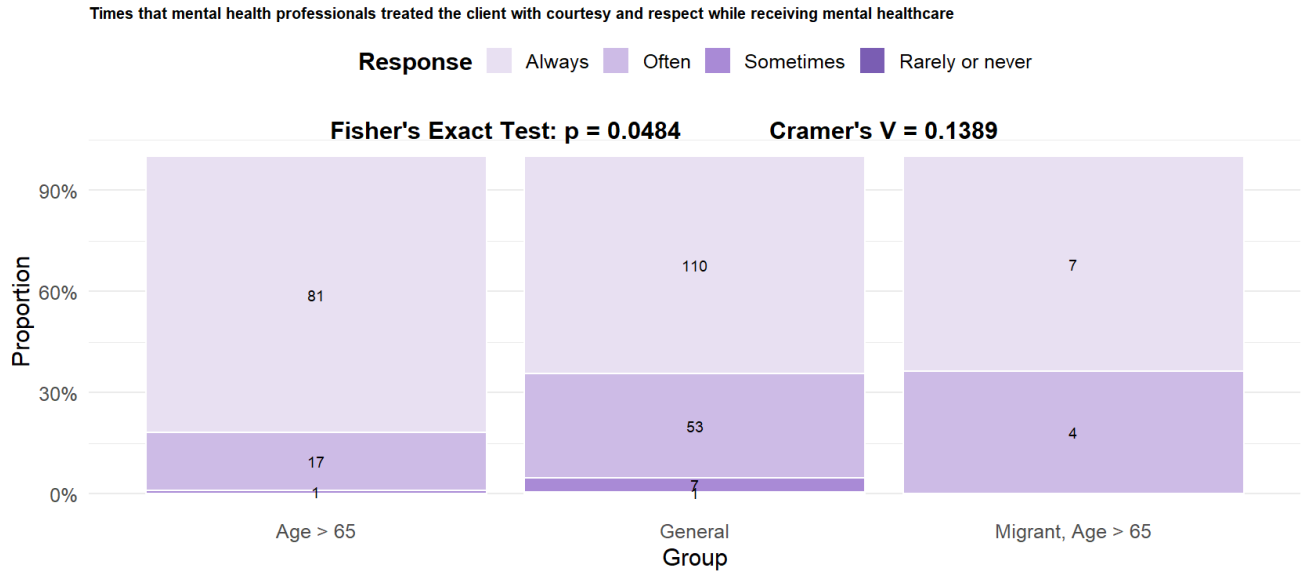

Figure 162: Fisher's exact test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare

Table 158: Pairwise comparison test of the times that mental health professionals treated the client with courtesy and respect while receiving mental healthcare in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.035	0.192
Age > 65 : Migrant, Age > 65	0.442	NC
General Group : Migrant, Age > 65	0.854	0.058

Differences were also identified in relation to whether mental health professionals explained information in an understandable way (Table XX). In this case, significant differences were observed between the general population and both elderly groups, including elderly respondents

with and without migrant status (p = 0.001, Cramer's V = 0.186; p = 0.0495, Cramer's V = 0.200; Table 159). In both comparisons, elderly respondents reported clearer explanations more frequently than respondents from the general population (Figure 165).

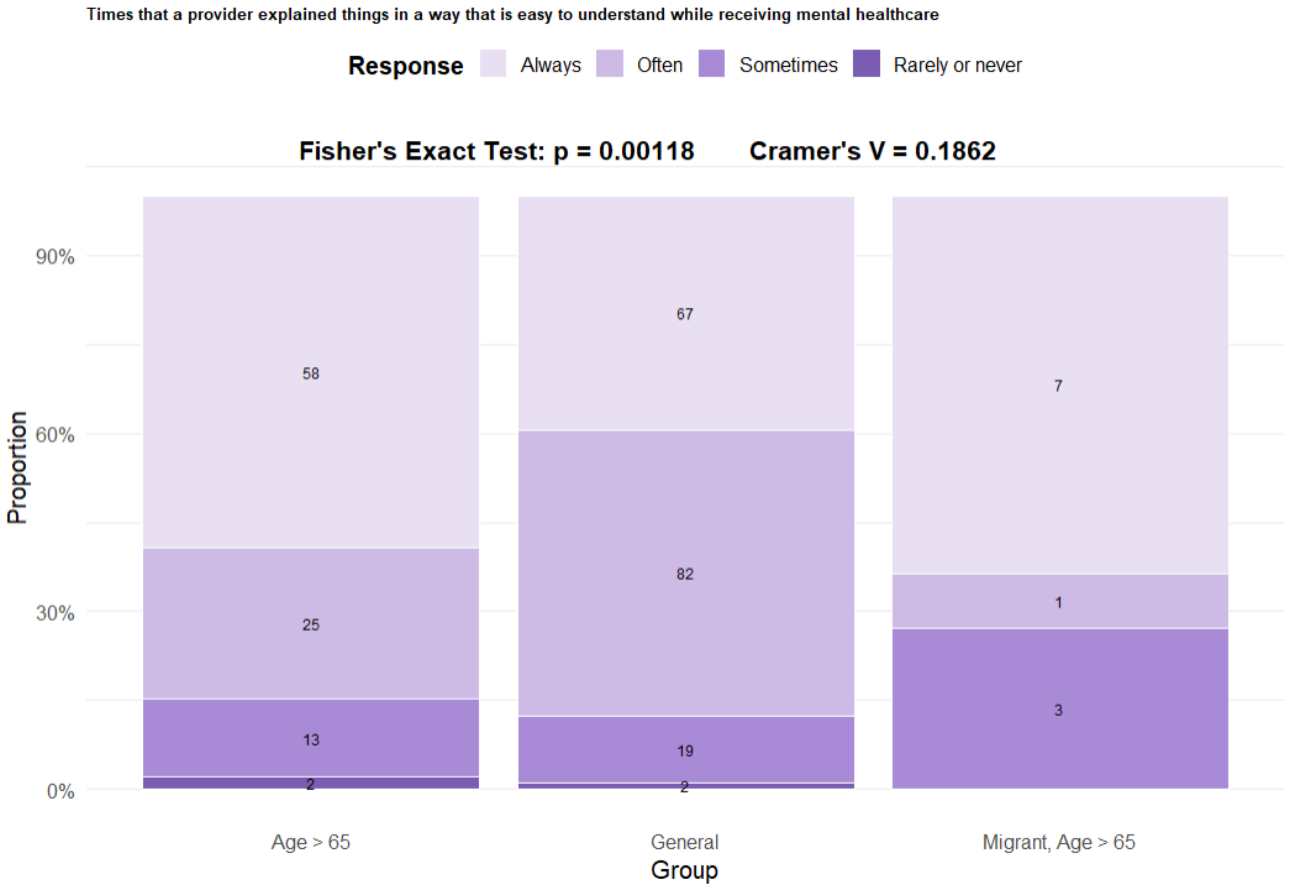

Figure 163: Fisher's exact test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Germany

Table 159: Pairwise comparison test of the times that a provider explained things in a way that is easy to understand while receiving mental healthcare item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.0011	0.224
Age > 65 : Migrant, Age > 65	0.407	0.157
General Group : Migrant, Age > 65	0.0495	0.200

Furthermore, experiences related to coordination between services differed between groups. Specifically, the item assessing whether referrals between professionals occurred smoothly, without requiring users to repeatedly explain their situation, showed significant variation These differences were primarily observed between the general population and the elderly group without migrant status, with elderly respondents more often reporting smoother referral processes (p = 0.0053, Cramer's V = 0.218) (Figure 166; Table 160).

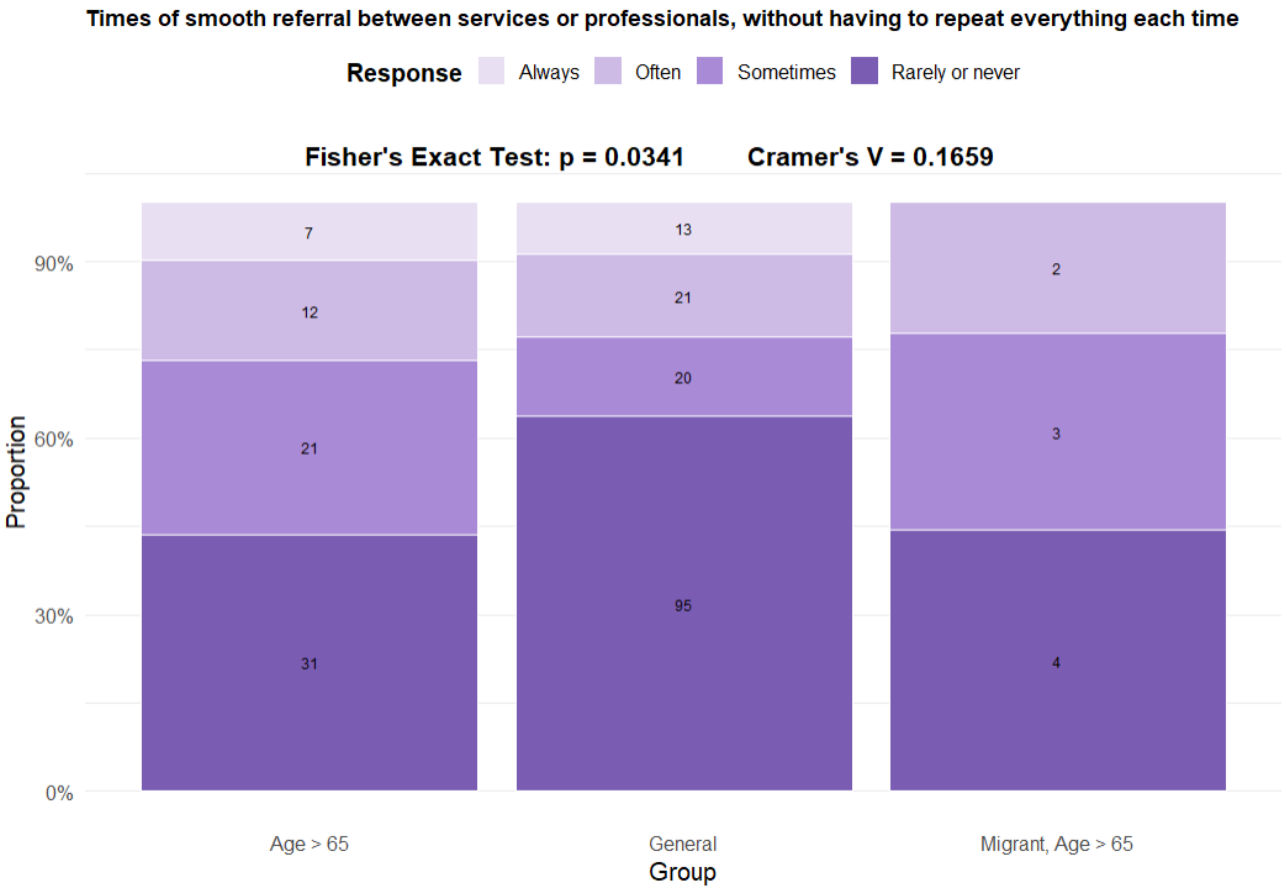

Figure 164: Fisher's exact test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Germany

Table 160: Pairwise comparison test of the times of smooth referral between services or professionals, without having to repeat everything each time item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.0053	0.218
Age > 65 : Migrant, Age > 65	0.951	0.115
General Group : Migrant, Age > 65	0.304	0.159

Finally, statistically significant differences were also found for the item assessing whether mental health users received invitations to provide feedback regarding their mental health treatment. This difference was mainly driven by variation between the general population group and the elderly group without migrant status, with elderly respondents more frequently reporting that they were invited to provide feedback on their care (Table 161; Figure 167; p = 0.029, Cramer's V = 0.232). The effect size indicates a small association, suggesting that although the difference was statistically significant, the magnitude of the relationship was modest.

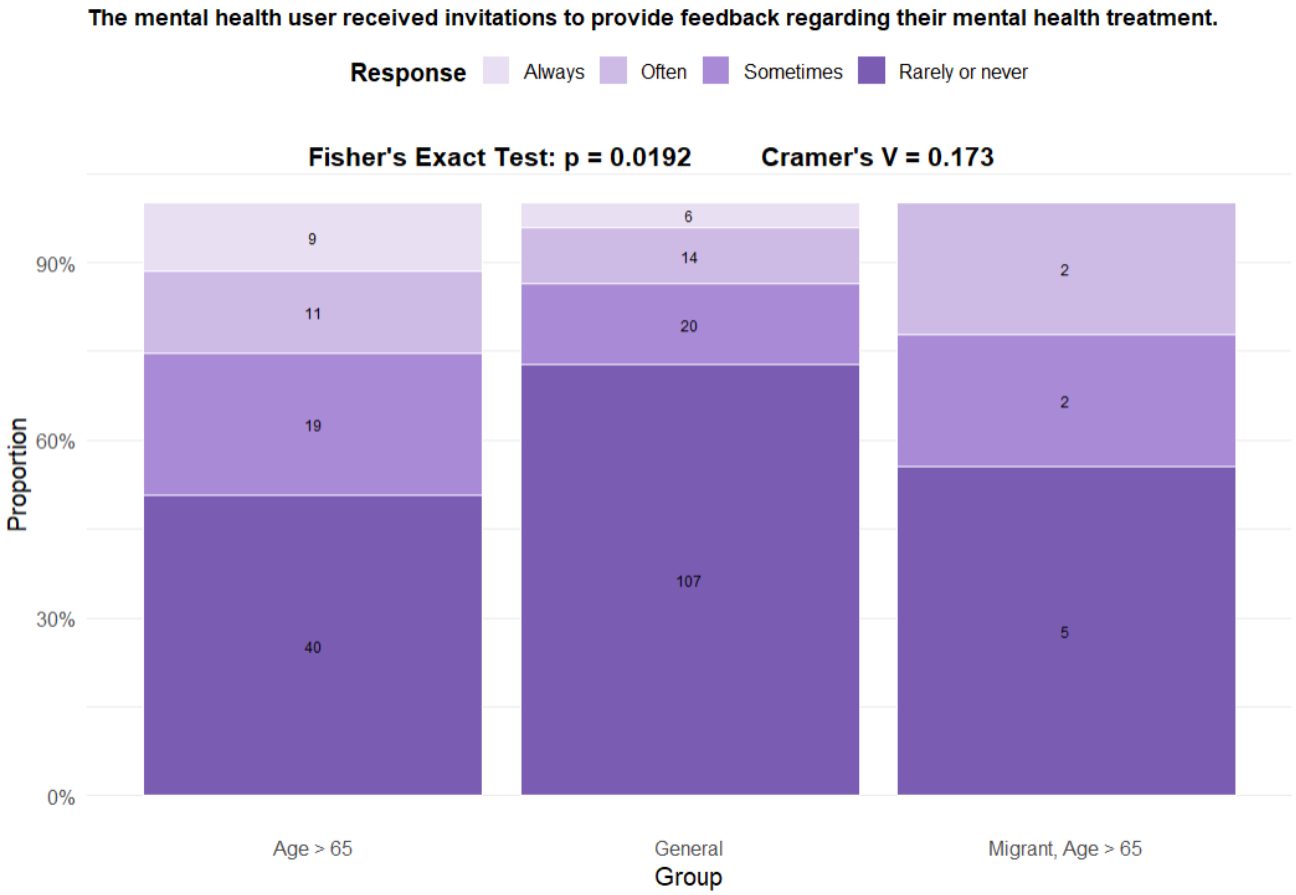

Figure 165: Fisher's exact test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Germany

Table 161: Pairwise comparison test of the mental health user received invitations to provide feedback regarding their mental health treatment item in Germany

Comparison	P Value adjusted Fisher test	Cramer's V
Age > 65 : General Group	0.029	0.232

Age > 65 : Migrant, Age > 65	0.795	0.128
General Group : Migrant, Age > 65	0.580	0.127

Participant-reported health, unmet need for care, and triangulation

Participant-reported health outcomes and unmet healthcare needs were compared with national reference values from German population-based datasets to contextualise findings and support triangulation. External reference data included EU-SILC Germany[12–14], EHIS Germany[15], and published German EQ-5D population norm datasets[20,21].

Health-related quality of life

The overall EQ-5D-5L utility score in the study population was 0.628 (SD = 0.302). Group-specific mean values were 0.653 (SD = 0.255) for the general group, 0.607 (SD = 0.353) for older adults aged 65 years and above, and 0.404 (SD = 0.311) for older adults aged 65 years and above with migrant status. When compared with national population norms derived from a German general adult population telephone survey dataset[18], which indicated a mean EQ-5D utility value of 0.88, utility values in the present dataset were descriptively lower across all groups. Similarly, comparison with reference values derived from a German elderly population dataset[17],which reported a mean utility value of 0.84, showed that utility scores in the present dataset remained lower across all population groups, with the lowest mean observed among older adults with migrant status.

Self-perceived health

Patterns of self-perceived health were examined using items aligned with those included in EU-SILC Germany[12]. Within the present dataset, relatively large proportions of respondents rated their health as fair or bad, particularly among older adults and older adults with migrant status (Table 162). For instance, 29.0% of the general group, 26.9% of older adults, and 37.5% of older adults with migrant status reported bad health. In contrast, EU-SILC Germany reference data showed smaller proportions reporting poor health and substantially higher proportions reporting good or very good health across comparable population groups (Table 163). Overall, the distribution of self-perceived health in the study sample reflected less favourable health ratings compared with national EU-SILC Germany benchmarks.

Table 162: Self-perceived health in the dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Very bad, %	9 (4.1)	5 (3.8)	1 (6.3)
Bad, %	64 (29.0)	35 (26.9)	6 (37.5)
Fair (neither good nor bad), %	87 (39.4)	55 (42.3)	6 (37.5)
Good, %	33 (14.9)	18 (13.8)	2 (12.5)
Very good, %	6 (2.7)	1 (0.8)	1 (6.3)
Missing, %	22 (10.0)	16 (12.3)	0 (0.0)

Table 163: Self-perceived health in the dataset of EU-SILC Germany

	General group	Age > 65	Migrant, Age > 65
Very bad, %	1.8	4.6	5.5
Bad, %	5.8	15.6	20.5
Fair (neither good nor bad), %	18.5	41.2	42.1
Good, %	53.3	35.1	29.0
Very good, %	23.2	3.5	2.9

Activity limitations

Levels of activity limitation were assessed using indicators corresponding to those reported in EU-SILC Germany[14]. A considerable proportion of respondents in the study population reported functional limitations. In particular, 27.6% of the general group, 20.8% of older adults, and 25.0% of older adults with migrant status reported being severely limited, while approximately half of respondents reported some level of limitation (Table 164). By comparison, EU-SILC Germany data indicated substantially lower levels of severe limitation and higher proportions of individuals reporting no activity limitations (Table 165). These differences were observed consistently across all population groups included in the study.

Table 164: Activity limitations in the dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Severely limited , *n (%)*	61 (27.6)	27 (20.8)	4 (25.0)
Limited, *n (%)*	106 (48.0)	66 (50.8)	10 (62.5)

Not limited, *n (%)*	32 (14.5)	21 (16.2)	2 (12.5)
Missing, *n (%)*	22 (10.0)	16 (12.3)	0 (0.0)

Table 165: Activity limitations in the EU-SILC dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Severely limited, *%*	5.4	18.4	21.2
Limited, *%*	14.8	36.9	39.1
Not limited, *%*	79.8	44.7	39.7

Unmet need for care

Information on unmet need for healthcare was collected using indicators aligned with those included in EU-SILC Germany[15]. Waiting lists emerged as the most frequently reported barrier to accessing care in the present dataset. This reason was reported by 49.8% of the general group, 25.4% of older adults, and 31.3% of older adults with migrant status (Table 166). Additional commonly reported barriers included fear of medical treatment, uncertainty about available providers, and travel-related difficulties. In contrast, national data from EU-SILC Germany indicated that the vast majority of respondents (approximately 99%) reported no unmet healthcare needs, with only small proportions reporting specific barriers such as cost, distance, or waiting times (Table 167).

Table 166: Unmet need for care in the dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Too expensive, *n (%)*	33 (14.9)	6 (4.6)	0.0
Too far to travel, *n (%)*	38 (17.2)	9 (6.9)	11.8
No time, *n (%)*	22 (10.0)	1 (0.8)	0 (0.0)
Didn't know any good doctor or specialist, *n (%)*	40 (18.1)	17 (13.1)	4 (25.0)
Waiting list, *n (%)*	110 (49.8)	33 (25.4)	5 (31.3)
Fear of doctor, hospital	62 (28.1)	17 (13.1)	2 (12.5)

examination or treatment, *n (%)*			
Wanted to wait and see if problem got better on its own, *n (%)*	58 (26.2)	21 (16.2)	4 (25.0)
Other reason, *n (%)*	31 (14.0)	10 (7.8)	2 (12.5)
No unmet needs to declare, *n (%)*	47 (21.3)	50 (38.5)	6 (37.5)
Missing, *n (%)*	22 (10.0)	16 (12.3)	0 (0.0)

Table 167: Unmet need for care in the EU-SILC dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Too expensive, *%*	0.2	0.1	0.3
Too far to travel, *%*	0.0	0.0	0.1
No time, *%*	0.2	0.0	0.0
Didn’t know any good doctor or specialist, *%*	0.0	0.1	0.0
Waiting list, *%*	0.1	0.6	0.7
Fear of doctor, hospital examination or treatment, *%*	0.0	0.0	0.0
Wanted to wait and see if problem got better on its own, *%*	0.1	0.0	0.0
Other reason, *%*	0.2	0.2	0.1

No unmet needs to declare, %	99.1	98.9	98.8

Depression severity

Depression severity levels were assessed using items corresponding to those included in EHIS Germany[16]. Across all groups in the present dataset, relatively high proportions of respondents reported moderate to severe depressive symptoms (Table 168). For example, 18.1% of the general group, 6.2% of older adults, and 25.0% of older adults with migrant status reported severe depressive symptoms. National distributions derived from EHIS Germany showed substantially lower proportions of severe depressive symptoms and higher proportions of respondents reporting no or minimal symptoms (Table 169). These differences were observed across comparable population groups.

Table 168: Depression severity in the dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Severe, *n (%)*	40 (18.1)	8 (6.2)	4 (25.0)
Moderately severe, *n (%)*	44 (19.9)	27 (20.8)	3 (18.8)
Moderate, *n (%)*	52 (23.5)	28 (21.5)	2 (12.5)
Mild, *n (%)*	53 (24.0)	45 (34.6)	6 (37.5)
None or minimum, *n (%)*	10 (4.5)	6 (4.6)	1 (6.3)
Missing, *n (%)*	22 (10.0)	16 (12.3)	0 (0.0)

Table 169: Depression severity in the EHIS dataset of Germany

	General group	Age > 65	Migrant, Age > 65
Severe, %	0.7	0.2	0.0
Moderately severe, %	2.4	0.9	2.1
Moderate, %	6.6	4.1	11.4
Mild, %	23.3	18.5	15.6
None or minimum, %	66.9	76.3	70.8

4.8.2 Qualitative results

Approachability

Information Awareness

All five stakeholders agree that mental health information exists in the Mannheim context, but that its reach is uneven and largely dependent on individual mediators rather than systemic outreach. The civil society respondent emphasizes that older people usually do not enter care on their own and that access depends on networks and institutions: "*not even ten percent of all people come on their own initiative*" and *"the GP is the key point for referrals and entry into care"* (ZI Mannheim, Civil Society). The civil society respondent observes that written materials such as flyers are distributed across the district in multiple languages yet stresses that passive information provision is insufficient: active networks and community events are necessary to reach vulnerable older populations. This mediation dependency is echoed by the service provider, who notes that awareness is created primarily during direct consultations and that no broad outreach strategy is in place. The service provider describes awareness as "*highly provider-mediated rather than system-wide*", meaning that the quality and reach of information is contingent on individual clinicians rather than systemic design.

The user representative gives a somewhat more positive picture locally, noting that language-compatible doctors in Mannheim can function as entry points, but explicitly limits this to their own local "*bubble*," which suggests that awareness may be highly context-dependent rather than systematically guaranteed (ZI Mannheim, User Representative).

The academic adds that the information environment is multi-layered: older adults may receive information through GPs, pharmacies, television, print media, specialized centres, and increasingly digital media. However, this does not automatically mean that awareness is equitable, because access to information depends on digital literacy, education, and familiarity with the healthcare system. The academic explicitly notes "*older adults differ in whether they are more digital or rely mainly on television and newspapers, and that social media platforms such as Facebook and also Instagram are becoming more relevant for older patients"* (ZI Mannheim, Academic). Finally, the policy maker indicates that from a policy perspective, mental health-specific information channels are poorly defined or poorly known: "*Specifically for mental health care, I'm not aware of anything*" (ZI Mannheim, Policymaker). This is important analytically because it suggests that weak information visibility may not just be a user problem, but also a governance problem.

Barriers to recognizing or seeking help

The civil society interview describes a system in which older people often "*do not know where they can turn*" and where support structures are "*incredibly complicated*" (ZI Mannheim, Civil Society). Administrative forms are difficult to understand, which makes access dependent on mediation. The service provider also underlines poor information and prejudice as reasons why older people do not seek help, but for migrants' language is the most central issue: "*language is the be-all and end-all*" (ZI Mannheim, Service Provider). This barrier affects not only knowledge of the system, but also the ability to describe inner states and therefore to be recognized as needing care.

The user representative emphasizes mistrust and unfamiliarity with formal healthcare, especially among first-generation labour migrants. They explain that people from rural backgrounds are "*not accustomed to good medical care, let alone good psychological or respectively psychiatric care"*, which leads to shame, avoidance, and distrust (ZI Mannheim, User Representative). The academic reinforces this by pointing out that many older people simply normalize symptoms, for example by thinking "t*hat's normal, that's just part of getting older*" (ZI Mannheim, Academic). They further identify bureaucratic systems, language barriers, low education, and the rapid digitalization of appointments as major barriers to seeking help. The policy maker, meanwhile, stresses that information is difficult not only for migrants but "*actually in general*", and that access depends more on fragmented individual efforts than on formal programmes (ZI Mannheim, Policymaker).

Across interviews, then, approachability barriers are not just about whether services are there, but whether people can interpret symptoms as needing care, understand what the system offers, know where to go, and navigate its requirements. For older migrants in particular, these processes are hindered by a combination of low health literacy, mistrust, language barriers, and delayed help-seeking.

Acceptability

Cultural and social fit

The five interviews reveal contrasting but complementary perspectives on cultural fit. Notably, the civil society stakeholder repeatedly states that many barriers are not sharply migration-specific, but rather linked to ageing, dependency, dignity, and loneliness. They explicitly say that there is often "*no difference*" between people with and without migration background when it comes to some of the problems older adults face (ZI Mannheim, Civil Society). Instead, the respondent frames acceptability issues as shared social-ageing problems: dependency, loneliness, and the erosion of dignity. This challenges ethnocentric framings of mental health access and foregrounds ageing as a universal structural vulnerability.

The service provider approaches cultural fit through adapted communication style rather than formal cultural tailoring. Rather than using clinical labels, the provider avoids direct designations such as *"you have depression"* and instead employs gentler, indirect entry points into mental health discussions. Family members are brought in as translators for patients with limited German, though the service provider recognises that translation always involves a loss of communicative quality. The user representative takes a more critical stance, highlighting honour, shame, family expectations, and religious interpretations of illness as significant cultural barriers, and flagging clinician insensitivity to visible religious symbols as a concrete example of cultural misfit in formal care settings.

The academic brings the most analytically differentiated perspective, arguing that acceptability has improved over time through education and greater information, but cautioning against treating vulnerable groups as a homogeneous category. Different migrant communities, educational levels, and social positions produce genuinely different expectations of care. The policy maker acknowledges the limits of cultural tailoring at scale, noting that translated materials and targeted programs exist primarily for larger linguistic groups (Arabic and Turkish) while smaller migrant communities receive "*very, very little*" (ZI Mannheim, Policymaker) in terms of specific support. Community participation is identified as essential, given that standard campaigns often fail to resonate with culturally specific communication norms.

Stigma

Stigma is one of the most consistently and forcefully identified barriers across all five interviews. The civil society respondent provides particularly vivid descriptions, including the belief among older adults that "t*he psychiatry gives you electric shocks in the brain*" (ZI Mannheim, Civil Society). This illustrates that stigma operates not merely as shame or social disapproval but as a fear of coercion and loss of bodily autonomy, making psychiatric care feel existentially threatening. The civil society respondent's response to this has been to organize community events that implicitly and indirectly address mental health, avoiding clinical framing in favour of social and creative engagement.

The service provider identifies gendered patterns of stigma, noting that older men are more defensive and resistant to mental health disclosure. The respondent navigates this by avoiding direct diagnostic labels and employing a gradual, relational approach. For migrants specifically, language barriers compound stigma: the provider notes the difficulty of distinguishing a mental health problem from a language barrier, a diagnostic challenge that risks both undertreatment and misattribution.

The user representative describes mental health as highly discreet in migrant communities, surrounded by gossip and fear of public exposure, suggesting that older migrants likely experience

stigma *"even worse*" (ZI Mannheim, User Representative) and that psychological help may be used only in "the per mille range" (ZI Mannheim, User Representative).

The academic notes that stigma is decreasing overall, especially around dementia, driven by media change and better diagnostics, but that it has *"not disappeared*" (ZI Mannheim, Academic) and remains stronger among socially marginalised and migrant populations. The policy maker identifies a structural gap in anti-stigma campaigning, noting that existing campaigns "*often end up going nowhere"* (ZI Mannheim, Policymaker) and are "*hardly noticed*" (ZI Mannheim, Policymaker) particularly among communities that do not engage through mainstream media channels. The policy maker also observes that mental illness among older people carries stronger intergenerational stigma, making youth-targeted informational campaigns strategically important.

Overall, stigma functions across multiple registers: shame, fear, gendered norms, cultural taboo, and media invisibility and its consequences are compounded for older migrants who are simultaneously subject to age-related and culturally specific stigmatising processes.

Availability

Distribution and sufficiency of services

There is strong convergence across the interviews that mental health services are insufficient relative to demand. The civil society respondent describes the system as *"completely underserved"* (ZI Mannheim, Civil Society) arguing that existing services are too narrowly defined around diagnosable clinical conditions and fail to address the broader psychosocial needs of older adults, including loss of purpose, social disconnection, and diminished self-worth. These needs fall outside the scope of traditional medical care, producing a mismatch between available services and actual population needs.

The service provider acknowledges that Mannheim's urban context offers some structural advantages but notes that even here "*demand is higher than supply*" (ZI Mannheim, Service Provider) particularly in psychotherapy. Appointment access is described as difficult, though outreach geropsychiatric home care services are highlighted as a genuinely valuable facilitator. The user representative corroborates the picture of scarcity, noting that counselling appointments can take up to six months, and describes this as a situation affecting everyone regardless of migration background, while acknowledging that language barriers add further constraint for migrants.

The academic provides the most structurally detailed account, mapping geographic inequalities across the Baden-Württemberg region and noting that urban clusters such as Mannheim, Heidelberg,

and Freiburg have much better specialist density than rural areas. Memory clinics are identified as numerically insufficient and qualitatively variable, with the academic noting that the label *"memory clinics is not associated with a specific quality label*" (ZI Mannheim, Academic) making it difficult for service users to assess what they are accessing. The policy maker speaks of centralisation tendencies and hospital closures as creating further uncertainty, while acknowledging limited awareness of specific mental health availability measures at the policy level.

Timing, format, and accessibility of delivery

Even where services exist, their format and delivery modalities are not always aligned with the realities of older adults and migrants. The civil society interview emphasizes the absence of low-threshold, proactive forms of support, such as outreach workers or early support before care dependency sets in (ZI Mannheim, Civil Society).

The service provider makes individual adaptations, allowing walk-ins, offering frequent follow-up but notes that these reflect personal flexibility rather than systemic guarantee. Language is identified as affecting not only approachability but also the practical usability of available appointments: consultations with migrants "*take longer*" and twenty-minute slots are often structurally insufficient. The academic highlights telemedicine and digital health applications as double-edged: they increase geographic reach but simultaneously exclude older adults with limited digital literacy, producing a new form of availability inequality. The user representative considers appointment timing to be the smallest of the problems, noting that scarcity and language barriers are the more fundamental constraints. The policy maker has little knowledge of policies guaranteeing flexible hours or emergency access for migrants, which is itself analytically significant: policy invisibility and policy absence may produce similar practical outcomes.

Affordability

Direct and indirect costs

The civil society respondent acknowledges that many older adults have major financial worries but does not frame direct healthcare costs as the dominant barrier. Instead, the respondent notes that co-payment exemptions exist for those who qualify, and that formal financial protection is in place. The service provider similarly does not identify direct costs as the main problem for statutory insured patients, though transport costs are acknowledged as a relevant indirect barrier: "*people with small pensions may think carefully about every trip"* (ZI Mannheim, Service Provider).

The user representative explicitly states they "*cannot imagine*" (ZI Mannheim, User Representative) that cost is the core reason people avoid care, redirecting attention to cultural norms and stigma as more fundamental obstacles. The academic provides the most comprehensive cost analysis, identifying co-payments, expensive non-reimbursed medications, taxi transport costs, digital device costs, and therapy sessions beyond insurance coverage as compounding financial barriers, particularly when combined with age-related frailty and cognitive impairment. This more granular account complicates the general optimism of other stakeholders and suggests that affordability operates as a meaningful barrier for specific subgroups even if it is not the primary obstacle for most. The policy maker does not identify specific affordability measures beyond the general insurance system, noting only a special budget for refugees in accommodation centres as a targeted arrangement.

Support mechanisms

A consistent tension emerges between the formal existence of support mechanisms and their practical accessibility. The civil society respondent describes a co-payment exemption card that reduces annual out-of-pocket costs to "*not even fifty euros per year*" (ZI Mannheim, Civil Society) but notes that this protection is only usable when someone actively supports individuals in applying for it. Affordability is therefore mitigated by policy but mediated by social support, meaning those with fewer social resources are least able to access the financial protections nominally available to them.

The service provider is not aware of specific financial support schemes beyond standard insurance coverage, suggesting that affordability protections are poorly communicated within the healthcare system. The user representative is similarly unfamiliar with support mechanisms, noting the limited visibility of existing schemes which itself suggests that invisible support mechanisms are functionally inaccessible ones. The academic notes that exemptions exist but are administratively difficult to obtain, especially for people with language barriers or cognitive impairments, and that social workers who could facilitate navigation are not universally available. The policy maker identifies health insurance and publicly funded refugee care as the main mechanisms, but otherwise acknowledges limited awareness of targeted affordability supports.

In sum, affordability is less uniformly identified as a primary access barrier than stigma or availability, but it functions as a compounding factor, particularly for older adults facing indirect costs and those who lack the social resources to navigate formal support systems.

Appropriateness

Fit and usefulness of care

When stakeholders reflect on whether care actually meets people's needs, a recurring pattern emerges care can be useful but often does not fit the realities of vulnerable groups well enough. The civil society respondent frames appropriateness in terms of person-centred, relational, and autonomy-preserving care. Care is appropriate when it moves gradually, respects the pace and agency of the individual, and is embedded in trusted social environments. The respondent explicitly states that "*the older person has to decide for themselves*" (ZI Mannheim, Civil Society)

Group-based and community-based approaches are described as especially effective because they allow people to disclose distress indirectly, avoiding the clinical framing that triggers defensiveness. Implicit, socially embedded mental health support is therefore positioned as more appropriate and more effective than direct clinical intervention for this population.

The service provider operationalises appropriateness through patient feedback, specialist letters, and family observations, and explicitly adapts care to patient preferences, for example, respecting when a patient declines antidepressants. This reflects a patient-led rather than protocol-led model of appropriateness. The user representative tends to view formal care as helpful when it is actually accessed, though this positive assessment is largely limited to younger or middle-aged users and dementia-related care. For older migrants specifically, psychological service use is so limited that the user representative cannot make robust assessments of usefulness and instead documents a significant shift toward alternative and online practitioners.

The academic frames appropriateness through a Value-Based Healthcare lens, emphasising patient benefit, patient satisfaction, multidisciplinary coordination, and the avoidance of unnecessary procedures. The respondent stresses that caregiver needs must be integrated into assessments of care fit particularly for chronic and neurodegenerative conditions. The policy maker openly acknowledges that they cannot define person-centred care in formal policy terms and reflects that the system does not achieve this well even for the general population, let alone for migrants facing additional barriers of cultural mismatch and geographical inequality.

Quality of interaction and respect

All five interviews indicate that the quality of interaction is central to access. Respect, patience, time, and human recognition are described not as optional extras, but as conditions of meaningful care. The civil society respondent offers one of the most striking formulations in the interviews: "*when a doctor takes even a moment of time and speaks as a human being, it is incredibly valuable"* (ZI Mannheim, Civil Society). This foregrounds relational quality, patience, presence, and humanising interaction, as central to whether care is experienced as meaningful. Respectful interaction is

therefore not merely a secondary nicety but a core therapeutic ingredient for older adults who often feel depersonalised by institutional care.

The service provider similarly emphasizes sitting at eye level, using simple language, listening, creating calm, and linking conversations to earlier visits (ZI Mannheim, Service provider). The user representative addresses quality of interaction less directly, instead documenting the rise of Turkish-language online practitioners who attract trust precisely because formal systems do not feel culturally close enough. The respondent describes this as "*extremely harmful to society"* (ZI Mannheim, User Representative) given the risk of misdiagnosis, suggesting that when formal systems fail on appropriateness, informal and potentially harmful alternatives fill the gap.

The academic approaches quality of interaction at the systemic rather than interpersonal level, emphasising multidisciplinary collaboration, standard-setting, and evidence-based protocols as the structural foundations of appropriate care. The policy maker raises concerns about insufficient cultural sensitivity training among staff and lack of interpreter availability in inpatient contexts, offering the example of a Ukrainian woman in crisis where, without interpreters and adequate training, "*the humanity aspect does get somewhat lost"* (ZI Mannheim, Policymaker). The policy maker strongly emphasises the need for mandatory intercultural training as a structural response to what are currently treated as individual staff improvisations.

5. Conclusion and Impact

This deliverable examined how meso-level factors shape access to mental healthcare for people in vulnerable situations across the EQUICARES pilot sides. Using the adapted Levesque framework of work package 1.2 as the central analytical structure, the work combined quantitative survey findings with qualitative stakeholder interviews to investigate how service organisation, coordination, availability, affordability, acceptability, and responsiveness influence access to care across different countries and vulnerable populations. In doing so, the deliverable addressed the three main objectives of the work package; identifying key meso-level barriers and enabling factors, examining cross-country variation in access barriers through a mixed-methods approach, and operationalising the adapted Levesque framework for meso-level analysis within work package 1. Across pilot sites, several recurring meso-level barriers became visible. The findings suggest that inequalities in mental healthcare are concentrated particularly at the stage of entering and navigating services rather than solely within the treatment encounter itself.

Within the approachability dimension, barriers were frequently related to limited awareness of available services, difficulties finding reliable information, low visibility of outreach activities, and uncertainty regarding where to seek help during crises. Although quantitative findings sometimes showed only modes group differences, qualitative interviews demonstrated that access to information often depended heavily on NGOs, peer workers, schools, community organisations, or trusted professionals rather than on clear and accessible system-level communication. In many contexts, vulnerable groups described mental health systems as fragmented, difficult to navigate, and insufficiently adapted to their needs. For acceptability, the findings highlighted the continuing role of stigma, mistrust, and cultural mismatch in shaping access to care. While several survey indicators related to respectful communication or trust in services were not significantly different between groups, qualitative findings indicated that fear of discrimination, confidentiality concerns, previous negative experiences, and social stigma remained major barriers to seeking support. These issues were particularly visible among migrants, Roma communities, LGBTIQ+ populations, people with disabilities, and unaccompanied minors. In some countries, respondents also reported that services did not sufficiently account for cultural beliefs, language needs, or broader social realities, which reduced the perceived safety and relevance of care. Within the availability and accommodation dimension, both quantitative and qualitative findings pointed towards structural under-provision of services. Long waiting lists, shortages of mental health professionals, fragmented referral pathways, limited continuity of care, and geographical inequalities in service distribution were commonly reported across pilot sites. Although differences between groups were not always statistically significant for indicators such as travel time or appointment waiting times, the qualitative findings revealed that services were frequently overstretched and heavily dependent on temporary or project-based funding structures. At the same time, several enabling factors were identified, including mobile outreach teams, integrated local care networks, community-based approaches, and flexible service delivery models that improved accessibility for underserved populations. Affordability-related barriers were also consistently observed across countries and vulnerable groups. Compared with national reference datasets, many EQUICARES populations reported substantially higher levels of unmet need for care and greater financial barriers to accessing services. Importantly, the findings showed that affordability extended beyond direct treatment costs. Transport expenses, housing instability, childcare responsibilities, loss of income, documentations requirements, digital exclusion, and difficulties navigating insurance systems frequently acted as indirect barriers to care. Vulnerable populations such as Roma communities, migrants, youth, people with disabilities, earthquake survivors, and older adults with migration backgrounds appeared particularly affected by these broader socio-economic constraints. Within the appropriateness dimension, the findings suggested that experiences within care were often more positive once access had been established. Across many pilot sites, respondents generally reported respectful treatment and perceived services as helpful or relevant. Nevertheless, differences

remained regarding continuity of care, clarity of communication, involvement in decision-making, support for caregivers, opportunities to provided feedback, and whether services considered broader life circumstances. Qualitative interviews further indicated that person-centred and responsive care often depended on the efforts of individual professionals rather than on structurally embedded systems of coordination and continuity. Short consultation times, staff turnover, fragmented referrals, and limited long-term follow-up reduced the overall responsiveness of services, particularly for individuals with more complex needs. Table .. provides a summary of the findings in this deliverable

Table 170: Summary of key meso-level barriers and enabling factors across EQUICARES pilot sites

Pilot site / target group	Main meso-level barriers	Main enabling factors	Levesque dimensions most affected	Implications / next steps
Turkey – Earthquake survivors (women and youth)	Limited awareness of services among youth, disrupted service infrastructure, transport barriers, affordability concerns, fragmented continuity of care	Community-based services, outreach initiatives, targeted financial support programmes	Approachability, Availability & Accommodation, Affordability	Strengthen outreach, continuity of care, and sustainable post-disaster service provision
Ireland – LGBTIQ+ population	Difficulties finding reliable information, limited outreach visibility, affordability barriers, unmet need for care	Community organisations, peer support networks, affirming providers	Approachability, Affordability, Acceptability	Improve visibility of inclusive services and strengthen publicly accessible affirming care
Spain – Roma communities	Cost-related barriers, waiting lists, travel barriers, unmet need for care, cultural fit concerns	Community mediators, NGO support, local outreach activities	Affordability, Acceptability, Availability & Accommodation	Strengthen mediation services and reduce structural barriers to access
Spain – Latin American migrants	Information and navigation challenges, waiting times, affordability concerns	Community networks and local support organisations	Approachability, Affordability	Improve navigation support and continuity of care
Bulgaria – Roma communities	Affordability barriers, unmet need, lower awareness of services, cultural	Community mediators and local support organisations	Affordability, Approachability, Acceptability	Expand culturally responsive and community-based mental health services

	responsiveness concerns			
Bulgaria – Ethnic and religious minorities	Limited awareness of services, lower knowledge of crisis support, difficulties understanding information	Community organisations and informal support networks	Approachability, Availability & Accommodation	Improve communication strategies and service visibility
Greece – Migrants and unaccompanied children	Insurance and documentation barriers, stigma, unmet need, higher depressive symptom burden	NGO support, specialised programmes, outreach initiatives	Affordability, Approachability, Acceptability	Improve continuity and sustainability of support programmes
Greece – Older adults and older migrants	Communication barriers, affordability concerns, service navigation difficulties	Primary care and community support services	Approachability, Affordability, Appropriateness	Strengthen age-friendly and culturally responsive navigation support
Germany – Older adults and migrants	Language barriers, digitalisation of access pathways, affordability concerns, unmet need	Community support organisations and migrant networks	Approachability, Affordability, Availability & Accommodation	Improve accessibility of information and support for navigating services
France – People with intellectual and/or physical disabilities	Communication difficulties, affordability barriers, waiting lists, reduced responsiveness and coordination	Disability support organisations and specialised services	Appropriateness, Affordability, Acceptability	Strengthen person-centred care, communication, and coordination mechanisms
Cross-country finding	Information barriers, affordability constraints, waiting lists, fragmented referral pathways, continuity challenges	Community mediators, NGOs, peer workers, integrated local networks, outreach models	All dimensions, particularly Approachability, Availability & Accommodation, and Affordability	Focus future interventions on improving navigation, coordination, outreach, and financial accessibility

A major contribution of this deliverable was the successful operationalisation and application of the adapted Levesque framework at the meso level across all pilot sites. The framework was consistently integrated into the questionnaire development, interview design, coding procedures, and cross-country synthesis, ensuring conceptual consistency throughout work package 1. This allowed direct comparison of barriers and enabling factors across countries and vulnerable

populations while maintaining a shared analytical structure. In addition, the deliverable used a broad triangulation strategy by comparing EQUICARES findings with multiple external dataset and population-level indicators, including the European Health Interview Survey (EHIS), the European Union Statistics on Income and Living Conditions (EU-SILC), Eurostat indicators, and national EQ-5D value sets and reference datasets. These external comparison strengthened interpretation of findings related to health-related quality of life, self-perceived health, activity limitations, unmet need for care, and depressive symptom severity, while also contributing to the EQUICARES KPI regarding the inclusion of external datasets within the project.

Despite the strengths of the mixed-methods design and the extensive triangulation with external datasets, several limitations should be considered when interpreting the findings. First, although a common protocol, questionnaire, and interview guide were used across all pilot sites, recruitment procedures were implemented locally and therefore varied between countries. Detailed information regarding interviewer characteristics, recruitment pathways, response rates, and reasons for non-participation was not systematically collected across all sites, which may have introduced variation in participant selection and data collection procedures. Second, the quantitative survey relied primarily on quota-based and convenience recruitment strategies to ensure inclusion of vulnerable populations. Consequently, the samples cannot be considered nationally representative and the findings should not be interpreted as prevalence estimates for the wider population. Rather, the survey was designed to identify potential barriers, enabling factors, and differences between groups within the EQUICARES pilot settings. Third, several vulnerable population groups were relatively small, limiting statistical power for some subgroup analyses. In some cases, overall group differences were identified but pairwise comparisons did not remain statistically significant after adjustment for multiple testing. Findings from smaller subgroups should therefore be interpreted with appropriate caution. Fourth, the study relied on self-reported experiences and perceptions of mental healthcare access. Such measures may be influenced by recall bias, cultural differences in reporting, and variation in interpretation of survey items. Similarly, the qualitative findings reflect stakeholder perspectives and may not capture all experiences within a given health system. Finally, although extensive efforts were made to triangulate findings with external datasets, direct comparisons were not always possible. National reference data originated from different sources, including EHIS, EU-SILC, Eurostat indicators, EQ-5D population norms, and national surveys, which varied in sampling strategies, years of data collection, population coverage, and indicator definitions. These comparisons should therefore be interpreted as contextual benchmarks rather than directly equivalent estimates.

In conclusion, the findings demonstrate that inequities in access to mental healthcare are strongly shaped by meso-level organisational and structural factors rather than by individual characteristics

alone. The study highlights the importance of improving service coordination, outreach, continuity of care, culturally sensitive support, financial accessibility, and navigation support for vulnerable populations. By identifying both common patterns and context-specific barriers across countries, the deliverable also creates opportunities for cross-country learning and adaptation of promising practices between pilot sites.

6. Reference List

1. *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*. (OECD Publishing, Paris, 2021).
2. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Psychiatry* **9**, 137–150 (2022).
3. Freeman, M. The World Mental Health Report: transforming mental health for all. *World Psychiatry* **21**, 391–392 (2022).
4. OECD & European Union. *Health at a Glance: Europe 2022: State of Health in the EU Cycle*. (OECD Publishing, 2022). doi:10.1787/507433b0-en.
5. *Mental Health Atlas 2020*. (World Health Organization, Geneva, 2021).
6. Cu, A., Meister, S., Lefebvre, B. & Ridde, V. Assessing healthcare access using the Levesque's conceptual framework– a scoping review. *Int. J. Equity Health* **20**, 116 (2021).
7. Levesque, J.-F., Harris, M. F. & Russell, G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int. J. Equity Health* **12**, 18 (2013).
8. Bammert, P. *et al.* The role of mesolevel characteristics of the health care system and socioeconomic factors on health care use - results of a scoping review. *Int. J. Equity Health* **23**, 37 (2024).
9. Cui, L. *et al.* Major depressive disorder: hypothesis, mechanism, prevention and treatment. *Signal Transduct. Target. Ther.* **9**, 30 (2024).
10. Thornicroft, G. Stigma and discrimination limit access to mental health care. *Epidemiol. Psichiatr. Soc.* **17**, 14–19 (2008).
11. Turja, T. Overview of barriers to healthcare access: Medical deserts and individual sandboxes. *J. Fam. Med. Prim. Care* **14**, 2608–2612 (2025).
12. Eurostat. Self-perceived health by sex, age and groups of country of birth. Eurostat https://doi.org/10.2908/HLTH_SILC_23 (2022).

13. Eurostat. Niveau de handicap (restriction d'activité) par sexe, âge et pays de naissance. Eurostat https://doi.org/10.2908/HLTH_SILC_27 (2023).
14. Eurostat. Self-reported unmet needs for medical examination by sex, age, main reason declared and groups of country of citizenship. Eurostat https://doi.org/10.2908/HLTH_SILC_30 (2022).
15. Eurostat. Severity of current depressive symptoms by sex, age and country of citizenhip. Eurostat https://doi.org/10.2908/HLTH_EHIS_MH2C (2022).
16. Kinchin, I., Engel, L. & Rencz, F. A Comparative Study of Health and Well-Being Measures in Ireland Using EQ Health and Wellbeing (EQ-HWB) and its Short Version, EQ-5D-5L, and ICEpop Capability Measure for Adults (ICECAP-A). *Value Health* **28**, 1268–1279 (2025).
17. Garcia-Gordillo, M. A., Adsuar, J. C. & Olivares, P. R. Normative values of EQ-5D-5L: in a Spanish representative population sample from Spanish Health Survey, 2011. *Qual. Life Res.* **25**, 1313–1321 (2016).
18. Gautier, L., Azzi, J., Saba, G., Bonnelye, G. & De Pouvourville, G. Population norms in France with EQ-5D-5L: health states, value indexes, and VAS. *Eur. J. Health Econ.* **24**, 1517–1530 (2023).
19. Encheva, M., Djambazov, S., Vekov, T. & Golicki, D. EQ-5D-5L Bulgarian population norms. *Eur. J. Health Econ.* **21**, 1169–1178 (2020).
20. Marten, O. & Greiner, W. EQ-5D-5L reference values for the German general elderly population. *Health Qual. Life Outcomes* **19**, 76 (2021).
21. Grochtdreis, T., Dams, J., König, H.-H. & Konnopka, A. Health-related quality of life measured with the EQ-5D-5L: estimation of normative index values based on a representative German population sample and value set. *Eur. J. Health Econ.* **20**, 933–944 (2019).

Appendix A - Questionnaire

Number	Question	Scale	Dimension	Source
1	What is your general health?	1)Very good 2)Good 3)Fair 4)Bad 5)Very bad	General Health	EU-SILC
2	Were you limited in daily activities because of health?	1)Severely limited 2)Limited 3)Not limited	General Health	EU-SILC
3	Did you ever have an unmet need for medical care?	1)Yes 2)At least once 3)No	Unmet Need	EU-SILC
4	Main reason for unmet medical care need?	1)Too expensive (Affordability) 2)Waiting list (availability) 3)Could not take time off (Affordability) 4)Too far (Availability) 5)Fear (Acceptability) 6)Waited to see if improved (Affordability) 7)Didn't know good provider (Approachability) 8)Other: ____	Multiple	EU-SILC
5	Do you know where to go if you need mental health support?	1)Yes 2)No 3)Not sure	Approachability	Literature
6	Did you know where to go for mental health care?	1)Yes 2)No 3)Not sure	Approachability	Literature
7	How easy is it for you to find clear information about available mental health services in your area?	1)Very easy 2)Easy 3)Neutral 4)Difficult 5)Very difficult	Approachability	Literature
8	How easy is it for you to understand the information provided by mental health services (e.g. websites, brochures)?	1)Very easy 2)Easy 3)Neutral 4)Difficult 5)Very difficult	Approachability	Literature

9	Are there mental health services available in your local area?	1)Yes 2)No 3)Not sure	Approachability	Literature
10	Are there mental health services available within reasonable travel distance from where you live?	1)Yes 2)No 3)Not sure	Availability	Literature
11	How long does it take you to get to your mental health service?	1)Less than 5 minutes 2)5–15 minutes 3)15–30 minutes 4)30–60 minutes 5)More than 1 hour	Availability	Literature
12	Last time you needed mental health care, how quickly could you get an appointment?	1)In the same week 2)The next week 3)The next month 4)After more than one month 5)Never able to get an appointment 6)Did not need to make an appointment 7)Not sure	Availability	Literature
13	How long is the average waiting time to get a mental health appointment in your area?	1)Less than 1 week 2)1–2 weeks 3)2–4 weeks 4)More than 1 month 5)Don’t know	Availability	Literature
14	How flexible are mental health services in scheduling appointments that suit your needs?	1)Very flexible 2)Somewhat flexible Neutral 3)Somewhat inflexible 4)Not flexible at all 5)Don’t know	Availability	Literature
15	Do you have health insurance that covers mental health services?	1)Yes, fully 2)Yes, partially 3)No 4)Not sure	Affordability	Literature
16	Have you delayed or avoided mental health care due to cost in the past 12 months?	1)Yes 2)No 3)Not sure	Affordability	Literature
17	How big of a financial burden are mental health care costs for you or your household?	1)None 2)Small 3)Moderate 4)Heavy 5)Unsustainable	Affordability	Literature
18	Have you ever not taken prescribed medication due to the cost?	1)Never 2)Rarely 3)Sometimes 4)Often 5)Very often	Affordability	Literature

19	Are there times when you find it difficult to access mental health care due to loss of income (e.g. taking time off work)?	1)Never 2)Rarely 3)Sometimes 4)Often 5)Very often	Affordability	Literature
20	Are there times when you find it difficult to access mental health care due to additional costs (e.g. travel, childcare)?	1)Never 2)Rarely 3)Sometimes 4)Often 5)Very often	Affordability	Literature
21	In the past 12 months, were there times when you had serious problems paying or were unable to pay for mental health services?	1)Yes 2)No 3)Not sure	Affordability	Literature
22	During the past 12 months, did your insurance deny payment or pay less than expected for mental health services?	1)Yes 2)No 3)Not sure	Affordability	Literature
23	Did the mental health care you received address your specific concerns and situation?	1)Excellent 2)Very good 3)Good 4)Fair 5)Poor 6)No care received in the past 12 months 7)Not sure	Appropriateness	Literature
24	Overall, how would you rate the mental health care that you have received in the past 12 months?	1)Excellent 2)Very good 3)Good 4)Fair 5)Poor 6)No care received in the past 12 months 7)Not sure	Appropriateness	Literature
25	During your mental health contact(s), how often did doctors treat you with courtesy and respect?	1)Always 2)Sometimes 3)Rarely 4)Never 5)No care received in the past 12 months	Appropriateness	Literature
26	When you need mental health care, how often does your provider explain things in a way that is easy to understand?	1) Always 2) Often 3) Sometimes 4) Rarely or never 5) No care received in the past 12 months	Appropriateness	Literature
27	When you need mental health care, how often does your provider spend enough time with you?	1) Always 2) Often 3) Sometimes 4) Rarely or never 5) No care received in the past 12 months	Appropriateness	Literature

28	Have you ever stopped using a mental health service because it didn't feel helpful or relevant?	1) Yes 2) No 3) Not applicable	Appropriateness	Literature
29	Do you feel that mental health care providers respect your cultural background?	1) Always 2) Often 3) Sometimes 4) Rarely or never 5) No care received in the past 12 months	Acceptability	Literature
30	Do you feel that you have received as much support from mental health professionals as needed to manage your mental health problems?	1) Yes 2) No 3) Not sure	Acceptability	Literature
31	Would you feel judged by others if you used mental health services?	1) Definitely 2) Probably 3) Not sure 4) Probably not 5) Definitely not	Acceptability	Literature
32	Have you ever avoided seeking mental health care due to fear of judgment or stigma? (e.g. gender, religion, ethnicity)?	1) Yes 2) No 3) Not sure	Acceptability	Literature
33	Which of the following statements best describes your overall view of the mental health care system in your country?	1) The system works well and needs only minor changes 2) Some good things exist but fundamental changes are needed 3) The system needs to be completely rebuilt 4) Not sure	Approachability	Literature
34	Extent of having little interest or pleasure in doing things over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS
35	Extent of feeling down, depressed or hopeless over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS
36	Extent of trouble sleeping or sleeping too much over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS
37	Extent of feeling tired or low energy over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS

38	Extent of feeling bad about yourself or like a failure over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS
39	Extent of having trouble concentrating over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	Mental Health	EHIS
40	Extent of moving or speaking slowly or being restless over the last 2 weeks	1) Not at all 2) Several days 3) More than half the days 4) Nearly every day	General Health	EHIS
41	Mobility	1 = No problems 2 = Slight problems 3 = Moderate problems 4 = Severe problems 5 = Unable to 9 = Missing value	MOBILITY	EQ-5D-5L
42	Self-care	1 = No problems 2 = Slight problems 3 = Moderate problems 4 = Severe problems 5 = Unable to 9 = Missing value	SELF-CARE	EQ-5D-5L
43	Activity	1 = No problems 2 = Slight problems 3 = Moderate problems 4 = Severe problems 5 = Unable to 9 = Missing value	ACTIVITY	EQ-5D-5L
44	Pain	1 = No pain 2 = Slight pain 3 = Moderatly pain 4 = Severe pain 5 = Extreme pain 9 = Missing value	PAIN	EQ-5D-5L
45	Anxiety	1 = Not anxious 2 = Slightly anxious 3 = Moderately anxious 4 = Severely anxious 5 = Extremely anxious 9 = Missing value	ANXIETY	EQ-5D-5L
46	EQ-VAS	0 = Worst imaginable health state - 100 = best imaginable health state	EQ-VAS	EQ-5D-5L

47	SELF-IMAGE	1) I think very positively about myself 2) I think positively about myself 3) I think negatively about myself 4) I think very negatively about myself	SELF-IMAGE	MHQoL
48	INDEPENDENCE	1) I am very satisfied with my level of independence 2) I am satisfied with my level of independence 3) I am dissatisfied with my level of independence 4) I am very dissatisfied with my level of independence	INDEPENDENCE	MHQoL
51	MOOD	1) I do not feel anxious, gloomy, or depressed 2) I feel a little anxious, gloomy, or depressed 3) I feel anxious, gloomy, or depressed 4) I feel very anxious, gloomy, or depressed	MOOD	MHQoL
52	RELATIONSHIPS	1) I am very satisfied with my relationships 2) I am satisfied with my relationships 3) I am dissatisfied with my relationships 4) I am very dissatisfied with my relationship	RELATIONSHIPS	MHQoL
53	DAILY ACTIVITIES	1) I am very satisfied with my daily activities 2) I am satisfied with my daily activities 3) I am dissatisfied with my daily activities 4) I am very dissatisfied with my daily activities	DAILY ACTIVITIES	MHQoL

54	PHYSICAL HEALTH	1) I have no physical health problems 2) I have some physical health problems 3) I have many physical health problems 4) I have a great many physical health problems	PHYSICAL HEALTH	MHQoL
55	FUTURE	1) I am very optimistic about my future 2) I am optimistic about my future 3) I am gloomy about my future 4) I am very gloomy about my future	FUTURE	MHQoL
56	MHQOL-VAS	0 (worst imaginable psychological well-being - 10 (Best imaginable psychological well-being	MHQOL-VAS	MHQoL

Appendix B – Interview guide

Anchor and Tailored Questions by Levesque Dimension and Stakeholder						
Dimension	**Anchor Question**	**Policymaker**	**Provider**	**Academic**	**User Representative**	**Civil Society**
Approachability	How accessible is information about mental health services for different population groups?	What policies are in place to ensure vulnerable communities are informed about available mental health services?	How do you ensure that patients from vulnerable communities are aware of the mental health services available to them?	What evidence exists regarding the effectiveness of information dissemination strategies aimed at improving mental health service awareness among vulnerable population groups?	Do people in vulnerable communities you represent know where and how to seek help for mental health concerns?	How do you support or observe the sharing of information about available mental health services for vulnerable populations in your community?
Approachability	What are the barriers to people knowing when and how to seek mental health care?	How do policies address barriers for vulnerable populations, like language difficulties, stigma, navigating the mental health care system?	In your experience, what are the main reasons patients from vulnerable populations do not seek mental health care when they need it?	What research has been conducted on barriers to recognizing or seeking mental health care among vulnerable communities in your country, and what were the key findings?	What do people in your community say about the challenges of knowing how to seek help for mental health issues?	What challenges do members of vulnerable communities face in identifying or navigating mental health services?

Acceptability	How well do mental health services align with the cultural and social expectations of users?	What national strategies are in place to ensure to ensure that mental health services are culturally appropriate and responsive to the needs of diverse vulnerable groups?	How do you adapt your mental health care delivery to meet the cultural, linguistic, or personal needs of patients from vulnerable groups?	What does the evidence show about acceptability of mental health services among vulnerable populations?	Do people in your community feel mental health care providers respect their cultural values?	What cultural or social concerns do people from vulnerable groups raise about seeking or using mental health services?
Acceptability	What role does stigma play in preventing access to mental health care?	Are there public policies or national campaigns specifically aimed at reducing mental health stigma, particularly among marginalised or vulnerable populations?	How do you address fear, stigma, or reluctance when engaging vulnerable patients in mental health care?	What research is available on the role of stigma in shaping attitudes toward mental health care access for vulnerable populations?	How does stigma influence whether people seek help for mental health in your community?	What initiatives have you seen or supported to reduce stigma surrounding mental health within vulnerable communities?
Availability	How well distributed are mental health services across the country, including remote areas?	What policy measures are taken to ensure that mental health services are sufficiently available in remote, rural, or otherwise underserved areas?	What challenges do you encounter in maintaining the availability and accessibility of mental health services for vulnerable populations in your care area?	What data or research exists on the geographic distribution of mental health services for vulnerable populations, and how accurately do these sources reflect access disparities?	Are there enough appropriate and accessible mental health services available for vulnerable populations in the area where you live?	Do the vulnerable populations you work with have sufficient access to local mental health services, including in underserved areas?

Availability	Are mental health services offered at times and in ways that people can actually use them?	Are there national policies that ensure flexible service hours or guarantee emergency access to mental health care for people facing complex life situations?	How flexible are your services in accommodating the scheduling needs of patients from vulnerable communities?	Has your research identified specific challenges in service accessibility for vulnerable groups, such as those related to the timing, delivery format, or service setting?	Are services offered at times that suit the people in your community?	What do people say about service hours and the ability to get timely appointments for mental health support?
Affordability	How do costs—both direct and indirect—impact access to mental health services?	How does national policy monitor and mitigate the financial barriers that vulnerable individuals face when accessing mental health services?	Do you observe that patients from vulnerable groups delay or avoid mental health care due to direct or indirect costs?	What is known from research about financial barriers to mental health care access for vulnerable communities in your country?	Do people you represent avoid care due to costs like fees, transport or time off work?	How significant are financial concerns or costs in preventing vulnerable groups from accessing mental health care?
Affordability	Are there any financial support mechanisms to make mental health care more accessible?	What funding schemes or social protection measures are in place to provide low-cost or free mental health services for those unable to pay?	Are you aware of any financial assistance, subsidies, or support mechanisms available to help vulnerable individuals access mental health care?	Have there been evaluations of national or regional mental health financing mechanisms, and what do they reveal about their effectiveness in improving affordability for vulnerable populations?	Are there support schemes for mental health care that people in your community use?	Do you help individuals from vulnerable communities access, financial support or subsidies for mental health services?

Appropriateness	Does the care provided meet the actual needs and preferences of people using mental health services?	How is person-centred care defined within national mental health policy, and how is its implementation monitored, especially for vulnerable populations?	How do you assess whether the care you provide meets the specific needs, values, and expectations of patients from vulnerable populations?	What indicators or frameworks are used in the literature to assess whether mental health care is appropriate to the needs of users, particularly in vulnerable groups?	Do people in your community feel that the care they receive truly helps them?	What do your members say about the usefulness, cultural fit, and personal relevance of the mental health care they receive?
Appropriateness	How is the quality of interaction between provider and user perceived and ensured?	Are provider–patient interactions covered in national quality standards for mental health?	What measures do you take to ensure that your communication with patients—especially those from vulnerable backgrounds—is respectful, clear, and supportive?	What research has been done on the quality of provider–patient relationships in mental health care, and how might these relationships differ for vulnerable populations?	Do people you represent feel heard and respected by mental health care providers?	How do people from vulnerable populations describe their interactions with mental health professionals in terms of respect, communication, and understanding?

Appendix C – participants and quotation identifiers

Each pilot site conducted five semi-structured interviews. Quotations in the qualitative results are attributed only by pilot site and stakeholder role, in the form (Site, Role). For example: (Koç University, Academic). No personal characteristics are reported. Because each site recruited from a slightly different stakeholder ecosystem, the role labels and abbreviations used in the attributions vary between countries as set out below.

Country	Pilot cite (as cited)	Interviewees (five per site)	In-text attribution and notes
Bulgaria	AMALIPE	Civil society representative; academic; user representative; policy maker; service provider	(AMALIPE, Role) - e.g. (AMALIPE, Civil Society), (AMALIPE User Representative).
Spain	FISEVI	Academic; NGO representative; service provider; civil society representative; health provider	(FISEVI, Role). The migrant-focused organisation is cited as (FISEVI, Civil Society); the Roma-focused organisation as (FISEVI, Community representative NGO); the clinician as (FISEVI, Health Provider).
Greece	GIVMED	Two providers; three civil society organisation representatives	(GIVMED, Role-number) - e.g. (GIVMED, Provider-1) and (GIVMED, Provider-2); civil society organisation informants abbreviated as (GIVMED, CSO-1-3), where CSO = civil society organisation.
Turkey	Koç University	Academic; NGO representative; user representative (termed a “customer” by site)’ policy maker; service provider	(Koç University, Role). The NGO informant is cited as “Civil Society’ and the service-provider as “Provider”
France	LADAPT	Two civil society representatives; two researchers; one policymaker	(LADAPT, Role). The two civil society informants are distinguished as Civil Society-1 and Civil Society-2, and the two researchers as Reasearcher-1 and Researcher-2.

Ireland	LGBT Ireland	Service provider; service user; NGO representative; policymaker; researcher	(LGBT Ireland, Role). The service user is cited as “User Representative” and the NGO representative as “Civil Society/NGO”.
Greece/Albania	SEERC	Academic; civil society representative; policymaker; provider; user representative	(SEERC, Role). The user representative is the site’s “representative”.
Germany	ZI Mannheim	Civil society representative; service provider; user representative; academic; policymaker	(ZI Mannheim, Role).

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KOÇ ÜNİVERSİTESİ

SEERC SOUTH-EAST EUROPEAN RESEARCH CENTRE

GIVMED Share medicine Share life

AMALIPE Center For Interethnic Dialogue and Tolerance

LADAPT

LGBT IRELAND For Inclusion For Equality For Everyone

FISEVI Fundación para la Gestión de la Investigación en Salud de Sevilla

Zentralinstitut für Seelische Gesundheit

Q-PLAN INTERNATIONAL

JIGSAW Young people's health in mind

EHTEL Collaborating for Digital Health and Care in Europe

diesis network

EUCOMS The European Community based Mental Health Service Providers Network www.eucoms.net

EASPD European Association of Service providers for Persons with Disabilities

SQUAREDEV

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