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D3.1 Report on mental health ecosystem profiles of pilot sites

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Executive Summary

Deliverable D3.1, “Report on Mental Health Ecosystem Profiles of Pilot Sites”, presents the mental health ecosystem profiles of the eight EQUICARES pilot sites and the corresponding local engagement strategies that will guide the establishment and operationalisation of the Smart Health Labs. The report provides the analytical and operational basis for future WP3 activities by examining the local conditions shaping access to mental health and care services for people in vulnerable situations. Particular attention is given to mental health inequalities, service exclusion trends, priority needs, stakeholder ecosystems, social economy initiatives, and opportunities for community-based innovation.

The profiling covers eight pilot ecosystems across seven countries: South Dublin / Wicklow / Dún Laoghaire–Rathdown in Ireland; Évreux in Normandy, France; Seville in Andalucía, Spain; Mannheim in Baden-Württemberg, Germany; Thessaloniki in Central Macedonia, Greece; Athens / Attica, Greece; Veliko Tarnovo / Strazhitsa and Pavlikeni in Bulgaria; and Antakya in Hatay Province, Türkiye. These sites represent diverse healthcare systems, socio-economic contexts, territorial conditions, policy environments and vulnerability profiles, enabling EQUICARES to examine mental health access barriers across a wide range of local realities.

Across the pilot sites, the report identifies priority groups of people in vulnerable situations whose access to mental health and care services is shaped by intersecting forms of disadvantage. These include LGBTQI+ people and LGBTQI+ refugees in Ireland; persons with intellectual, psychosocial and physical disabilities in France; Roma women and Latin American migrants in Seville; migrants, refugees and older migrants in Mannheim; older adults, migrants and refugees in Thessaloniki; young people and unaccompanied children in Athens / Attica; Roma communities and ethnoreligious minorities in Bulgaria; and earthquake survivors and older adults in Hatay. The prioritisation of these groups reflects both the evidence collected through the ecosystem profiling process and the capacity of pilot partners to engage them meaningfully in co-creation, awareness-raising and piloting activities.

A central finding of the report is that the formal existence of mental health services does not automatically ensure effective, equitable or trusted access. In several pilot sites, mental health systems include a broad range of public services, specialised providers, NGOs, community organisations and social economy actors. However, people in vulnerable situations often encounter barriers when trying to identify, reach, use and benefit from these services. Common barriers include long waiting times, workforce shortages, fragmented referral pathways, limited culturally appropriate support, low mental health literacy, digital exclusion, financial constraints, stigma, discrimination, language barriers, transport difficulties and limited trust in formal institutions. These barriers are often intensified by wider structural conditions, including rurality, housing insecurity, poverty, post-disaster disruption, migration status, disability, age, social isolation and minority identity.

The report also shows that mental health inequalities are closely linked to broader social determinants of wellbeing. Across the pilot ecosystems, access to care is affected not only by healthcare provision, but also by employment insecurity, housing conditions, digital skills, education levels, transport infrastructure, social networks, legal and administrative status, and exposure to discrimination or trauma. This confirms the need for Smart Health Labs to adopt a community-based and ecosystem-oriented approach, connecting mental health support with social inclusion, empowerment, participation and local innovation.

The engagement strategies developed for each pilot site translate the profiling findings into practical local action plans. They define how pilot partners will identify, reach and involve people in vulnerable situations, service providers, community actors, social economy organisations, public authorities and other relevant stakeholders. Rather than applying a uniform model, each engagement strategy is tailored to the specific characteristics of the local ecosystem, the priority People in Vulnerable Situations (PVS) groups and the barriers identified in the profiling process and the work conducted in WP1.

The engagement plans therefore, act as the bridge between ecosystem analysis and the operationalisation of the Smart Health Labs. They ensure that future activities in WP3 are grounded in local evidence, responsive to the needs of PVS and aligned with existing community dynamics. They also provide a practical framework for building trust, strengthening local ownership and supporting sustained collaboration between formal services and community-based actors.

Overall, D3.1 suggests that improving access to mental health and care services requires more than expanding service availability. It requires clearer pathways, stronger coordination, culturally and socially responsive outreach, improved mental health and digital literacy, and meaningful involvement of people with lived experience.

Reader's Note

D3.1 is submitted as a consolidated report covering the ecosystem profiles and local engagement strategies of all eight EQUICARES pilot sites. Its length reflects the diversity of the pilot contexts and the need to present sufficient site-specific information to support the establishment and operationalisation of the Smart Health Labs. The report provides a detailed profile for each pilot site rather than only a short comparative summary.

To support practical use after submission, the consolidated material may also be repackaged into shorter pilot-specific booklets, each focusing on one pilot ecosystem and its tailored engagement strategy. These booklets will support pilot partners in adapting Lab activities, stakeholder engagement, outreach and co-creation processes to their local context.

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List of Terms and Definitions

Abbreviation	Definition
AAH	Allocation aux Adultes Handicapés / Adult Disability Allowance in France
ABPRS	Address-Based Population Registration System

ACCEM	Spanish organisation supporting refugees, migrants and people in vulnerable situations
ACCMR	Athens Coordination Center for Migrant and Refugee Issues
AFAD	Disaster and Emergency Management Presidency, Türkiye
AHEPA	AHEPA University Hospital, Thessaloniki
AI	Artificial Intelligence
AMALIPE	Center for Interethnic Dialogue and Tolerance AMALIPE
ARS	Agence Régionale de Santé / Regional Health Agency, France
ARSIS	Association for the Social Support of Youth
ASAENES	Association of Mental Health in Seville
ASE	Aide Sociale à l'Enfance / Child Welfare Services, France
AUEB	Athens University of Economics and Business
AUTH	Aristotle University of Thessaloniki
AWO	Arbeiterwohlfahrt / German welfare association
CAMHI	Child and Adolescent Mental Health Initiative
CAMHS	Child and Adolescent Mental Health Services
CESER	Conseil Économique, Social et Environnemental Régional / Regional Economic, Social and Environmental Council, France
CGLPL	Contrôleur Général des Lieux de Privation de Liberté / General Controller for Places of Deprivation of Liberty, France
CHO	Community Healthcare Organisation
CHU	Centre Hospitalier Universitaire / University Hospital Centre, France
CLS	Contrat Local de Santé / Local Health Contract, France
CLSM	Conseil Local de Santé Mentale / Local Mental Health Council, France
CMP	Centre Médico-Psychologique / Medico-Psychological Centre, France
CMPP	Centre Médico-Psycho-Pédagogique / Medico-Psycho-Pedagogical Centre, France
CORE	Coexistence and Social Reintegration Service
COSO	Social Cooperation Service
COVID-19	Coronavirus Disease 2019
CREP	Centre de Proximité de Réhabilitation Psychosociale / Local Psychosocial Rehabilitation Centre, France

CRESS	Chambre Régionale de l'Économie Sociale et Solidaire / Regional Chamber for Social and Solidarity Economy, France
CSO	Central Statistics Office, Ireland
CSOs	Civil Society Organisations
CT	Therapeutic Community
D3.1	Deliverable 3.1: Report on Mental Health Ecosystem Profiles of Pilot Sites
DLR	Dún Laoghaire–Rathdown
DYPA	Public Employment Service, Greece
EAM/FAM	Établissement d'Accueil Médicalisé / Foyer d'Accueil Médicalisé, France
EANM	Établissement d'Accueil Non Médicalisé / Non-Medicalised Residential Facility, France
EASP	Andalusian School of Public Health
EASPD	European Association of Service Providers for Persons with Disabilities
EIB	European Investment Bank
EIT	European Institute of Innovation and Technology
ELSTAT	Hellenic Statistical Authority
EMAS	Équipes Mobiles d'Appui à la Scolarisation / Mobile School Inclusion Support Teams, France
EMPEIC	Équipes Mobiles de Psychiatrie pour Enfants et Adolescents en Intervention de Crise / Mobile Child and Adolescent Psychiatry Crisis Intervention Teams, France
EOPYY	National Organisation for Healthcare Services Provision, Greece
EPAPSY	Association for Regional Development and Mental Health, Greece
EQUICARES	Community-driven Healthcare Access and Mental Health Promotion for Inclusive, Equitable, and Resilient European Societies
ERACIS+	Regional Strategy for Cohesion and Social Inclusion in Andalucía
ESAT	Établissement et Service d'Aide par le Travail / Supported Work Establishment and Service, France
ESY	Greek National Health System
EU	European Union
FAISEM	Andalusian Public Foundation for the Social Integration of People with Mental Illness
FAKALI	Federation of Associations of Roma Women
FIOP	Fonds d'Innovation Organisationnelle en Psychiatrie / Organisational Innovation Fund in Psychiatry, France

FRA	European Union Agency for Fundamental Rights
GA	Grant Agreement
GCR	Greek Council for Refugees
GEM	Groupe d'Entraide Mutuelle / Mutual Aid Group, France
GIVMED	Greek non-profit organisation "Share medicine Share life"
GP	General Practitioner
GPV	Gemeindepsychiatrischer Verbund / Community Psychiatric Network, Germany
HADEA	European Health and Digital Executive Agency
HAS	Haute Autorité de Santé / French National Authority for Health
HDSM	Hospital de Día de Salud Mental / Mental Health Day Hospital, Spain
HEALTH-IQ	Greek digital quality and health service assessment programme
HSE	Health Service Executive, Ireland
IACP	Irish Association for Counselling and Psychotherapy
ICT	Information and Communication Technologies
IHR	Individual Electronic Mental Health Record
IHU	International Hellenic University
INE	Instituto Nacional de Estadística / National Statistics Institute, Spain
INSEE	Institut National de la Statistique et des Études Économiques / National Institute of Statistics and Economic Studies, France
IOM	International Organization for Migration
IRIDA	Irida Women's Center
JETA	Albanian community organisation active in Thessaloniki
KAPI	Open Care Centres for Older Adults, Greece
KIFI	Daily Care Centres for Older Adults, Greece
KVBW	Association of Statutory Health Insurance Physicians Baden-Württemberg
KVJS	Municipal Association for Youth and Social Affairs Baden-Württemberg
KYADA	Athens Homeless Shelter and Social Support Centre
L'ADAPT	French association supporting the social and professional inclusion of people with disabilities
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer/Questioning

LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and other diverse identities
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and other diverse identities
MAS	Maison d'Accueil Spécialisée / Specialised Residential Care Facility, France
MDA	Maison des Adolescents / Adolescent Support Centre, France
MDAT	Organisation/source referenced in relation to migration and housing discrimination in Thessaloniki
MDPH	Maison Départementale des Personnes Handicapées / Departmental House for Disabled Persons, France
MENTBEST	Horizon Europe project on mental health and the tools created, ifrightdepression/ifight4wellbeing
MHC	Mental Health Commission, Ireland
MHRS	Central Physician Appointment System, Türkiye
MKU	Mustafa Kemal University, Türkiye
MMHU	Mobile Mental Health Unit
MOOC	Massive Open Online Course
MSF	Médecins Sans Frontières / Doctors Without Borders
NEETs	Young people Not in Employment, Education or Training
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund, Bulgaria
NHS	National Health System
NIFA plus	Labour market integration initiative supporting migrants and refugees in Germany
NOSP	National Office for Suicide Prevention, Ireland
NSI	National Statistical Institute, Bulgaria
NTUA	National Technical University of Athens
NUTS	Nomenclature of Territorial Units for Statistics
OECD	Organisation for Economic Co-operation and Development
PATHI	Professional Association for Trans Health Ireland
PESMA-A	Strategic Mental Health Plan of Andalucía
PISMA	Plan Integral de Salud Mental de Andalucía / Comprehensive Mental Health Plan of Andalucía

PRAKSIS	Greek NGO providing health, psychosocial, legal and social integration support
PRS	Projet Régional de Santé / Regional Health Project, France
PTSD	Post-Traumatic Stress Disorder
PTSM	Projet Territorial de Santé Mentale / Territorial Mental Health Project, France
PU	Public dissemination level
PVS	People in Vulnerable Situations
PwD	People with Disabilities
R&D	Research and Development
RCM	Region of Central Macedonia
RELAS	Local Network for Health Action, Andalucía
RHI	Regional Health Inspectorate, Bulgaria
RKI	Robert Koch Institute, Germany
RQTH	Reconnaissance de la Qualité de Travailleur Handicapé / Recognition of Disabled Worker Status, France
RSA	Revenu de Solidarité Active / Active Solidarity Income, France
S3A	Specialised home-help service focused on autonomy and support
SAMSAH	Service d'Accompagnement Médico-Social pour Adultes Handicapés / Medico-Social Support Service for Disabled Adults, France
SAS	Servicio Andaluz de Salud / Andalusian Public Health System
SEERC	South-East European Research Centre
SGB	Sozialgesetzbuch / German Social Code
SGK	Social Security Institution, Türkiye
SHL	Smart Health Lab
SHM	Healthy Life Centre, Türkiye
SMI	Severe Mental Illness
SOPSI	Association of Families and Friends for Mental Health, Greece
SpDi	Sozialpsychiatrischer Dienst / Social Psychiatric Service, Germany
SROI	Social Return on Investment
SURGE	Spanish social economy and labour integration network
SWOT	Strengths, Weaknesses, Opportunities and Threats

TENI	Trans Equality Network Ireland
TGEU	Trans Europe and Central Asia
TNDI	Trinity National Deprivation Index
TOMY	Local Health Unit, Greece
TRSM	Toplum Ruh Sağlığı Merkezi / Community Mental Health Centre, Türkiye
UCD	University College Dublin
UGC	Unidad de Gestión Clínica / Clinical Management Unit, Spain
UHSM	Unidad de Hospitalización de Salud Mental / Mental Health Inpatient Unit, Spain
UNAFAM	Union Nationale de Familles et Amis de Personnes Malades et/ou Handicapées Psychiques, France
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
URSM	Unidad de Rehabilitación de Salud Mental / Mental Health Rehabilitation Unit, Spain
USMC	Unidad de Salud Mental Comunitaria / Community Mental Health Unit, Spain
USMI-J	Unidad de Salud Mental Infanto-Juvenil / Child and Youth Mental Health Unit, Spain
WHO	World Health Organization
WHH	Welthungerhilfe
WP	Work Package
WR	White Research
YPE	Regional Health Authority, Greece
ZI	Zentralinstitut für Seelische Gesundheit / Central Institute of Mental Health, Mannheim

1. Introduction

1.1 Background and objective of the report

The objective of “D3.1 Report on mental health ecosystem profiles of pilot sites” is to present an anthology of the EQUICARES pilot site profiles, offering an in-depth analysis of the local conditions shaping access to mental health services.

More particularly, the report provides a comprehensive profiling of the local mental health ecosystems across the EQUICARES pilot sites, with a particular focus on identifying inequalities and barriers in access to mental health services, priority groups of PVS, their specific needs, and the main service exclusion trends and structural barriers affecting access to care. It also captures key dimensions, including geographical and demographic characteristics, techno-economic and environmental conditions, and the regulatory and policy landscape. Particular emphasis is placed on the justification and selection of target groups, as this step defines the focus of the Smart Health Labs (hereafter referred to as Labs) and the populations that will be actively engaged throughout the project.

The profiling covers eight pilot ecosystems across seven countries, representing distinct socio-economic, regulatory and healthcare realities, allowing EQUICARES to explore diverse forms of mental health inequalities and accessibility barriers across the following pilot sites in Europe:

- South Dublin / Wicklow / Dún Laoghaire–Rathdown (Ireland)
- Évreux, Normandy (France)
- Sevilla, Andalucía (Spain)
- Mannheim, Baden-Württemberg (Germany)
- Thessaloniki, Central Macedonia (Greece)
- Attica / Athens region (Greece)
- Antakya, Hatay (Türkiye)
- Strazhitsa & Pavlikeni, Veliko Tarnovo Region (Bulgaria)

The report feeds into all WP3 tasks, including the establishment and operationalisation of the Smart Health Labs under T3.2, the capacity-building and empowerment activities under T3.3, the citizen science activities under T3.4, and the development and testing of the AI-based Assistant under T3.5. The report also supports the establishment and operationalisation of the Labs (T3.2) by supporting stakeholder engagement strategies and the development of locally tailored solutions. These strategies identify key stakeholders within each local ecosystem (service users, healthcare providers, social economy actors, community organisations, and policymakers) and define tailored approaches for their involvement. They further outline engagement channels, communication methods, and participation mechanisms adapted to the needs of the identified PVS, ensuring inclusive, ethical, and context-sensitive participation. By clearly defining who should be engaged, how, and under what conditions, the engagement strategies provide a concrete roadmap for initiating and sustaining multi-actor collaboration at the local level.

Furthermore, they support the effective mobilisation of stakeholders, facilitate the recruitment and retention of participants, especially among hard-to-reach groups, and ensure that co-creation activities are grounded in the lived experiences and priorities of PVS. This enables the transition from

analysis to action, ensuring that the Labs are built on existing community dynamics, trusted relationships, and locally relevant practices.

The insights generated through the pilot profiles and the corresponding engagement strategies directly inform the establishment and operation of the Labs under Task 3.2, guiding stakeholder engagement, co-creation processes, and awareness-raising actions. At the same time, the identification of system gaps, priority areas for intervention, and relevant social economy initiatives provides a strong foundation for the co-design and piloting of innovative solutions in subsequent WP3 and WP4 activities. In this way, D3.1 establishes the analytical and operational basis for the implementation of participatory, community-based, and innovation-oriented activities throughout the project lifecycle, ensuring that WP3 and WP4 actions are evidence-based, context-sensitive, inclusive, and responsive to the specific characteristics and needs of each pilot ecosystem.

1.2 Project Context

EQUICARES supports access to innovative and sustainable mental health and care services by people in vulnerable situations through a blend of research, co-creation and policy solutions. The project uses innovative methodologies, such as an advanced application of Levesque's framework for evaluation of mental health services; the deployment of Computational Social Sciences to increase access for hard-to-reach populations in vulnerable situations and collect accurate quantitative and qualitative data on inequalities and opportunities in mental healthcare services; and the combination of complementary cost-analysis techniques. To unlock the design of innovative solutions, the project maps, through digital ethnography, existing innovative solutions, analyses for accessible mental health services, and links them with different parts of the mental health system. Such informative insights are visualised and offered to policymakers through a dedicated Atlas and a policy Dashboard.

EQUICARES pilots innovative solutions in 8 areas from 7 countries, which represent diverse socioeconomic and healthcare settings and cover a wide range of vulnerability factors, while informing various strategic frameworks of the EU. Through “Smart Health Labs”, the project engages people in vulnerable situations at the community level to co-design, implement and assess innovative solutions based on the principles of social economy and user innovation. At the individual level, the project provides awareness-raising and capacity-building and pilots a novel AI-based Assistant, making advancements in the landscape of AI-generated mental health ecosystem, and fostering mental health and digital literacy of users. EQUICARES tests the value of its innovative solutions and applies novel cost analysis techniques to provide solid evidence of the negative impact of no action. Finally, the project aims to replicate its outcomes in 4 additional cases and to develop the Inclusive Mental Health and Care Policy Dashboard towards the sustainability and policy uptake of its results.

1.3 Structure of the report

This report is structured to provide coherent progression from the methodological foundations of the analysis to the profiling of pilot ecosystems and the preparation of subsequent project activities.

- **Chapter 1. Introduction:** Presents the objectives, scope, and positioning of Deliverable D3.1 within the EQUICARES framework and its links with previous project activities, particularly WP1.

- **Chapter 2. Methodology and Conceptual Approach:** Describes the methodological framework, data sources, key concepts, and analytical approach used for profiling pilot ecosystems and designing stakeholder engagement strategies.
- **Chapter 3. Profiles of EQUICARES Pilot Mental Health Ecosystems:** Provides detailed profiles of the eight pilot sites, analysing local contexts, mental health ecosystems, accessibility barriers, target groups of PVS, and priority needs.
- **Chapter 4. Local Engagement Strategies for Smart Health Labs:** Presents the stakeholder ecosystems and tailored engagement strategies developed for each pilot site to support co-creation and Smart Health Lab implementation.
- **Chapter 5. Cross-cutting Insights:** Synthesises common findings, shared challenges, and emerging opportunities across pilot sites, supporting comparative learning and knowledge transfer.
- **Chapter 6. Conclusions:** Summarises the main findings and outlines their implications for the next phases of the project (WP3, WP4), including the establishment, co-creation and piloting activities in Smart Health Labs.

2. Methodology and Conceptual Approach

2.1 Overall Approach and Design

The report follows a qualitative, context-sensitive and multi-stage methodological approach designed to analyse the mental health ecosystems across the eight EQUICARES pilot sites and support the development of tailored stakeholder engagement strategies for the eight Smart Health Labs. The process included an initial pre-profiling exercise with pilot partners (Stage 1), the development and completion of a shared Mental Health Ecosystem Profiling Template and pilot partners (Stage 2), and the synthesis of findings into pilot ecosystem profiles and pilot-specific stakeholder engagement strategies (Stage 3).

The report consists of two closely interconnected components:

Mental health ecosystem profiling, focusing on the analysis of local structural, socio-economic, environmental, and service-related conditions shaping mental health inequalities, accessibility barriers to care and unmet needs of PVS; The ecosystem profiling provides the contextual evidence base necessary to understand local inequalities, unmet needs, and service gaps, while the **engagement strategies** operationalise this knowledge into participatory structures and collaborative processes that will guide the implementation of WP3 activities.

This report constitutes a foundational operational component of EQUICARES, designed to support the establishment and operationalisation of the Labs and to prepare the ground for the participatory engagement, co-creation, and piloting activities implemented under WP3 and WP4. By identifying local inequalities, priority groups of PVS, stakeholder ecosystems, service gaps, and context-specific barriers to care, the report provides the evidence base necessary for the design, implementation, and validation of locally grounded innovative mental health interventions across the pilot sites. More specifically, the findings directly inform:

- the establishment of Smart Health Labs;
- the prioritisation of PVS;
- the tailoring of engagement strategies;

- the identification of local stakeholders and community actors;
- the prioritisation of innovation and investment areas within local mental health ecosystems.

In this sense, the methodology bridges evidence generation and implementation by ensuring that future Smart Health Lab activities are grounded in the realities, inequalities, and capacities of each local ecosystem.



Figure 1. EQUICARES Pilot Ecosystems

2.1.1 Data sources and analytical process

The methodological approach combined desk research, review of policy and strategic documents, analysis of secondary contextual and demographic data, and synthesis of input collected by pilot partners. The findings informed the ecosystem profiling and the development of stakeholder engagement strategies, enabling a structured and context-sensitive understanding of local mental health systems, inequalities, accessibility barriers, stakeholder ecosystems, and service gaps across the pilot sites.

A **common analytical framework** was used as a basis for the analysis. Each pilot site was analysed using a shared profiling template covering the same thematic dimensions across all pilot ecosystems. The collected information was synthesised and organised according to the predefined thematic dimensions of the profiling template, enabling a structured interpretation of local inequalities, accessibility barriers, stakeholder ecosystems, and service gaps across the pilot sites. This ensured

consistency in the collection, organisation, and presentation of information, while still allowing sufficient flexibility to reflect the specific characteristics and mental health service realities of each local context. The approach was not intended to produce a standardised comparison across pilot ecosystems, but rather to reflect the specific realities and mental health service contexts of each pilot area. The template served to capture the complex interaction between socio-economic, territorial, demographic, institutional, environmental, and service-related factors shaping access to mental health and care services for PVS. At the same time, it aimed to identify the local actors, community structures, and enabling conditions necessary for the establishment and operationalisation of Labs. The ecosystem analysis relied on close collaboration with pilot partners, whose local expertise and direct knowledge of the respective ecosystems ensured that the analysis reflected the specific characteristics, challenges, and priorities of each pilot area.

Given the diversity of the pilot ecosystems and data availability across countries, the depth and specificity of the analysis varied between pilot sites. Furthermore, the report relied significantly on secondary sources and partner-provided contextual inputs, which may reflect differences in local data ecosystems and institutional capacities. Nevertheless, the use of a shared profiling structure ensured a coherent and systematic analytical approach across all pilot areas.

2.1.2 Stage 1: Pre-Profiling Exercise

As a first step, all pilot partners completed a **pre-profiling exercise**¹ coordinated by WR during the early stages of the project. The purpose of this exercise was to collect preliminary information regarding the social, demographic, economic, and mental health characteristics of each pilot area, while also identifying initial groups of PVS and key local challenges related to mental health inequalities.

The pre-profiling template worked as an exploratory mapping tool and provided the foundation for the subsequent ecosystem profiling process. Pilot partners contributed primary contextual information based on their local knowledge, organisational experience, stakeholder networks, and available regional or national evidence as described below:

- **General information about the pilot site**
- **Description of the geographical and territorial context**
- **Identification of PVS in the pilot site**
- **Main mental health challenges and inequalities**
- **Existing mental health services and support structures**
- **Key barriers in accessing mental health care**
- **Local stakeholders and community actors**
- **Existing social economy initiatives and community structures**
- **Preliminary engagement considerations for vulnerable groups**
- **Existing local policies, strategies, or programmes relevant to mental health and social inclusion**

The information collected during this stage contributed to the broader WP1 research activities and enabled an initial comparative understanding of inequalities and local ecosystem characteristics across the pilot sites.

1. THE TEMPLATE IS PRESENTED IN THE ANNEX.

2.1.3 Stage 2: Mental Health Ecosystem Profiling Template

Building upon the findings of the pre-profiling exercise, WR developed a comprehensive “Mental Health Ecosystem Profiling Template” for Task 3.1². The template was designed to ensure methodological consistency and analytical depth across all EQUICARES pilot cases.

The template guided pilot partners in conducting a structured ecosystem analysis and stakeholder engagement planning exercise. It combined contextual mapping, inequalities assessment, stakeholder ecosystem analysis, and engagement strategy development.

The **profiling template** included the following analytical sections:

- ✓ **Geographical Context**
- ✓ **Demographic Overview**
- ✓ **Techno-Economic Context**
- ✓ **Ecological and Environmental Factors**
- ✓ **Regulatory and Policy Landscape**
- ✓ **Priority Groups of People in Vulnerable Situations (PVS) and Current Mental Health Needs**
- ✓ **Local Mental Health Ecosystem**
- ✓ **Service Exclusion Trends**
- ✓ **Priority Areas for Investment within the Mental Health Care System**
- ✓ **Social Economy Initiatives to Be Prioritised by the Smart Health Labs**
- ✓ **Key Stakeholders and Local Stakeholder Ecosystem**
- ✓ **Strategy for Stakeholder Engagement**
- ✓ **Stakeholder Engagement Action Plan**
- ✓ **References and Data Sources**

The template also included guiding notes and methodological instructions to support pilot partners in producing contextually grounded and evidence-based analyses.

2.1.4 Stage 3: Synthesis of Findings and Development of Engagement Strategies

Following the completion of the Mental Health Ecosystem Profiling Templates by pilot partners, WR reviewed and synthesised the collected information to develop the pilot ecosystem profiles and corresponding stakeholder engagement strategies. This stage focused on organising the information provided by partners according to the predefined thematic dimensions of the template. The synthesis process was primarily qualitative and interpretative in nature. It aimed to produce a structured and context-sensitive understanding of each pilot ecosystem rather than a standardised comparison across sites.

The information collected by pilot partners was complemented by:

- findings from WP1 tasks and deliverables;
- statistical and demographic datasets;
- policy documents and mental health strategies;
- scientific literature and local reports;
- local organisational expertise and stakeholder knowledge;

2. THE TEMPLATE IS PRESENTED IN THE ANNEX.

- contextual observations and experiential insights.

Where gaps, inconsistencies, or unclear points were identified, iterative exchanges with pilot partners supported clarification, refinement, and contextual validation of the analysis. Importantly, the profiling process also aligns with the broader EQUICARES approach, which emphasises the integration of multiple perspectives. By combining structured templates, existing research, and local knowledge, the approach enables a comprehensive and nuanced understanding of each pilot ecosystem.

The development of the stakeholder engagement strategies is built on this synthesis process. In particular, the strategies were informed by the findings of WP1, especially in relation to accessibility barriers and inequalities, as well as by the contextual analysis conducted for each pilot site. Insights related to socio-economic conditions, service provision gaps, stakeholder ecosystems, existing community structures, and priority PVS supported the adaptation of engagement approaches to local realities.

The engagement strategies also draw on the participatory and ethnographic principles which emphasise the importance of understanding the lived experiences of PVS and engaging them in ways that are accessible, meaningful, and responsive to their needs. In this context, the strategies anticipate the use of qualitative and participatory methods, such as focus groups, workshops, community interactions, and feedback loops, to support inclusive engagement and the continuous refinement of Lab activities.

Finally, each pilot site developed a structured engagement action plan outlining specific activities, timelines, and methods for stakeholder involvement across different project tasks. These include, among others, warm-up events, co-creation workshops, awareness-raising campaigns, citizen science activities, and capacity-building initiatives, which will be progressively implemented throughout WP3 and beyond. The design of these actions follows key guiding principles, including feasibility, inclusivity, and alignment with the characteristics of the target groups, ensuring that engagement strategies are both effective and sustainable.

2.2 Conceptual Framework and Analytical Perspective

2.2.1 Mental health inequalities and ecosystem perspective

The conceptual framework of this report reflects the EQUICARES understanding of mental health as a multidimensional and socially embedded phenomenon shaped by the interaction between individual experiences and broader structural determinants³. It provides the conceptual lens through which the collected information was interpreted and through which the pilot ecosystem profiles and stakeholder engagement strategies were structured.

Central to this approach is the recognition that mental health inequalities are not solely determined by clinical or individual factors, but are strongly influenced by:

- socio-economic conditions;
- poverty and material deprivation;
- discrimination and stigma;

3. DEFINITION DERIVED FROM WORLD HEALTH ORGANISATION. (2022). WORLD MENTAL HEALTH REPORT: TRANSFORMING MENTAL HEALTH FOR ALL. WORLD HEALTH ORGANISATION

- migration and displacement;
- digital exclusion;
- territorial inequalities;
- institutional fragmentation;
- unequal access to services and resources.

The analysis, therefore, adopts a **mental health ecosystem perspective**, whereby mental health outcomes and access to care are understood as products of interconnected systems involving:

- healthcare providers;
- social services;
- public institutions;
- civil society organisations;
- community actors;
- social economy initiatives;
- governance and policy frameworks;
- environmental and territorial conditions.

This ecosystem perspective enables a holistic understanding of how formal and informal structures interact to either facilitate or hinder equitable access to mental health support.

2.2.2 Understanding vulnerability and identifying PVS

Within the above framework, the concept of PVS is central. Vulnerability is not treated as a fixed or inherent characteristic of individuals, but rather as a dynamic condition produced through structural inequalities, exclusionary systems, and intersecting disadvantages⁴. Factors such as poverty, discrimination, social exclusion, migration status, territorial isolation, limited access to services, and unequal healthcare opportunities are understood as key determinants shaping mental health inequalities and accessibility gaps. The project therefore adopts an intersectional understanding of vulnerability, recognising that individuals may simultaneously experience multiple forms of disadvantage that reinforce barriers to mental health care.

The identification of PVS represented a core methodological step within the profiling of pilot ecosystems, as it defines the primary target groups for engagement and directly informs the design and implementation of the Labs. This process builds on D1.1, which provides a common framework for identifying target populations across the project, including ethnoreligious minorities, refugees and asylum seekers, persons with disabilities, LGBTQIA+ individuals, Roma communities, migrants, natural disaster survivors, older adults, and youth populations. At the same time, the methodology acknowledges the intersectional nature of vulnerability, recognising that individuals may experience overlapping forms of disadvantage that further intensify barriers to mental health care.

Building on this framework, pilot partners prioritised PVS groups based on local contextual analysis, WP1 evidence, desk research, and organisational expertise. The selection process considered:

- exposure to barriers in accessing mental health services;
- degree of marginalisation and social exclusion;
- prevalence of unmet mental health and psychosocial needs;

4. THIS UNDERSTANDING IS ALIGNED WITH THE EQUICARES GRANT AGREEMENT AND D1.1, WHICH FRAME VULNERABILITY IN RELATION TO SOCIAL, ECONOMIC, TERRITORIAL, CULTURAL AND SYSTEMIC BARRIERS AFFECTING ACCESS TO MENTAL HEALTH AND CARE SERVICES.”

- local demographic and socio-economic conditions;
- relevance to the local context and feasibility of engagement within Labs

Across the pilot sites, the identified PVS groups reflect both common mental health inequalities and context-specific vulnerabilities. The PVS groups analysed in this report include:

- Earthquake survivors and older adults in Antakya, Hatay;
- Older adults, migrants, and refugees in Thessaloniki;
- Youth and unaccompanied children in Attica;
- Roma communities and ethnoreligious minorities in Bulgaria;
- Persons with intellectual and physical disabilities in France;
- LGBTQIA+ individuals and LGBTQIA+ refugees in Ireland;
- Roma women and Latin American migrants in Sevilla;
- Migrants, refugees, and older migrants in Mannheim.

The identification of PVS serves both an analytical and operational function within WP3. Beyond supporting the understanding of inequalities and exclusion trends, it directly shapes stakeholder engagement strategies, recruitment approaches, co-creation activities, and the development of tailored and culturally sensitive participation methods within the Labs.

The methodological approach is also strongly linked to the operational philosophy of the Labs, which is understood as participatory, community-based, and hybrid (physical and digital) spaces that bring together:

- PVS;
- healthcare and social care providers;
- NGOs and grassroots organisations;
- researchers and universities;
- policy actors;
- community leaders and intermediaries.

Through co-creation and collaborative problem-solving, the Labs aim to design and test inclusive and context-sensitive solutions to improve accessibility and responsiveness of mental health services.

Stakeholder engagement is therefore conceptualised not as a parallel activity, but as a core component of this report, linking ecosystem profiling with the future co-creation and piloting activities of the Labs.

3. Profiles of EQUICARES Pilot Mental Health Ecosystems

The following section presents an overview of the mental health ecosystem profiles developed for the eight EQUICARES pilot sites.

3.1 Overview of Pilot Sites

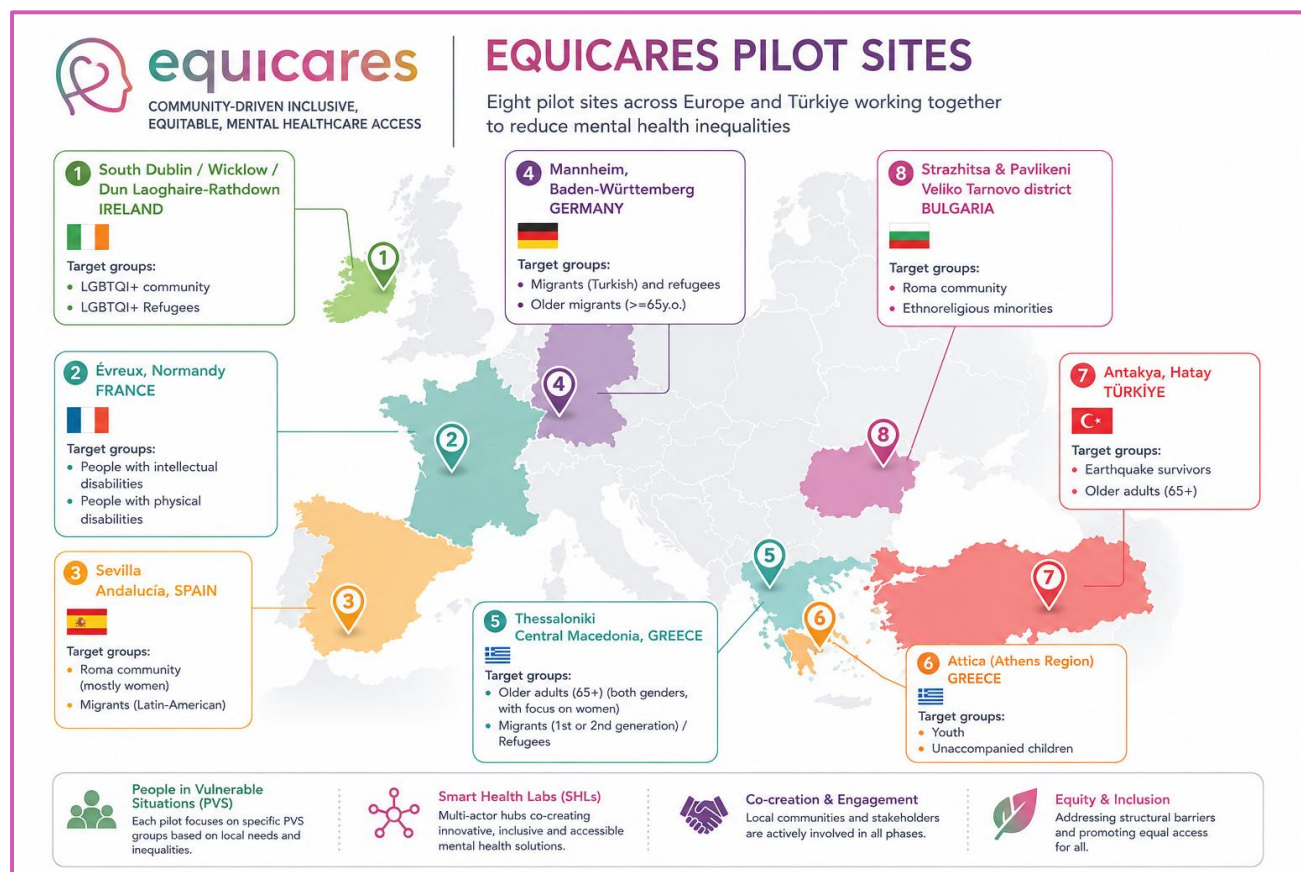


Figure 2. EQUICARES pilot sites

3.2 South Dublin / Wicklow / Dún Laoghaire–Rathdown (Ireland)

3.2.1 Geographical Context & Demographic Overview

Key territorial and demographic characteristics

The Ireland pilot site covers the South Dublin, Wicklow and Dún Laoghaire–Rathdown area, corresponding broadly to the former CHO 6 healthcare area and the IE061/IE062 territorial classification. This pilot territory brings together a diverse mix of urban, peri-urban, rural and coastal environments, creating a varied local context for analysing mental health service accessibility, community resources and place-based barriers to care.

The area has an estimated population of approximately 393,239 inhabitants, including around 98,502 residents under the age of 18. Its demographic profile is predominantly White-Irish, although the proportion varies across Wicklow, Dún Laoghaire–Rathdown, and Dublin City Council areas. At the same time, the territory is becoming increasingly diverse, with growing representation of residents from other White backgrounds, as well as Asian and Asian-Irish communities. While most residents hold Irish citizenship, citizenship diversity is more visible in urban areas, particularly in Dublin City Council. These demographic and territorial characteristics are important for understanding local needs, potential inequalities in access to mental health and care services, and the design of inclusive Smart Health Lab activities in the Ireland pilot site.

The infographic below presents the location and demographic overview of the Ireland pilot site, covering South Dublin, Wicklow and Dún Laoghaire–Rathdown, broadly corresponding to the former CHO 6 healthcare area and the IE061/IE062 territorial classification. As illustrated, the pilot area combines urban, suburban, rural and coastal environments, which creates a diverse territorial setting for examining mental health needs, service accessibility and social inclusion challenges.

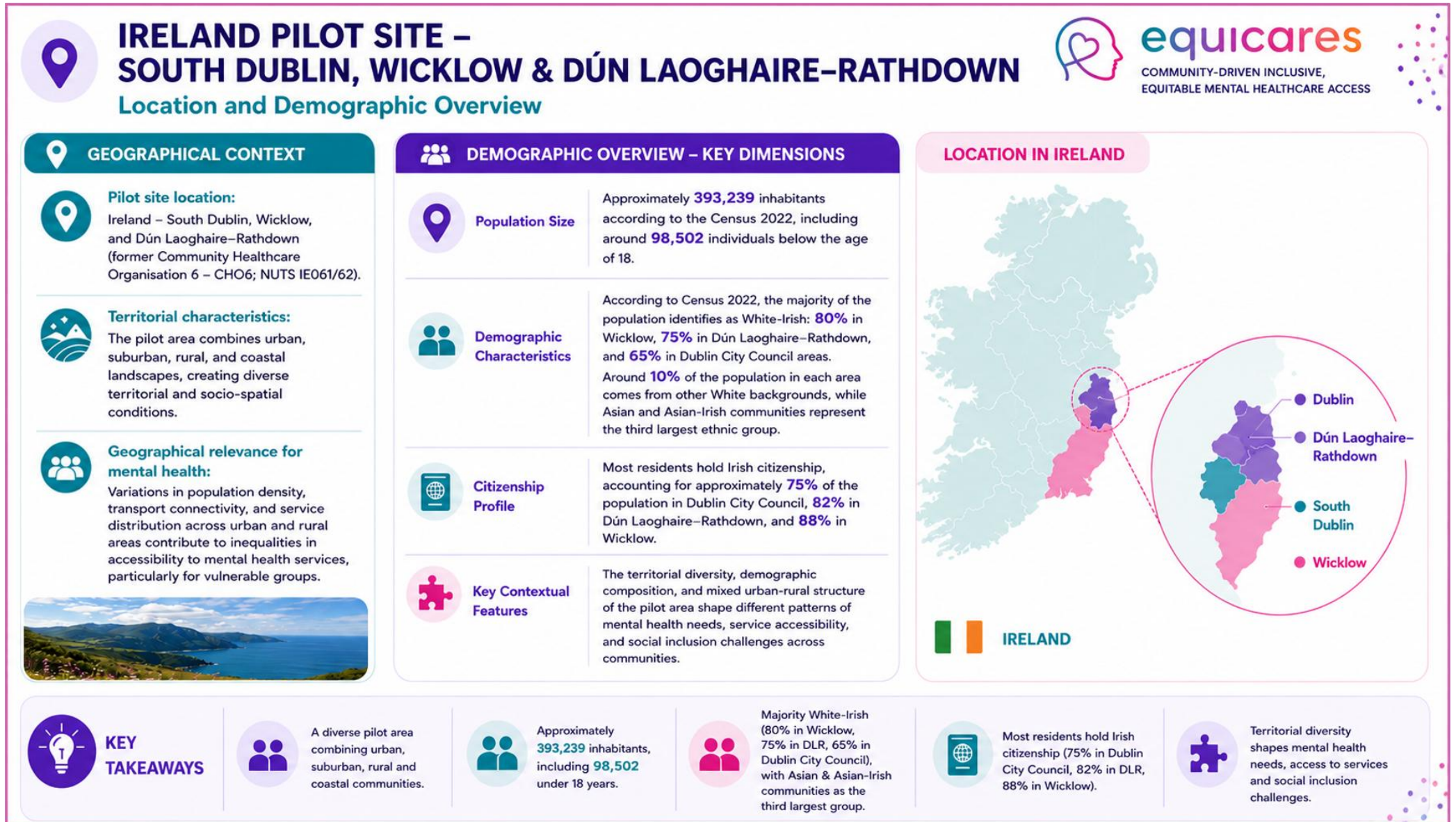


Figure 3. South Dublin, Wicklow & Dun Laoghaire-Rathdown (Ireland) Location and Demographic Overview

The chart below (Figure 4) indicates that White Irish residents form the largest ethnic/cultural group across all three areas, although the proportion varies by territory. Wicklow has the highest share of White Irish residents, followed by Dún Laoghaire–Rathdown, while Dublin City Council shows the lowest proportion and the most diverse population profile.

In all three areas, Other White is the second-largest category, reflecting the presence of residents from other European and international backgrounds. Dublin City Council appears to have the highest level of ethnic and cultural diversity, with larger shares of Other White, Asian or Asian Irish, Other, and Not stated categories compared with the other two areas. Dún Laoghaire–Rathdown also shows a visible level of diversity, while Wicklow remains comparatively more homogeneous.

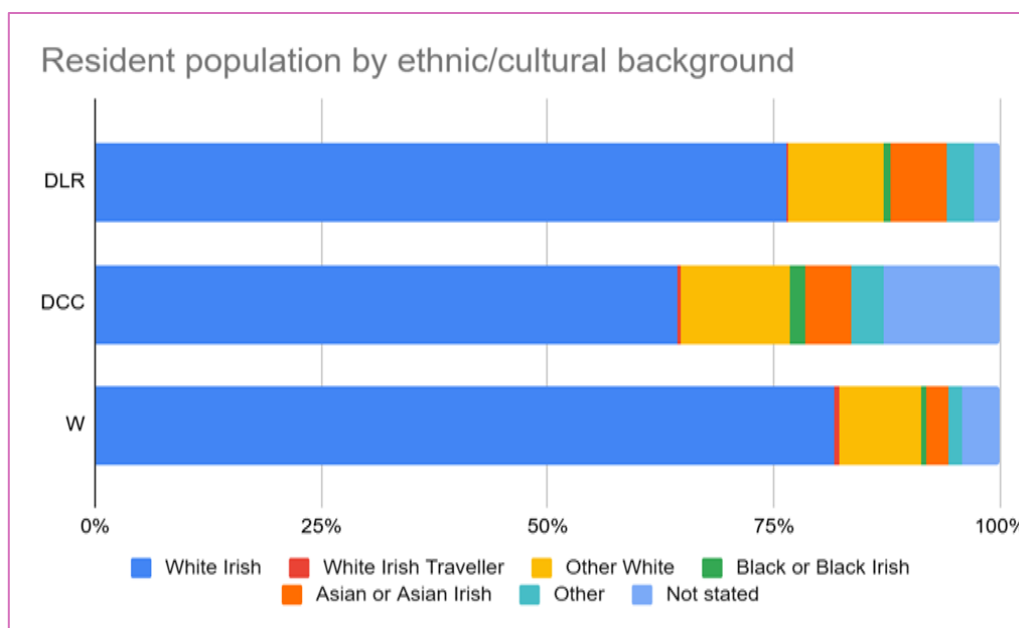


Figure 4. Resident population in South Dublin by ethnic/cultural background ⁵

Overall, the graph highlights that the Ireland pilot site is predominantly White Irish, but with important territorial differences in diversity. These differences are particularly relevant for understanding local needs, inclusive outreach, and culturally responsive mental health and care services.

Figure 5 shows that Irish citizens represent the largest share of the resident population across all three areas. Wicklow has the highest proportion of residents with Irish citizenship, followed by Dún Laoghaire–Rathdown, while Dublin City Council has the lowest share and the most diverse citizenship profile.

Dublin City Council presents the greatest citizenship diversity, with more visible shares of residents from Other EU27 countries, the rest of the world, India, Poland and the UK. Dún Laoghaire- Rathdown also shows some diversity, particularly among residents from the rest of the world and other EU countries, while Wicklow remains comparatively more concentrated in Irish citizenship.

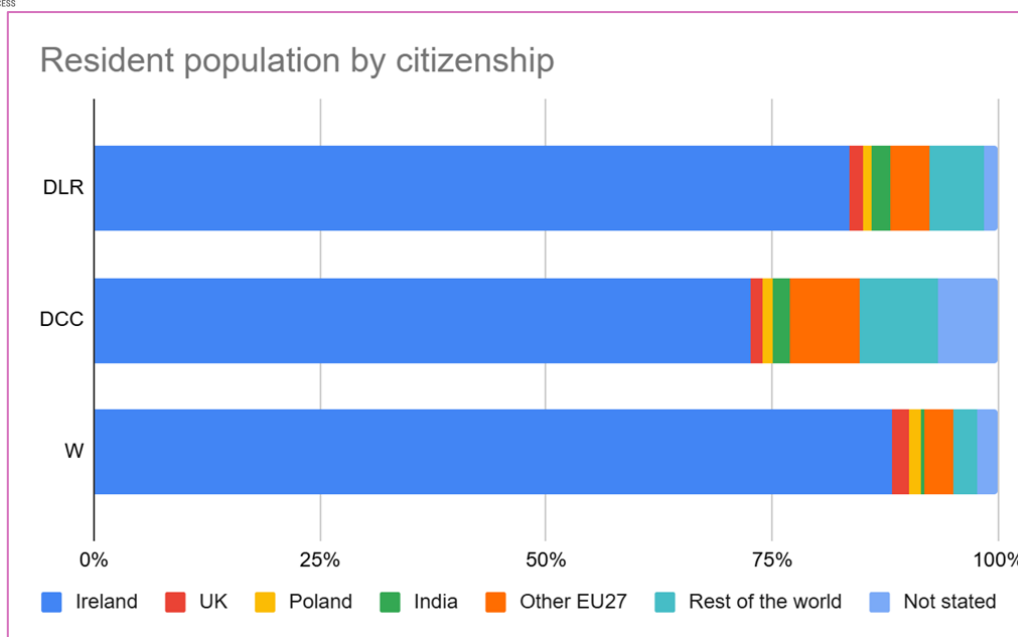


Figure 5. Resident population in South Dublin by citizenship ⁶

Overall, the graph highlights that while the pilot area is predominantly composed of Irish citizens, citizenship diversity is more pronounced in urban areas, especially Dublin City Council. This is relevant for understanding potential differences in service needs, language and cultural accessibility, and inclusive outreach within the Ireland Smart Health Lab.

3.2.2 Techno-Economic Context

Digital infrastructure and socio-economic inequalities

The area generally benefits from high broadband connectivity, which can support access to digital mental health services and online support tools. However, connectivity is not evenly distributed across the territory. Lower levels of broadband access are mainly observed in Wicklow, particularly in more rural areas, where digital exclusion may reinforce existing barriers to service access.

From a socio-economic perspective, the pilot area presents important internal disparities. The Trinity National Deprivation Index (TNDI) highlights significant heterogeneity across the three county council areas:

- Dún Laoghaire-Rathdown is ranked as the least deprived county council in Ireland.
- Wicklow ranks 11th out of 34 county councils.
- South Dublin ranks 18th out of 34 county councils.
- South Dublin and DLR record higher Gini coefficients than the national average, indicating stronger income inequality.
- In South Dublin and DLR, affluent and deprived neighbourhoods often exist in close proximity, which may contribute to weaker social cohesion and territorial segregation.

These socio-economic and digital disparities are relevant for the Irish Lab, as they may influence who can access mental health information, digital tools, community-based support, and formal services.

They also underline the need for outreach approaches that consider both rural accessibility barriers and inequalities within more urbanised areas.

Educational attainment and human capital

The educational profile of the Irish pilot site indicates relatively strong human capital across South Dublin, Dún Laoghaire–Rathdown, and Wicklow. The educational attainment graph below shows that higher education is strongly represented among residents aged 15 and above, with bachelor-level qualifications forming the largest category. This suggests a favourable context for awareness-raising, digital engagement and participation in Smart Health Lab activities, although territorial differences may still influence how evenly these advantages are distributed across the pilot area.

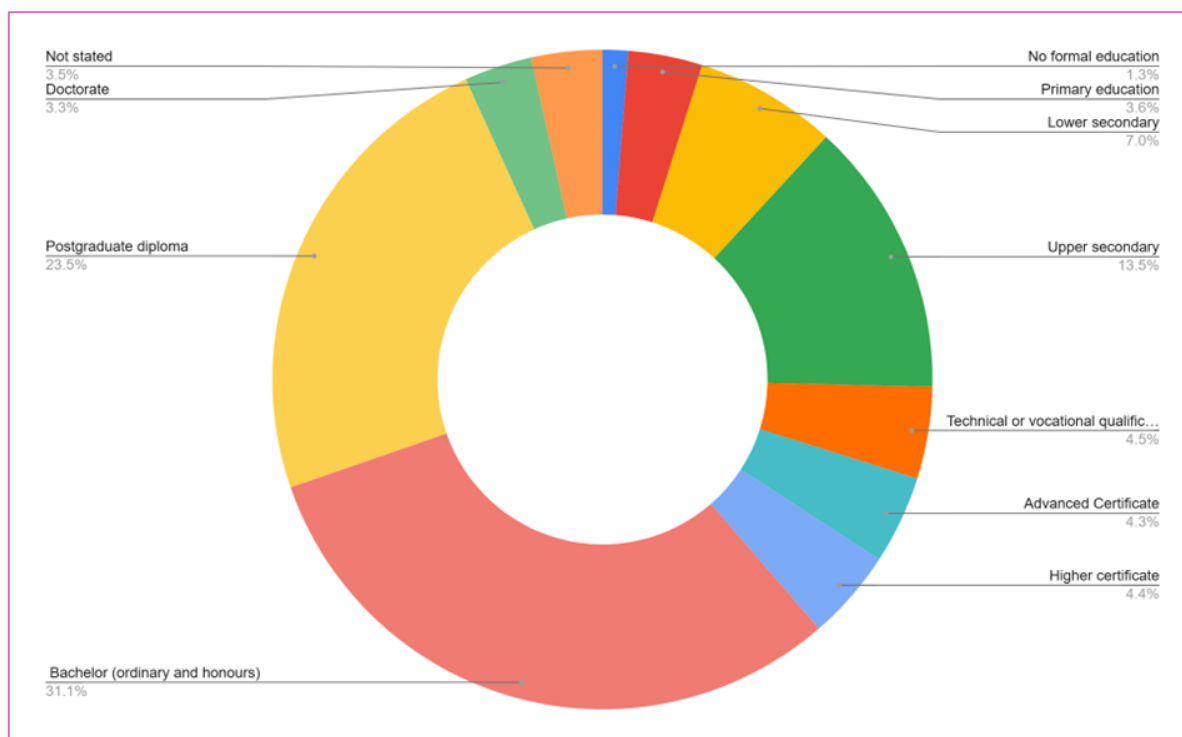


Figure 6. Highest degree obtained by population aged 15 or above ⁷

Key points emerging from the graph include:

1. Bachelor-level qualifications represent the largest educational category, accounting for approximately 31.1% of the population aged 15 and above.
2. Around 23.5% of residents hold a postgraduate qualification, while approximately 3.3% have a doctorate.
3. More than 50% of the population aged 15 and above therefore holds at least a bachelor's degree.
4. Upper secondary education accounts for around 13.5%, while lower secondary and primary education represent smaller shares.

The relatively high level of educational attainment may support the uptake of digital mental health tools, capacity-building activities and community-based engagement, but targeted outreach may still be needed for groups with lower educational or digital literacy levels.

Employment patterns and dominant industries

The employment profile of the pilot site also points to a relatively skilled labour market. The employment-type graph (Figure 7) shows that the largest share of the working population is employed in managerial and technical occupations, followed by professional occupations. Together, these groups account for approximately 61.3% of the employed population, indicating a strong concentration of higher-skilled employment across the pilot area.

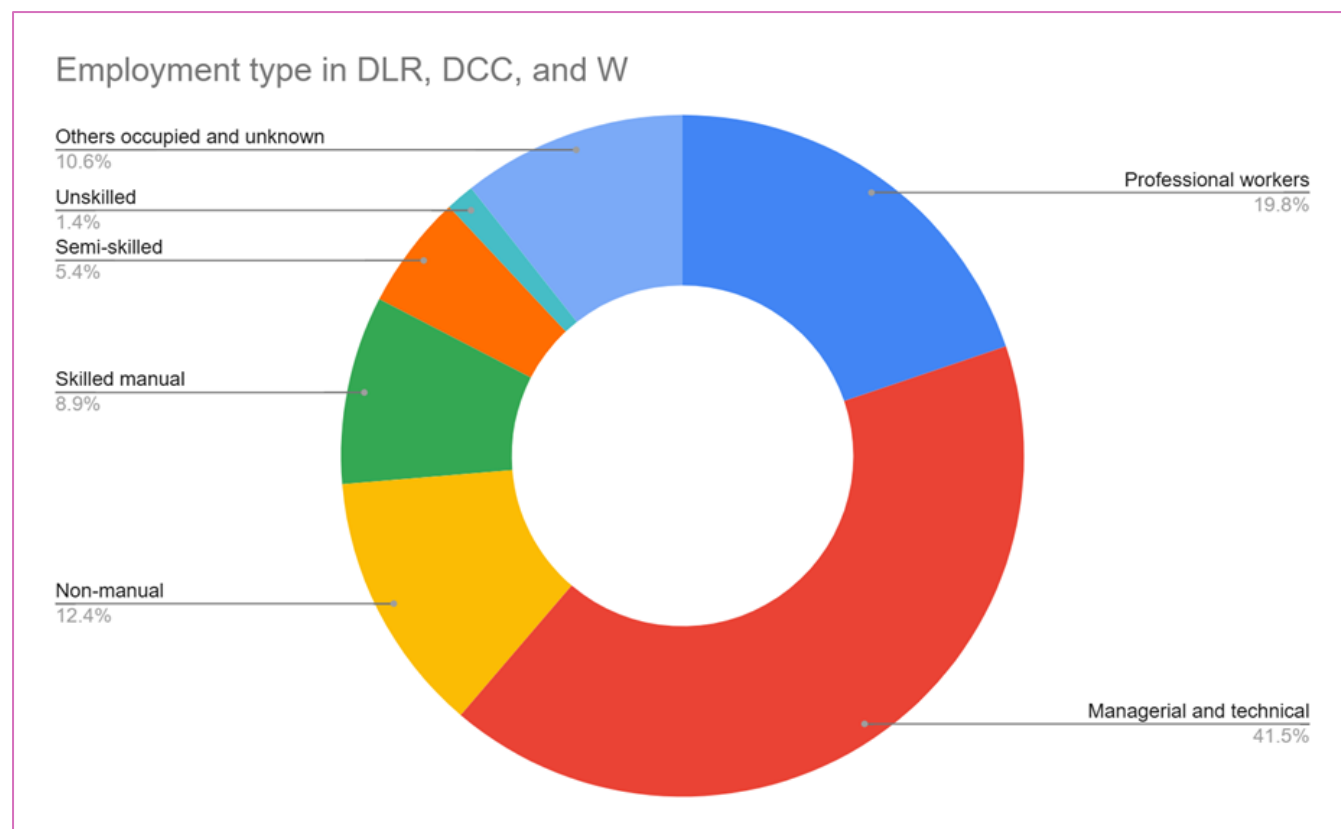


Figure 7. Employment type in South Dublin, DLR, and Wicklow ⁸

Key points emerging from the employment-type graph include:

1. Managerial and technical occupations represent the largest employment category, accounting for approximately 41.5%.
2. Professional workers account for around 19.8% of the employed population.
3. Non-manual occupations represent approximately 12.4%, while skilled manual work accounts for around 8.9%.
4. Semi-skilled and unskilled occupations account for a smaller share, around 6.8% combined.

These patterns suggest strong employment capacity overall, but also point to the presence of groups that may face greater socio-economic vulnerability, particularly those in lower-skilled, unstable or lower-paid employment.

Dominant industries in South Dublin, Dún Laoghaire–Rathdown (DLR), and Wicklow

The industry distribution graph (Figure 8) further shows that commerce and trade, and professional services are among the dominant sectors across Dún Laoghaire–Rathdown, Dublin City Council and Wicklow. However, the sectoral profile varies across the three county council areas, reflecting the mixed urban, suburban and rural character of the pilot site.

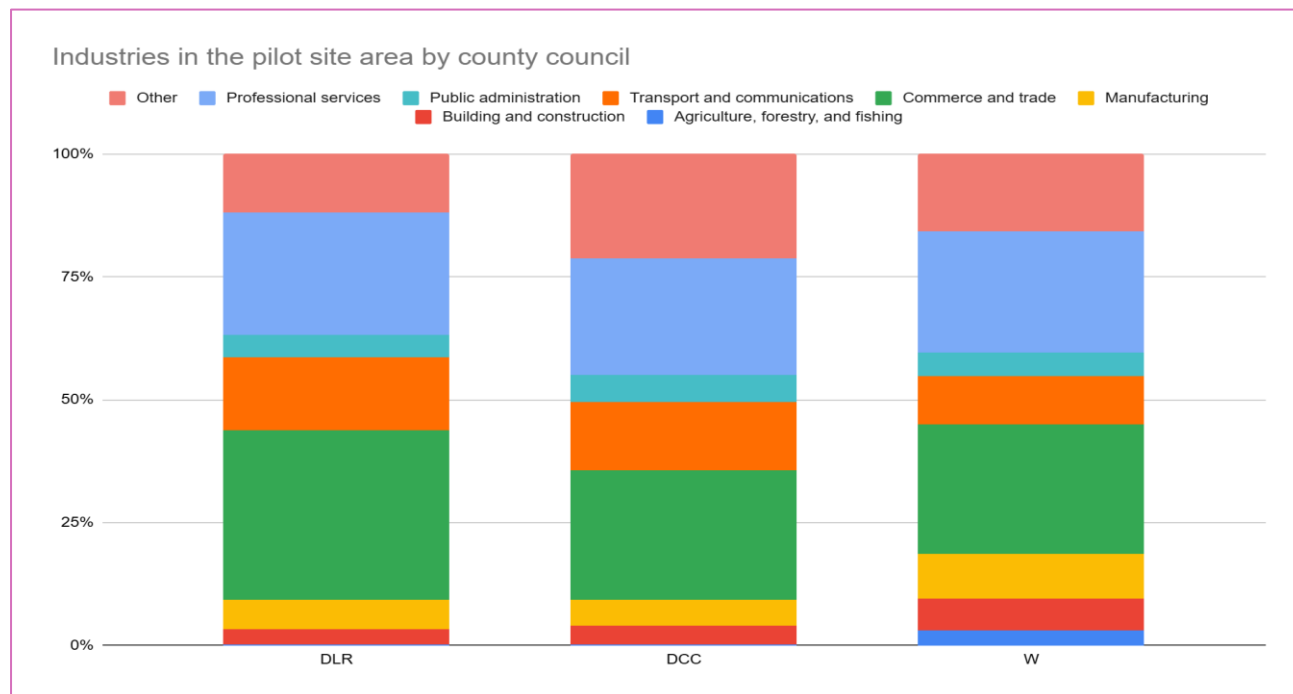


Figure 8. Distribution of industries by country council ⁹

Key points emerging from the industry graph include:

1. Commerce and trade represent a major sector across all three county council areas.
2. Professional services are also strongly represented, particularly in the more urbanised parts of the pilot site.
3. Dublin City Council shows a more diversified employment structure, with notable shares across professional services, commerce and trade, transport and communications, public administration and other sectors.
4. Dún Laoghaire–Rathdown shows a strong presence of commerce and trade and professional services, consistent with its more urban and economically advantaged profile.
5. Wicklow demonstrates a stronger presence of agriculture, forestry and fishing compared with the more urbanised areas, while also showing visible activity in manufacturing, commerce and trade.

3.2.1 Ecological and Environmental Factors

Environmental and climate-related factors

The Ireland pilot site does not present major environmental risks that directly affect the mental health ecosystem. However, Ireland's climate is characterised by high rainfall levels, which may occasionally cause localised flooding. While flooding is not considered a frequent or structural barrier in the pilot area, temporary road disruption may affect access to services in specific locations, particularly where public transport or alternative routes are limited.

Housing conditions

Housing conditions represent a more significant social vulnerability factor. South Dublin is strongly affected by the ongoing housing crisis, including high rental prices and poor housing conditions for people with low or no income. Housing affordability pressures are also visible in parts of Dún Laoghaire–Rathdown, despite its overall affluent profile, due to the high cost of housing in the area.

3.2.2 Regulatory and Policy Landscape

Ireland has a relatively developed policy and legislative framework for mental health, inclusion and equality. The national framework includes mental health legislation, strategic policy documents, implementation plans, and monitoring indicators. At the same time, important regulatory gaps remain, particularly in relation to the distinction between public and private mental health provision and the availability of LGBTQI+-affirming services.

Table 1. Key regulatory and policy frameworks shaping mental health service access, LGBTQI+ inclusion, suicide prevention, and governance in the Ireland pilot site

Policy / Governance Area	Main Features
National mental health framework	The Mental Health Acts 2001–2022 provide the main legislative framework for mental healthcare and treatment in Ireland. The Mental Health Bill 2024 introduces reforms to update the existing legal framework.
Mental health promotion and reform	Sharing the Vision and its implementation plan guide mental health reform, while the National Mental Health Promotion Plan 2024–2030 sets priorities for promotion and prevention. Policy indicators have also been developed to monitor mental health policy implementation.
LGBTQI+ inclusion and equality	The National LGBTQI+ Inclusion Strategy II 2024–2028 aims to strengthen equality, participation, inclusion and wellbeing among LGBTQI+ communities. The Mental Health Commission has also issued guidance for professionals working with LGBTQIA+ people in mental health services.
Suicide prevention and inclusion training	The National Office for Suicide Prevention supports targeted initiatives for vulnerable groups, including LGBTQI+ people, refugees, Travellers, Roma communities, people experiencing homelessness and victims of domestic and gender-based violence. HSE Land also offers training and re/upskilling opportunities for healthcare professionals, including LGBTQI+ health modules.
Governance and regulatory gaps	Existing legislation and policies mainly regulate public mental health services. Many services perceived as more culturally appropriate for LGBTQI+ people are privately provided. Private counselling and psychotherapy services are regulated separately through the Irish Association for Counselling and Psychotherapy, while quality assurance processes remain under development.

The existing policy and regulatory landscape in Ireland provides an enabling environment for the development and operation of a Smart Health Lab. National mental health policies, including *Sharing the Vision*, the National Mental Health Promotion Plan 2024–2030 and the related implementation framework, create a strong basis for aligning the Lab with national priorities on prevention, early intervention, community-based care, service accessibility and mental health promotion.

3.2.3 Priority PVS and Current Mental Health Needs in South Dublin, DLR and Wicklow



Figure 9. Priority PVS and Current Mental Health Needs in South Dublin, DLR and Wicklow

The Irish Smart Health Lab will prioritise LGBTQI+ people, including LGBTQI+ refugees, as its main target group. Although national census data do not currently capture sexual orientation or gender identity, recent estimates suggest that around 10% of the Irish population identifies as LGBTQI+¹⁰, corresponding to approximately 40,000 people within the pilot area.

This group faces persistent barriers to culturally appropriate, accessible and affordable mental health care. Public services do not consistently provide LGBTQI+-inclusive support, while long waiting lists affect both public and low-cost private services. Trans and gender non-conforming people face additional challenges, particularly due to limited access to gender-affirming healthcare and the continued use of psychiatric assessment processes, which may discourage openness about mental health difficulties.

LGBTQI+ people in Ireland continue to experience stigma, discrimination, harassment and hate speech, with young people, trans people and gender non-conforming individuals facing particularly high levels of anxiety, depression, self-harm, suicidal behaviour and other mental health risks. Existing support is provided by organisations such as LGBT Ireland, TENI, Outhouse LGBTQ+ Centre, BeLonG To and LGBTQI+-inclusive private providers, although gaps remain in mainstream public provision.

3.2.4 Local Mental Health Ecosystem

Workforce, Service Capacity and Governance

The local mental health ecosystem in the Ireland pilot site is shaped by a mixed public, private and community-based service structure. Public Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services are delivered through St John of God Community Mental Health Services, including Lucena CAMHS. However, the ecosystem faces important capacity constraints, particularly in relation to CAMHS staffing, availability of specialised services, and consistency of LGBTQI+-inclusive care.

Team	WTE During MHC Inspection (July 2022)	% VFC (Clinical)	Current WTE (March 2023)	% VFC (Clinical)
Marine 56	Clinical: 7.8 Admin: 0.8	51%	Clinical: 8.1 Admin: 1	53%
Dun Laoghaire	Clinical: 13.2 Admin: 3	53%	Clinical: 14.3 Admin: 3	57%
Rathgar Team A	Clinical: 10.5 Admin: 1.5	38%	Clinical: 10.3 Admin: 1.5	37%
Rathgar Team C	Clinical: 10.2 Admin: 1.5	40%	Clinical: 9.62 Admin: 1	38%
Bray	Clinical: 6.95 Admin: 2	48%	Clinical: 8.05 Admin: 2	55%
Wicklow	Clinical: 8.2 Admin: 2	62%	Clinical: 8.65 Admin: 2	66%
Tallaght Team 1	Clinical: 11 Admin: 1.5	76%	Clinical: 11.4 Admin: 2	79%
Tallaght Team 2	Clinical: 6.37 Admin: 1	73%	Clinical: 7.77 Admin: 1	90%

*Numbers supplied by CHO.
Whole time equivalents

Figure 10. CAMHS staffing levels by team: Whole-Time Equivalents (WTE) and percentage of Vision for Change clinical staffing recommendations, July 2022 and March 2023.

Figure 10 compares staffing levels across eight CAMHS teams between the Mental Health Commission inspection in July 2022 and March 2023. It shows that clinical staffing increased slightly

in several teams, including Marine 56, Dún Laoghaire, Bray, Wicklow, Tallaght Team 1 and Tallaght Team 2. Tallaght Team 2 shows the strongest improvement, rising from 73% to 90% of the recommended clinical staffing level. Wicklow also records a relatively high staffing level, reaching 66% of the recommended level in March 2023.

Despite these improvements, the table clearly indicates that most teams remain below the recommended staffing levels. In March 2023, the percentage of recommended clinical staffing ranged from 37% in Rathgar Team A to 90% in Tallaght Team 2. Rathgar Team A and Rathgar Team C show slight decreases over time, while several other teams remain only around half of the recommended clinical capacity. This confirms that workforce shortages remain a major structural challenge for the local mental health ecosystem, contributing to long waiting lists and limiting the range, intensity and timeliness of therapeutic interventions.

Table 2. Local mental health ecosystem in Ireland

Ecosystem Dimension	Key Findings
Workforce and service capacity	CAMHS and Adult Mental Health Services are delivered through St John of God Community Mental Health Services, including Lucena CAMHS. CAMHS community and liaison teams remain below recommended levels, and no day hospital is currently available in the pilot site area.
Staffing gaps	The service operates through eight clinical teams, including two teams with only part-time consultant psychiatrists. Staffing levels remain below recommended capacity across most teams. Mental healthcare in Ireland is organised through a combination of public and private services.
Service organisation	Public services generally require GP referral, while some private or online services may be accessed more directly. Community mental health services exist, but coverage varies geographically.
Governance and regulation	Public mental health services are governed by the Health Service Executive and regulated through national legislation and policy frameworks. Private counselling and psychotherapy services are regulated separately, mainly through the Irish Association for Counselling and Psychotherapy.
Role of GPs and NGOs	GPs play a central role in referral pathways, but LGBTQI+ education and competency training are not mandatory. NGOs provide important peer-support and community-based activities, often free of charge, but usually group-based rather than one-to-one clinical care.
System-wide challenges	Main challenges include workforce shortages, limited facilities, long waiting times, insufficient specialised services and inconsistent LGBTQI+-inclusive care.

Overall, the graph and ecosystem analysis show that the Ireland pilot site has an established service structure but faces persistent capacity and workforce limitations. These constraints are particularly important for LGBTQI+ people and LGBTQI+ refugees, who may also face stigma, low trust in

mainstream services, and difficulties identifying safe and inclusive support. The Smart Health Lab could add value by improving service navigation, strengthening community-based support, supporting professional awareness, and creating a more coordinated local ecosystem around inclusive mental health access.

3.2.5 Service Exclusion Trends

The table below summarises the main service exclusion trends identified in South Dublin, Wicklow, and Dún Laoghaire-Rathdown. It highlights how access to mental health and care services may be affected by territorial, financial, geographical, social, and digital barriers across the pilot territory. Given the area's mixed urban, suburban, rural, and coastal character, exclusion is not experienced equally by all residents.

While some areas benefit from stronger transport connections and service availability, more rural and dispersed communities face greater mobility and accessibility challenges. At the same time, the cost of private mental health support, limitations in public provision, stigma, low literacy, and limited digital access may further restrict service use, particularly among LGBTQI+ people and other vulnerable groups. These trends provide an important basis for understanding where targeted outreach, inclusive communication, and adapted service pathways may be needed during the Smart Health Lab implementation.

Table 3. Main service exclusion trends affecting access to mental healthcare and psychosocial support in South Dublin, Wicklow, Dún Laoghaire-Rathdown

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Territorial Accessibility and Mobility	The pilot site area combines urban, suburban, and rural territories with varying levels of accessibility to health and social care services.
	South Dublin benefits from relatively well-functioning public transport systems.
	Dún Laoghaire–Rathdown is serviced by buses, trains, and trams, although many residents still rely on private cars for commuting.
	Wicklow, particularly its rural areas, is considerably more difficult to navigate without access to a car due to limited public transport frequency.
Financial	Territorial and mobility disparities directly affect access to mental health services, particularly for individuals living in rural or isolated areas.
	Public mental health services are free of charge but are generally limited to approximately six sessions unless inpatient treatment is required.
	The cost of private mental health services represents a significant accessibility barrier.
	The Irish insurance system is two-tiered, with a medical card being issued to no or low-income earners, while others may access private medical insurance that can cover some psychological support.

	Medical cards for low-income populations do not generally cover mental health services. Some online providers, such as Turn2Me, offer six free counselling sessions.
Geographical	Rural areas within Wicklow experience lower accessibility to mental health services due to transport limitations and territorial barriers. Geographic dispersion and reduced public transport frequency contribute to inequalities in service accessibility across the pilot territory.
Social and Digital	Certain LGBTQI+ groups remain particularly difficult to reach due to low literacy levels, limited digital literacy, and non-supportive social environments. Social stigma and exclusion may reduce engagement with formal mental health support systems among vulnerable populations.

While the pilot site benefits from existing public, private and community-based support structures, these resources are not equally accessible across the territory. Rural parts of Wicklow face stronger mobility and transport-related barriers, while financial constraints limit access to private mental health care for people who cannot afford out-of-pocket support. At the same time, stigma, low literacy, limited digital skills and non-supportive social environments may prevent some LGBTQI+ people and other vulnerable groups from seeking or sustaining engagement with services.

3.2.6 Priority Areas for Investment within the Mental Health Care System in Ireland

Table 4 identifies key priority areas for investment and innovation within the mental health care ecosystem of South Dublin, Wicklow, and Dún Laoghaire-Rathdown. It builds on the main system gaps identified in the pilot site, including long waiting times, limited service capacity, barriers to gender-affirming care, inconsistent LGBTQI+-inclusive practices, and broader legislative and structural protection gaps. These challenges are particularly relevant for LGBTQI+ people, including transgender individuals and other groups who may experience stigma, discrimination, or reduced trust in formal mental health services. The table links each identified gap to potential investment and innovation areas in the Irish mental health ecosystem, and the expected outcomes. In this way, it provides a practical basis for aligning pilot activities with local needs and for supporting more inclusive, accessible, and rights-based mental health care.

Table 4. Priority Areas for Investment within the Mental Health Care in South Dublin, Wicklow, Dún Laoghaire-Rathdown

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment / Innovation Area	Expected Outcomes
Oversubscribed Mental Health System and Long Waiting Times	- The Irish healthcare system is currently oversubscribed, with extensive waiting lists across most healthcare services. - Waiting times for public mental health services are significantly longer than the national healthcare average. - Waiting lists remain particularly severe within Child and Adolescent Mental Health Services (CAMHS).	- Expanding workforce and service capacity; - Strengthening early intervention and community-based care pathways; - Developing hybrid digital and face-to-face follow-up models.	- Reduced waiting times; - Improved continuity of care; - Earlier intervention and reduced crisis escalation.
Limited Access to Gender-Affirming Care	- Access to public gender-affirming care for transgender individuals currently involves waiting lists of approximately 4.5 years, although community organisations estimate considerably longer delays. - Ireland has ranked last in the TGEU Trans Health Map for the past three years. - Delays and limited service capacity create substantial barriers to timely and affirming care.	- Increasing accessibility and capacity of gender-affirming healthcare services; - Ensuring transgender individuals can access mental health support without compromising access to gender-affirming pathways; - Strengthening integrated and affirming mental healthcare.	- Improved accessibility to affirming care; - Reduced exclusion and distress among transgender populations; - Strengthened trust in mental healthcare services.

Discrimination and Lack of LGBTQI+-Inclusive Care	• LGBTQI+ people continue to experience inconsistent and sometimes discriminatory treatment within mental health services. • LGBTQI+ individuals report feeling less respected and listened to by mental health professionals compared to cisgender heterosexual populations. • Experiences of stigma and exclusion discourage engagement with formal mental health support systems.	• Upskilling mental health professionals in LGBTQI+-inclusive care; • Increasing visibility of trained and LGBTQI+-affirming providers; • Strengthening anti-discrimination and affirming approaches within mental healthcare services.	• Improved service inclusivity and cultural competence; • Increased engagement with mental health services among LGBTQI+ populations; • Reduced experiences of discrimination and stigma.
Legislative and Structural Protection Gaps	• Ireland still does not have a full legislative ban on conversion practices targeting LGBTQI+ people. • Concerns regarding conversion practices may discourage LGBTQI+ individuals from seeking mental health support. • Structural protection gaps contribute to mistrust and perceived lack of safety within mental healthcare systems.	• Advocating for a complete ban on conversion practices in Ireland, strengthening safe, rights-based, and affirming mental healthcare environments; • Improving awareness of available LGBTQI+ support services and referral pathways.	• Safer and more inclusive mental healthcare environments; • Increased trust and service engagement among LGBTQI+ populations; • Strengthened rights-based mental health governance.

3.2.7 Social Economy Initiatives to be Prioritised by the Smart Health Lab in Ireland

Table 5 below presents selected social economy and social enterprise initiatives in Ireland that may support the implementation of the Irish Smart Health Lab. These organisations were chosen because of their relevance to community development, social inclusion, local service coordination, social innovation, rural access, social finance, housing, training and voluntary-sector engagement. Their involvement is particularly relevant for ensuring that the Smart Health Lab is embedded within Ireland's broader social economy ecosystem and can build on existing community-based structures.

Table 5. Social Economy Initiatives to be prioritised by the Smart Health Lab in South Dublin, DLR, Wicklow in Ireland

Social Economy Initiative / Organisation	Ireland Smart Health Lab Relevance
<u>Irish Local Development Network (ILDN) / Local Development Companies Network (LDCN)</u>	Highly relevant for connecting the Lab with Local Development Companies and community-based inclusion structures across Ireland.
<u>Local Development Companies (LDCs)</u>	Suitable for local outreach, community engagement, social inclusion actions, and identifying vulnerable groups at territorial level.
<u>Public Participation Networks (PPNs)</u>	Useful for reaching community and voluntary organisations and strengthening local stakeholder engagement in the Lab.
<u>Local Community Development Committees (LCDCs)</u>	Relevant for linking the Lab with local planning, community development priorities, and county-level inclusion structures.
<u>Social Enterprise Republic of Ireland (SERI)</u>	Important national actor for social enterprise knowledge, advocacy, ecosystem-building and potential Lab sustainability pathways.
<u>Rethink Ireland</u>	Relevant for social innovation, funding, scaling community-led solutions, and supporting innovative responses to mental health and inclusion challenges.
<u>Social Entrepreneurs Ireland (SEI)</u>	Useful for mentoring, innovation support and potential development of scalable community-based solutions emerging from the Lab.
<u>The Wheel</u>	Strong umbrella organisation for the community, voluntary and charity sector; relevant for networking, capacity-building and stakeholder mobilisation.
<u>Social Impact Ireland</u>	Relevant for social impact design, measurement and strengthening the Lab's ability to demonstrate community value and outcomes.
<u>Community Finance Ireland</u>	Useful for exploring financial sustainability, community investment and future development of Lab-related initiatives.
<u>Clann Credo</u>	Relevant for social finance and supporting community-based or social enterprise initiatives that may emerge from the Lab.

Pobal

Important for linking the Lab with publicly supported social inclusion, community services and programmes targeting disadvantage.

Irish Rural Link

Particularly relevant for addressing rural access barriers in Wicklow and improving participation among people affected by mobility limitations.

3.2.8 SWOT Analysis of the Irish Pilot Site and strategic directions for the design of the Smart Health Lab

The SWOT analysis presented below provides a strategic assessment of the Irish pilot site, focusing on the capacity of the local mental health ecosystem to address the needs of LGBTQI+ people, including LGBTQI+ refugees, and to support the implementation of the Smart Health Lab. The analysis draws on the territorial, socio-economic, policy, and service-level characteristics identified throughout the ecosystem profiling exercise, as well as the specific barriers and opportunities affecting access to mental health care.

The findings provide a foundation for tailoring Smart Health Lab activities to local needs, strengthening stakeholder collaboration, and addressing persistent inequalities experienced by LGBTQI+ communities within the pilot area.

Table 6. SWOT Analysis of the Irish Pilot Site

Strengths	Weaknesses
Strong and well-established LGBTQI+ support ecosystem, including LGBT Ireland, TENI, Outhouse, and BeLonG To.	Long waiting lists and significant capacity constraints within public mental health services, particularly CAMHS.
High levels of educational attainment and digital connectivity across most of the pilot territory.	Severe workforce shortages and insufficient specialised mental health services.
Strong policy framework supporting mental health promotion, suicide prevention, and LGBTQI+ inclusion.	Limited access to public gender-affirming healthcare, with exceptionally long waiting times for transgender individuals.
LGBT Ireland possesses extensive expertise, credibility, and community trust, supporting effective co-creation and stakeholder engagement.	LGBTQI+-inclusive care is not consistently available across mainstream mental health services.
Existing community-based and peer-support structures provide valuable complementary support.	Regulatory fragmentation between public and private mental health services.
Mixed urban, suburban, and rural setting enables testing of diverse service delivery approaches.	Rural parts of Wicklow experience transport and accessibility barriers that may limit access to services and participation.
High levels of human capital and professional employment support the adoption of innovative and digital approaches.	National census data do not collect sexual orientation and gender identity information, limiting evidence-based planning and monitoring.
Opportunities	Threats
Smart Health Lab activities can strengthen co-creation with LGBTQI+ communities and improve service responsiveness.	Continued workforce shortages may further increase waiting times and reduce service quality.

Expansion of hybrid and digital mental health services can improve accessibility, particularly for rural and underserved populations.

Growing national policy focus on mental health reform through Sharing the Vision and the National Mental Health Promotion Plan.

Contributing to awareness-raising and capacity-building exchanges on LGBTQI+-affirming and culturally sensitive approaches, within the limits of the project's scope.

Development of stronger referral pathways between public services, NGOs, and community organisations.

AI-assisted support tools and digital innovation offer opportunities for earlier intervention, self-management, and outreach.

Increased recognition of LGBTQI+ mental health needs creates opportunities for targeted funding, advocacy, and service innovation.

Persistent stigma, discrimination, hate speech, and minority stress may continue to discourage help-seeking behaviours.

Delays in reforming gender-affirming healthcare services may further erode trust among transgender communities.

Economic pressures and the ongoing housing crisis may exacerbate mental health inequalities among vulnerable groups.

Geographic inequalities and digital exclusion among specific groups may limit equitable participation in Smart Health Lab activities.

Legislative gaps, including the absence of a full ban on conversion practices, may contribute to ongoing mistrust of mental health systems.

Rising demand for mental health services may outpace planned reforms and investments.

Strategic directions for the design of the Smart Health Lab in Dublin, DLR and Wicklow

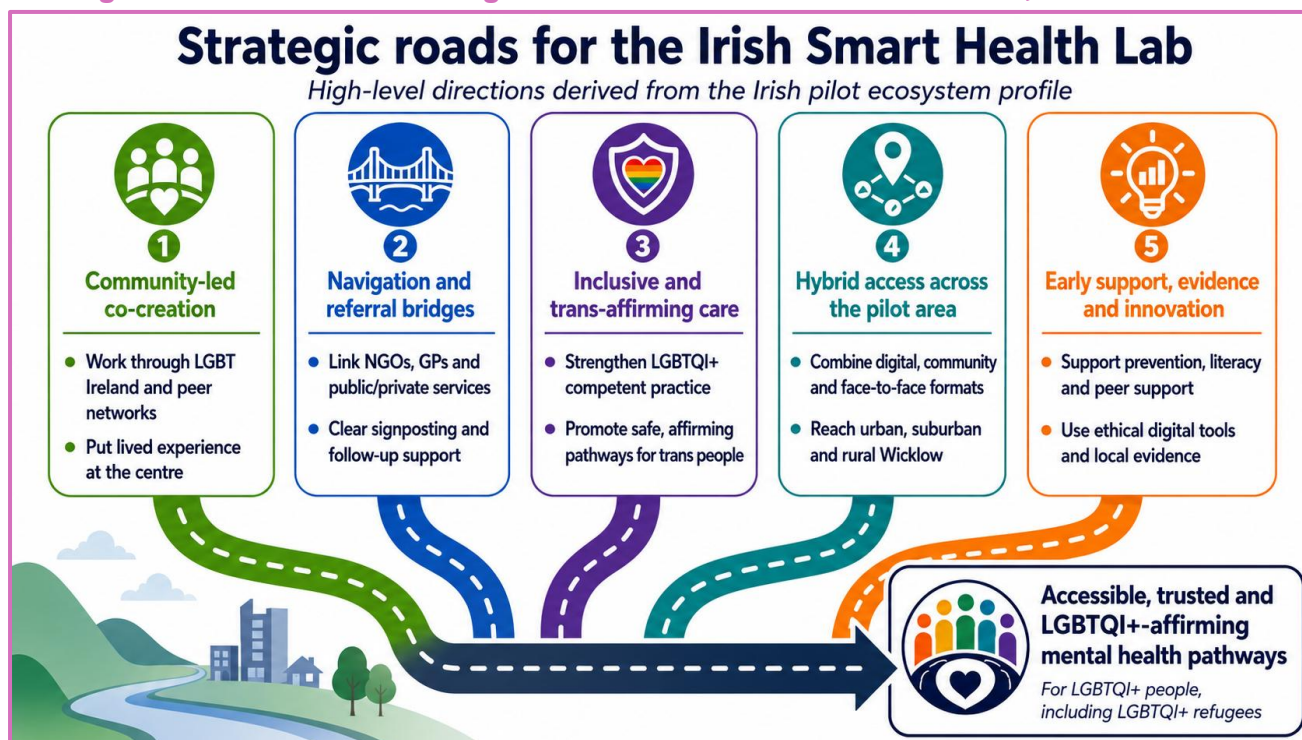


Figure 11. Strategic directions for the Irish Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Irish Smart Health Lab could be shaped in response to the main

findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The SWOT analysis in **Table 6** indicates that the Irish Smart Health Lab could build on the strong LGBTQI+ community support ecosystem, the expertise and trust of LGBT Ireland, and the favourable policy environment for mental health promotion and LGBTQI+ inclusion.

The Irish Smart Health Lab could be developed as a trusted, community-driven platform within the existing LGBTQI+ mental health and wellbeing ecosystem. Its role should not be to duplicate existing services, but to connect community expertise, service providers, professionals and policy actors around the practical needs of LGBTQI+ people, including LGBTQI+ refugees.

Strengthening LGBTQI+-led co-creation and community trust

A central strategic direction would be to ensure that LGBTQI+ people are meaningfully involved throughout the Lab's design and implementation. LGBT Ireland and other community organisations already hold strong trust, lived-experience knowledge and established support channels. The Smart Health Lab could therefore place LGBTQI+ people, including LGBTQI+ refugees, at the centre of priority-setting, co-design activities, testing of solutions and validation of outputs.

Improving service navigation and referral pathways

The Lab could also support clearer service navigation and referral pathways. The mental health support environment in the pilot area includes public, private, NGO and peer-support services, but access routes are often complex and difficult to understand. The Smart Health Lab could help simplify this landscape by developing practical information tools and referral guidance that connect users with GPs, public mental health services, LGBTQI+-inclusive providers, NGOs, online support options and peer-based services.

Promoting LGBTQI+-inclusive and culturally competent care

Another key priority could be the promotion of LGBTQI+-inclusive and culturally competent care. Although Ireland has a favourable policy framework, inclusive practice is not consistently embedded across mainstream mental health services, and professional training remains uneven. The Lab could therefore contribute to awareness-raising and capacity-building for professionals, service providers and community actors. Training and engagement activities could address LGBTQI+ inclusion, minority stress, trauma-informed practice, intersectional vulnerability and the specific needs of people who experience multiple forms of marginalisation.

Addressing trans-specific access barriers

Particular attention could be given to trans and gender non-conforming people. Limited access to gender-affirming healthcare, long waiting times and negative service experiences might create significant distress and reduce confidence in formal care systems. The Smart Health Lab could ensure that trans and gender non-conforming perspectives are fully represented in co-creation activities. It could also help identify safe, affirming support pathways and promote mental health support that does not reinforce stigma, gatekeeping or exclusion.

Developing hybrid access models across urban, suburban and rural areas

The Lab could be designed to reach people across urban, suburban and rural contexts. The pilot area covers South Dublin, Dún Laoghaire–Rathdown, and Wicklow, with rural parts of Wicklow facing additional transport and accessibility barriers. A hybrid model combining face-to-face, community-based and digital formats would allow broader participation across the territory. This approach might help ensure that people living outside central service areas are not excluded from engagement, support or co-design opportunities.

Using digital innovation inclusively

Digital innovation could be introduced in an inclusive and supported way. Ireland benefits from strong digital connectivity and human capital, creating favourable conditions for digital mental health tools, online resources and the AI Assistant. However, some people may still face barriers related to digital access, privacy concerns, literacy or confidence. The Irish Smart Health Lab could combine digital tools with offline support, guided use and accessible formats, ensuring that innovation strengthens rather than limits participation.

Strengthening early support, prevention and mental health literacy

The Lab could also place emphasis on early support and prevention. The Smart Health Lab would contribute by promoting mental health literacy, early signposting, peer support, self-management resources and community-based prevention activities. These actions might help people seek support earlier and reduce reliance on crisis-driven pathways.

Generating local evidence on LGBTQI+ mental health needs

Another important role of the Lab would be to generate local evidence on LGBTQI+ mental health needs and access barriers. Since national datasets do not systematically capture sexual orientation and gender identity, local evidence would be essential for better planning and advocacy. Through participatory methods, community feedback and ethical data collection, the Lab could document service experiences, unmet needs and barriers affecting LGBTQI+ people across the pilot area. This evidence might inform future service development and strengthen the visibility of groups whose needs are often underrepresented.

Connecting policy commitments with local implementation

The Smart Health Lab could also act as a bridge between policy commitments and local implementation. Ireland has a strong policy framework for mental health and LGBTQI+ inclusion, but gaps remain in how these commitments are translated into everyday service practice. The Lab could create a structured space for dialogue between public services, NGOs, private providers, professionals, community representatives and policy actors. This might support more practical alignment between national strategies and local action.

Building resilience against social and structural risks

Finally, the Lab could contribute to resilience against wider social and structural pressures. Stigma, discrimination, housing insecurity, workforce shortages and increasing demand for mental health support continue to affect access and wellbeing. Lab activities would therefore consider the broader social determinants of mental health and create trusted spaces for engagement, support and co-design.

3.2.9 Useful Resources

Table 7. Key Ecosystem Actors, Support Programmes, and Social Innovation Resources Contributing to Mental Health and Social Inclusion in South Dublin, DLR and Wicklow

Resource / Initiative	Official Link
Irish Association for Counselling and Psychotherapy (IACP)	https://iacp.ie
HSELand Training Platform	https://www.hseland.ie
Health Service Executive (HSE) Ireland	https://www.hse.ie
LGBT Ireland	https://lgbt.ie

Mental Health Commission (MHC) Ireland	https://www.mhcirl.ie
Ipsos Ireland	https://www.ipsos.com/en-ie
Professional Association for Trans Health Ireland (PATHI)	https://www.pathi.ie
Trans Equality Network Ireland (TENI)	https://teni.ie
Outhouse LGBTQ+ Centre	https://outhouse.ie
Insight Matters	https://insightmatters.ie
BeLonG To Youth Services	https://www.belongto.org
Turn2Me	https://turn2me.ie
BetterHelp	https://www.betterhelp.com
National Office for Suicide Prevention (NOSP)	https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life
Sharing the Vision – National Mental Health Policy	https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone
National LGBTQI+ Inclusion Strategy II	https://www.gov.ie/en/publication/7d8c5-national-lgbtqi-inclusion-strategy-ii
Central Statistics Office (CSO) Ireland	https://www.cso.ie
Census 2022	https://www.cso.ie/en/census
Mental Health Reform	https://www.mentalhealthreform.ie
Gender Service (Ireland)	https://www.hse.ie/eng/services/list/4/mental-health-services/national-gender-service
TGEU Trans Health Map	https://tgeu.org/trans-health-map-2024
Lucena Child and Adolescent Mental Health Services (CAMHS)	https://www.lucenaclinic.ie
St John of God Community Mental Health Services	https://www.sjogcommunityservices.ie
Oireachtas – Mental Health Bill	https://www.oireachtas.ie
Department of Health Ireland	https://www.gov.ie/en/organisation/departments-of-health

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3.3 Évreux, Normandy (France)

3.3.1 Geographical Context & Demographic Overview

Key territorial and demographic characteristics

The French pilot site is located in Évreux, within the Eure department (FRD21) in the Normandy region. The area of Évreux Portes de Normandie covers a diverse territorial context, combining urban, peri-urban and rural environments, and has a population of approximately 110,000 inhabitants.

Within this wider territory, the city of Évreux itself has around 48,000 residents. The local context is marked by a gradual ageing trend, alongside socioeconomic vulnerabilities. Unemployment and poverty levels remain higher than national averages, contributing to increased pressure on local health and social support systems. At the same time, significant territorial inequalities continue to affect access to health and social care services, particularly for residents living in more peripheral or rural areas.

In rural and peri-urban parts of the territory, travel time, limited transport options and physical accessibility constraints can make specialised mental health and social support services harder to reach, particularly for persons with disabilities, people with reduced mobility and low-income residents.



Figure 12. Évreux (France) Location and Demographic Overview

3.3.2 Techno-Economic Context

The Évreux pilot territory presents a combination of infrastructure progress and persistent social vulnerability. While digital connectivity is being strengthened through major public investment in fibre optic coverage, digital exclusion remains a significant barrier for older adults and socially disadvantaged groups. At the same time, socio-economic precarity, unemployment, poverty and territorial inequalities continue to shape access to healthcare, employment, social support and mental health services. These conditions are reflected in the regional mental health indicators, including suicide rates in Normandy that remain substantially higher than the French national average.

Table 8. Digital connectivity, socio-economic vulnerability and mental health risks are shaping access to care in the Évreux pilot territory

Key Area	Main Findings
Digital infrastructure and connectivity	Digital infrastructure in Évreux is being expanded through the Eure Normandie Numérique public network, aiming to provide 100% fibre optic coverage across the territory. The initiative is financed by regional, departmental and state authorities, with 64% public funding.
Territorial digital inequalities	The fibre optic network seeks to reduce territorial inequalities by improving high-speed internet access in peri-urban and rural areas surrounding Évreux.
Digital exclusion	Digital exclusion, or “illelectronisme”, remains a significant challenge. A 2019 study found that 17% of the French population experiences digital illiteracy, rising to approximately 40% among people aged 75 and over.

Digital inclusion support	Évreux Portes de Normandie deploys Conseillers Numériques France Services to help residents use e-government tools and complete essential online administrative procedures.
Socio-economic precarity	Approximately 30% of the population lives in highly disadvantaged areas, while around 21% of residents receive the RSA, indicating substantial socio-economic vulnerability.
Mental health and poverty	Financial insecurity is associated with higher rates of depressive episodes and anxiety disorders. Unemployment also contributes to psychological distress and social exclusion.
Territorial inequalities	Uneven access to healthcare, employment and social support services continues to affect the territory.
Suicide trends in Normandy	Normandy has a higher suicide rate than the French national average, estimated at 18.1 per 100,000 inhabitants compared to 13.4 nationally.
Young men and suicide risk	Young men aged 15–34 are particularly vulnerable, with suicide mortality around 30% higher than the national average. Among people aged 20–24, suicide rates for men are 6.5 times higher than for women.
Student mental health	Approximately 13% of Norman students report at least one suicide attempt during their lifetime, while 5.4% report multiple suicide attempts.
Worsening male suicide trends	Normandy recorded a 12.5% increase in male suicides between 2016–2018 and 2019–2021, unlike other French regions where suicide rates have stabilised or declined.

Saturation of services and digital access barriers

Public mental health structures, including *Centres Médico-Psychologiques* (CMPs), are currently under strong pressure, contributing to long waiting times and delayed access to care. This is particularly problematic for people requiring continuous psychosocial support, early intervention or specialised follow-up.

Digital tools and telemedicine could help reduce some territorial access barriers, especially in rural areas. However, this potential is limited by the persistence of “digital dead zones” in parts of the countryside, where weak connectivity restricts access to online health services. Digital exclusion can delay or prevent access to mental health support when people are unable to book appointments, complete administrative procedures, use teleconsultation tools or identify available services online. This may reinforce isolation, frustration and delayed help-seeking among people with disabilities, older adults and socio-economically vulnerable groups.

The Évreux pilot territory benefits from a strong digital infrastructure agenda, with public investment supporting the expansion of fibre optic coverage and the reduction of territorial connectivity gaps. However, digital access remains uneven, as digital exclusion continues to affect PVS, particularly older adults and people with limited digital literacy.

Socio-economic vulnerability is a major determinant of mental health risk in the territory. High levels of disadvantage, RSA dependency, unemployment and financial insecurity contribute to psychological distress and may limit access to timely mental health support.

Territorial inequalities remain a cross-cutting challenge. Residents in peri-urban, rural and disadvantaged areas may face more limited access to healthcare, employment support and social services, reinforcing existing inequalities in mental health outcomes.

Mental health indicators in Normandy are particularly concerning. Suicide rates remain significantly higher than the national average, with young men and students emerging as priority groups for prevention, early intervention and targeted outreach.

3.3.3 Ecological and Environmental Factors

Environmental commitments and quality of life

Évreux Portes de Normandie has positioned ecological transition and quality of life as important territorial priorities. The local authority is engaged in actions related to biodiversity, energy transition, sustainable mobility and environmental protection. In 2024, the territory was recognised for the second time as a “Territory Committed to Nature”, reflecting its efforts to support local biodiversity and strengthen ecological planning.

These environmental commitments are relevant to mental health because quality of life, access to safe public spaces, sustainable mobility and environmental wellbeing can contribute to social participation and community resilience. For PVS, local environmental policies can also support healthier living conditions and reduce some everyday stressors affecting wellbeing.

Territorial disparities in access to mental healthcare

Access to mental healthcare in Normandy varies significantly between departments. Although the region records an overall availability of approximately 103 psychologists per 100,000 inhabitants, this figure masks substantial territorial differences. Calvados, Seine-Maritime and Orne are comparatively better equipped, with 125, 113 and 109 psychologists per 100,000 inhabitants, respectively. By contrast, Eure and Manche each have only around 80 psychologists per 100,000 inhabitants, placing them among the least well-equipped departments in France.

These disparities have direct implications for residents of rural areas, smaller municipalities and disadvantaged neighbourhoods. People living outside central urban areas may have fewer local service options and may need to travel longer distances to access specialised mental health support. Limited mobility, transport constraints and financial difficulties can further restrict access, particularly for people with disabilities, older adults, low-income households and socially isolated individuals.

Housing, poverty and social vulnerability

Living conditions represent a major determinant of mental health in the Évreux pilot area. Poverty remains a significant concern, with around 29% of the population living below the poverty line. Financial insecurity can increase stress, reduce access to care and contribute to social exclusion, particularly when combined with housing difficulties, unemployment or health problems.

Housing vulnerability is also an important issue. In the Eure department, the association L’Abri provides accommodation, housing and support for people made vulnerable by social and/or health-related difficulties. Such services are essential for people whose mental health needs are closely linked to homelessness, insecure housing, poor living conditions or social marginalisation.

Ageing and social isolation

Social isolation is another critical factor affecting mental health, particularly among older adults. The Eure department has allocated €1.4 million in 2024 to address social isolation among senior citizens through the “Pack à Dom” initiative. This is especially relevant given demographic ageing in the department. Eure currently has around 51,000 residents aged over 75, a figure expected to rise to 75,000 by 2030.

The expected increase in the older population will likely intensify demand for community-based support, home assistance, social connection initiatives and accessible mental health services. Although older adults are not the central target group of the French pilot, ageing may intersect with disability, reduced autonomy and caregiver burden, increasing the need for coordinated mental health, social care and home-based support.

Mental health impacts

The combined effect of territorial inequalities, poverty, social isolation, service saturation and limited access to care is reflected in concerning mental health indicators. Psychiatric disorders are reported to be 18.4% higher than the national average, while antidepressant consumption is also high. Suicide mortality among men is significantly above the national average, with an excess mortality of +29.4%.

Service saturation could also shift pressure to emergency services, hospitals, families, schools, social workers and community organisations, while weakening continuity of care for people who need regular psychosocial support or specialised follow-up

Since the COVID-19 pandemic, mental distress among minors has also increased sharply, with psychiatric emergency visits doubling since 2016. These trends highlight the urgent need for earlier intervention, stronger community-based mental health support and improved coordination between health, social care, housing and local inclusion services.

3.3.4 Regulatory and Policy Landscape

The French mental health and social inclusion framework is shaped by a combination of national policy priorities, regional governance structures, territorial planning mechanisms and social inclusion measures.

At national level, mental health has gained increasing visibility through initiatives such as the “Grande Cause Nationale” 2025–2026, which aims to strengthen public awareness, reduce stigma and accelerate mental health-related actions. In parallel, the “Mon Soutien Psy” programme supports access to reimbursed psychological consultations through the national health insurance system, while the FIOP finances innovative local pilot projects in psychiatry and mental health care.

The French system also relies on a territorial organisation of psychiatric care. Article L3221-2 of the French Public Health Code promotes the organisation of psychiatry through Territorial Psychiatric Communities, encouraging coordinated territorial networks rather than isolated hospital-based approaches. This is complemented by the sectorisation model, through which each resident is assigned to a dedicated public psychiatric team according to their place of residence, regardless of income level.

Social inclusion policies also play a significant role in shaping access to care and autonomy for vulnerable groups. Recent reforms to the Allocation aux Adultes Handicapés (AAH), particularly the introduction of “de-conjugalisation”, calculate disability benefits based on individual rather than household income, thereby strengthening the financial autonomy of people with disabilities. At the same time, Aide Sociale à l’Enfance (ASE) policies aim to support young adults aged 18–21 leaving child welfare services and reduce risks of homelessness. However, the end of ASE support may itself create a critical transition period, increasing vulnerability and potentially triggering mental health crises among young adults leaving care.

Table 9. National Mental Health and Social Inclusion Framework

Policy / Framework	Main Role
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Grande Cause Nationale 2025–2026

Mon Soutien Psy	National initiative aiming to strengthen public awareness and accelerate mental health actions.
FIOP – Fonds d’Innovation Organisationnelle en Psychiatrie	National programme providing reimbursed psychological consultations through the French national health insurance system.
Funding mechanism supporting innovative local pilot projects in psychiatry and mental health care.	
French Public Health Code, Article L3221-2	Organises psychiatry through Territorial Psychiatric Communities.
Psychiatric sectorisation model	Assigns each resident to a dedicated public psychiatric team according to their place of residence.
AAH reform – De-conjugalisation	Calculates disability benefits based on individual rather than household income.
ASE – Aide Sociale à l’Enfance	Supports young adults aged 18–21 leaving child welfare services and aims to reduce homelessness risks.

At regional level, governance in Normandy is increasingly based on territorialised and evidence-based public health planning. Santé publique France operates as the central public health surveillance authority, providing the methodological basis for identifying national and regional health trends.

The 2024 Health Barometer further supports territorialised analysis by including approximately 1,700 respondents from Normandy within a wider national sample of 35,000 respondents. These data allow public authorities to better understand regional health determinants and adapt interventions to local realities.

ARS Normandie plays a central role in the strategic and operational governance of healthcare in the region. Its responsibilities include public health prevention, hospital regulation, healthcare organisation and medico-social services. Through the Projet Régional de Santé (PRS), ARS Normandie aims to reduce territorial inequalities and strengthen continuity between healthcare and social support systems. Local authorities also contribute by working with regional actors to develop “health-favourable environments” adapted to the specific needs of local populations.

Coordination mechanisms are essential for translating national priorities into effective local action. PTSM, CLSM and CLS structures aim to connect psychiatric services, municipalities, social care actors and community organisations. As described below, PTSM initiatives support coordination between actors involved in mental health promotion, prevention, continuity of care and service integration. CLSM structures provide a local governance mechanism linking psychiatric services with municipalities and community stakeholders, while CLS agreements help adapt health policies to local needs through partnerships between ARS authorities and local governments.

Table 10. Coordination Mechanisms and Territorial Planning

Mechanism	Description	Relevance
PTSM – Projets Territoriaux de Santé Mentale	Territorial Mental Health Projects coordinating actors involved in mental health promotion, prevention, continuity of care and service integration.	Supports person-centred and recovery-oriented care pathways, while improving coordination between services.

CLSM – Conseils Locaux de Santé Mentale	Local Mental Health Councils linking psychiatric services, municipalities and community actors.	Strengthens local governance and helps align mental health actions with municipal and community needs.
CLS – Contrats Locaux de Santé	Local Health Contracts between ARS authorities and local governments.	Enable locally adapted implementation of health policies and stronger coordination between regional and local actors.
Territorial Psychiatric Communities	Coordinated psychiatric networks organised at territorial level.	Promote cooperation between psychiatric services and reduce dependence on isolated hospital-based models.
Normandy Vaping Model	Example of coordinated regional action that reportedly reduced socio-economic disparities in nicotine product use.	Demonstrates the potential of territorial coordination to address public health inequalities through targeted local action.

Employment and inclusion policies

Employment and social inclusion policies are also relevant to the mental health ecosystem, especially for people with intellectual, psychosocial or physical disabilities. The “Supported Employment” programme in Rouen provides long-term coaching for both employees with disabilities and employers, supporting labour market participation and professional autonomy. France Travail, formerly Pôle Emploi, provides employment and labour market support, while Cap Emploi offers specialised counselling for workers with recognised disabilities, including people with RQTH status.

However, some social protection measures may create additional challenges for people with mental health vulnerabilities. The RSA is managed at territorial level by the Seine-Maritime Departmental Council and provides income support for people experiencing socio-economic precarity. Recent “Renovated Support” policies require RSA recipients to engage in 15–20 hours of weekly activity. For individuals experiencing severe anxiety, psychiatric vulnerability or psychosocial disability, these requirements may become difficult to meet if their mental health condition is not formally recognised as a disability, potentially creating risks of benefit suspension or further exclusion.

The table below presents key social protection, employment and inclusion policies that shape access to support for people in vulnerable situations in the Normandy pilot context. The table highlights both opportunities and implementation challenges. While programmes such as Emploi Accompagné, France Travail and Cap Emploi support professional integration and adapted employment pathways, the RSA framework may create additional barriers for people with unrecognised mental health vulnerabilities when activity requirements are not sufficiently adapted to their condition.

Table 11. Policy Programmes and Challenges identified

Policy Programme	Description	Potential Benefits and Challenges
RSA – Revenu de Solidarité Active	Social assistance scheme managed	Provides income support for people in socio-economic precarity. However, recent “Renovated

territorially by the Seine-Maritime Departmental Council.

Support” requirements for 15–20 hours of weekly activity may create barriers for people experiencing severe anxiety or psychiatric vulnerability if their condition is not formally recognised as a disability.

Emploi Accompagné – Supported Employment	Long-term coaching support for employees with intellectual or psychosocial disabilities and for employers.	Supports labour market participation, workplace inclusion and professional autonomy for people with disabilities.
France Travail	National employment and labour market support service.	Provides employment support and access to specialised pathways for jobseekers, including people with disabilities.
Cap Emploi	Specialised employment support for workers with recognised disabilities, including RQTH status.	Helps people with disabilities access, maintain or return to employment through adapted counselling and support.

The French and Norman policy landscape provides a strong institutional basis for improving access to mental health care and social inclusion. National frameworks support awareness, reimbursement, innovation and territorial psychiatric coordination, while regional governance structures strengthen evidence-based planning and local adaptation.

Implementation challenges remain, particularly around fragmented pathways, transitions out of child welfare support, recognition of psychosocial disability, and the risk that employment or activation requirements may unintentionally deepen exclusion for people experiencing mental health vulnerability

3.3.5 Priority PVS and Current Mental Health Needs

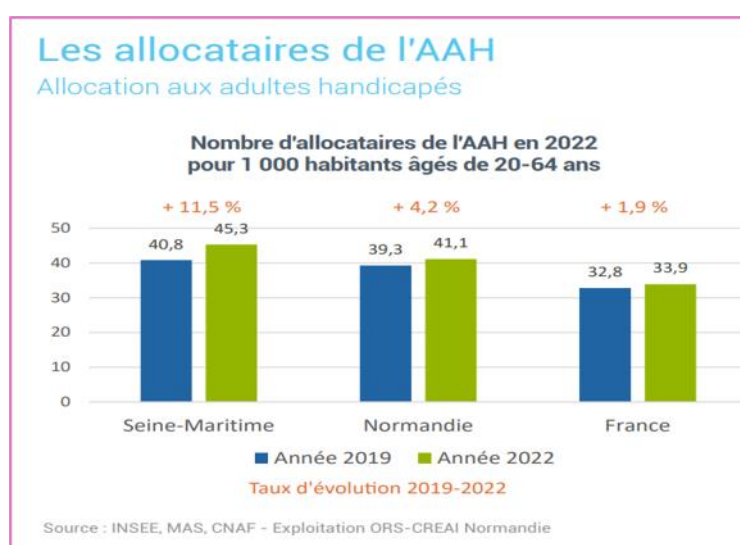
Figure 13. Evolution of AAH beneficiaries in Seine-Maritime, Normandy, and France (2019–2022)

Priority PVS

The Évreux pilot will focus primarily on two target groups:

- persons with intellectual and psychosocial disabilities,
- and persons with physical disabilities.

Intellectual disability refers to cognitive impairments that appear during the developmental period and affect learning, reasoning, adaptive functioning and everyday autonomy. Psychosocial disability refers to the



social and functional consequences of chronic mental health conditions, such as schizophrenia or bipolar disorder, which may affect a person's participation in daily, social and professional life.

In addition to these two main groups, the pilot context also highlights the vulnerability of young adults leaving child welfare services, many of whom may experience psychiatric or cognitive disorders during the transition to independent adulthood. Older adults experiencing social isolation and physical frailty also represent an important vulnerable population within the territory. The pilot, therefore, also needs to consider groups facing "double vulnerability", where mental health conditions intersect with socio-economic precarity, disability, ageing, isolation or other factors that increase the risk of exclusion from care and support services.

Who they are

Some definitions¹¹ need to be stated before: psychic disabilities (handicap psychique) and mental disabilities (handicap mental), often distinguishing between the two:

- **Intellectual Disability (Handicap Intellectuel):** This is associated with intellectual deficiencies (deficiences intellectuelles) that appear during development, affecting cognitive functions.
- **Psychic Disability (Handicap Psychique):** This refers to the consequences of chronic mental illnesses (such as schizophrenia or bipolar disorder) on a person's social and daily functioning, without necessarily implying an intellectual deficit.
- **Individuals with cognitive disorders:** The CESER report notes that 30% to 35% of youth coming from Child Social Assistance (ASE) suffer from psychiatric or cognitive disorders that can be classified as a psychic disability
- **Physical Disabilities:** While the report mentions "somatic" (physical) health, it focuses less on specific categories of physical disability and more on how mental health disorders can be comorbid with or lead to physical ailments like hypertension and diabetes in rural seniors.
- **The "Double Vulnerability" Group:** These are individuals who accumulate several factors, such as psychiatric disorders combined with age-related physical frailties (seniors) or socio-economic precariousness.

Figure 13 above presents the number of beneficiaries of the **Allocation aux Adultes Handicapés** (AAH) per 1,000 inhabitants aged 20–64 years between 2019 and 2022 across Seine-Maritime, the Normandy region, and France overall. The data indicate a higher increase in AAH beneficiaries in Seine-Maritime (+11.5%) compared to regional (+4.2%) and national (+1.9%) trends, highlighting growing disability-related and socio-economic vulnerabilities within the territory.¹²

Current Mental Health Needs

The Infographic below summarises the main mental health needs and systemic challenges affecting persons with disabilities in the Normandy pilot site. It highlights that people with intellectual, psychosocial and physical disabilities require more than clinical care; they need integrated support combining psychosocial rehabilitation, stable housing, peer support, continuity of care and self-determination. These can be concluded as follows:

11. [Santé mentale en Normandie](#)

12. [Les chiffres-clés du handicap](#)

- People with Disabilities (PwD) require more than just clinical treatment¹³; they need a holistic support system focused on rehabilitation and social inclusion:
- Psychosocial rehabilitation: There is a critical need for tools like cognitive remediation and social skills training to help individuals regain autonomy and access active social lives.
- Stable housing: Access to housing is described as a "prerequisite" for mental stability. Programs like "*Un chez-soi d'abord*" (Housing First) are highlighted as essential for those with severe disorders.
- Peer support (Pair-aidance): Individuals benefit significantly from "peer-practitioners" meaning people who have lived experience with mental illness and can guide others through recovery.
- Continuity of care: A major need is the "fluidification" of care pathways to prevent ruptures in treatment when moving between hospital and community settings.
- Self-Determination: Following HAS (Haute Autorité de Santé) recommendations, the report stresses the need for PwD to be recognised as actors in their own lives and care plans.

At the same time, the regional ecosystem faces important structural barriers, including fragmented services, care pathway ruptures, workforce shortages, stigma, geographic and informational barriers, and unstable funding for innovative support models. These challenges contribute to significant unmet mental health needs, with many individuals experiencing depression or anxiety remaining outside formal care pathways.

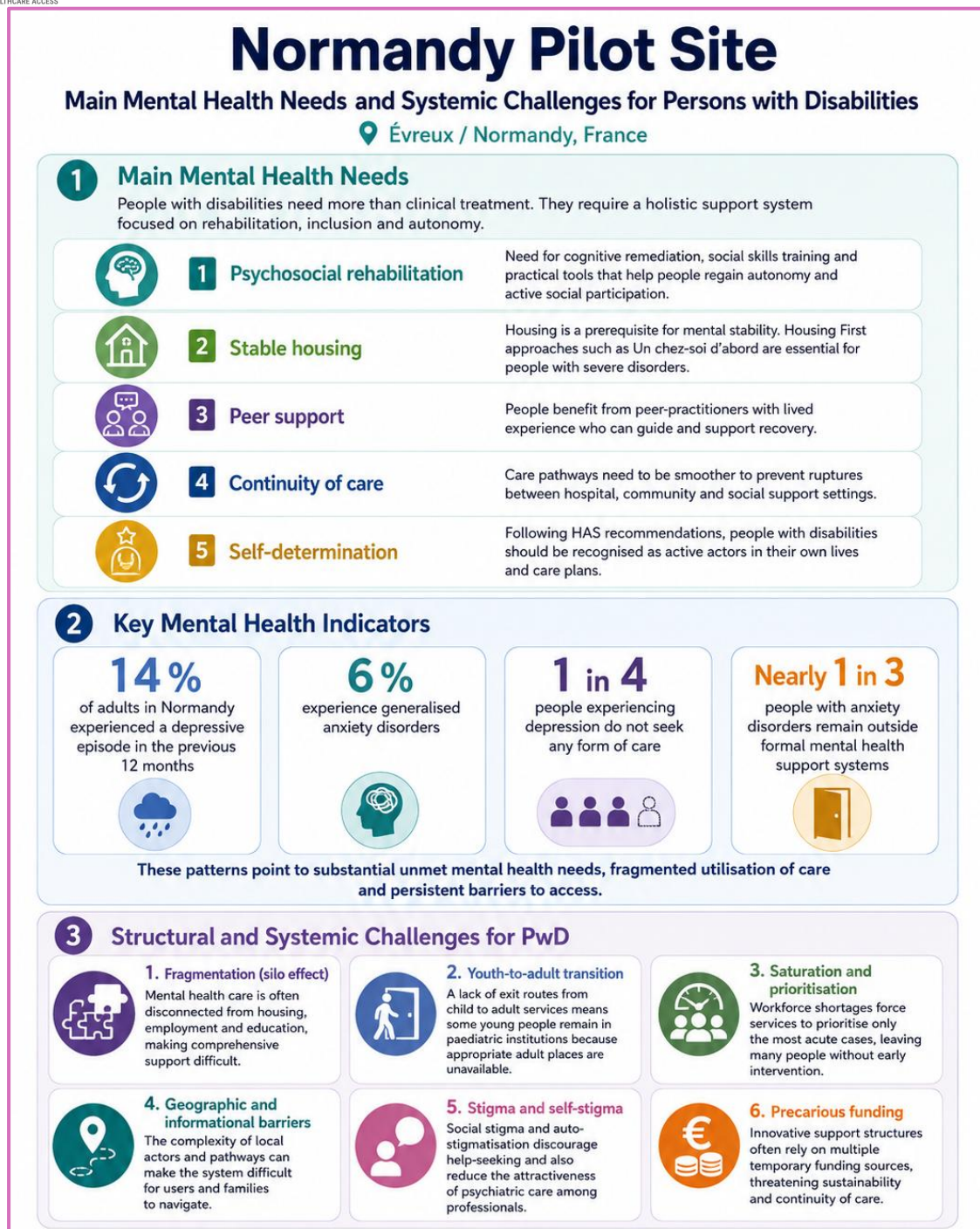


Figure 14. Priority PVS and Current Mental Health Needs in Evreux, France

- LADAPT Normandie plays a central role in promoting the “inclusive turn” within disability and mental health support. Within the French pilot, LADAPT brings direct experience in supporting the social and professional inclusion of persons with disabilities.
- The organisation focuses on psychosocial rehabilitation, socio-professional inclusion, system coordination, and self-determination.
- Digital cognitive remediation, e-coaching, and remote support tools may strengthen autonomy and self-management among persons with disabilities.
- Digital-first approaches are particularly relevant in a context characterised by territorial isolation and psychiatric workforce shortages.

- Community-based and destigmatised support environments may improve early intervention and engagement with mental health services.

3.3.6 Local Mental Health Ecosystem

The mental health ecosystem in Évreux and the wider Normandy region combines public psychiatric services, private providers, medico-social facilities, peer-support structures, housing initiatives, mobile teams, rehabilitation networks and territorial governance mechanisms. This creates a relatively broad support landscape for people with mental health needs and persons with disabilities. However, the ecosystem remains affected by long waiting times, uneven territorial distribution of services, fragmented coordination, limited psychosocial rehabilitation capacity and insufficient visibility of informal or community-based actors within institutional data systems.

The map (Figure 15) presents the geographical distribution of medico-social services for adults with disabilities across Seine-Maritime as of 31 December 2023. It maps different types of facilities, including Maisons d'Accueil Spécialisées (MAS), Établissements d'Accueil Médicalisés (EAM/FAM), Établissements d'Accueil Non Médicalisés (EANM), Foyers de Vie, Foyers d'Hébergement and experimental facilities for adults with disabilities. The size of each circle indicates the reception capacity of each facility, while the colour represents the type of establishment.

The map shows that the medico-social offer is not evenly distributed across the territory. Services and higher-capacity facilities appear more concentrated around larger urban and service areas, particularly around Le Havre, Rouen, Dieppe and other central localities, while some more rural or peripheral areas have fewer visible facilities. This spatial pattern highlights the importance of territorial planning when assessing access to disability-related and psychosocial support services.

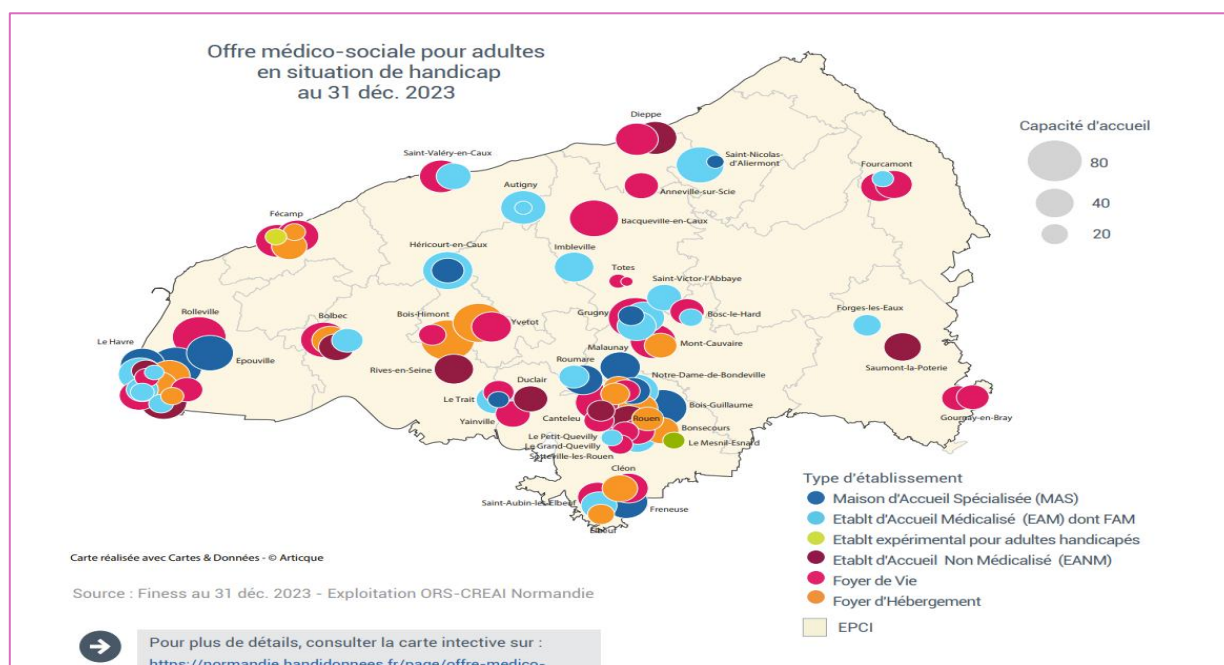


Figure 15. Medical-Social Services for Adults with Disabilities as of December 31, 2023

For the ecosystem profiling of the Normandy pilot site, the figure is particularly relevant because it illustrates the territorial organisation of support available to people with disabilities. It shows that the regional ecosystem includes a wide range of specialised facilities, but also points to potential

accessibility challenges linked to distance, uneven service distribution, capacity limits and the complexity of navigating different types of medico-social support.

The table below maps the main components of the mental health ecosystem in Évreux and the wider Normandy region. It presents the key public, private, medico-social, community-based and peer-support structures currently contributing to mental health service provision, psychosocial rehabilitation, social inclusion and territorial coordination. The table also highlights the main accessibility and governance challenges affecting the ecosystem, including long waiting times, uneven service distribution, limited rehabilitation capacity, fragmented coordination and the incomplete visibility of informal or community-based actors in institutional monitoring systems.

Table 12. Overview of mental health service provision, community-based support structures and governance mechanisms in the Évreux and Normandy mental health ecosystem

Ecosystem Component	Main Services / Structures	Key Features and Challenges
General mental health service provision	Public and private mental health providers; Mon Soutien Psy; CMPs; CMPPs	Mental health support is provided through both public and private actors. Mon Soutien Psy reimburses up to 12 psychological sessions at 60% coverage for mild to moderate distress. CMPs and CMPPs provide specialised support, often free of charge, but long waiting times remain a major barrier.
Public psychiatric infrastructure	Nouvel Hôpital de Navarre, Évreux	The hospital is the main public psychiatric hospital for the Eure department and provides specialised psychiatric services across the wider territory. Concerns have been raised regarding mechanical restraint practices, including reported cases involving minors, which conflict with national objectives to reduce isolation and restraint in psychiatric care.
Psychosocial rehabilitation	Six psychosocial rehabilitation units in Normandy; Normandie REHAB; CREP Canteleu	Long-term recovery support remains uneven. Normandy has six psychosocial rehabilitation units, with three in Caen, two in Rouen and only one serving the wider Évreux area. This unequal distribution creates accessibility and continuity-of-care challenges.
Medico-social infrastructure for persons with disabilities	MAS, EAM/FAM, EANM, Foyers de Vie, Foyers d'Hébergement and experimental disability facilities	The region has a wide range of specialised facilities for adults with disabilities. However, reception capacity and geographical distribution vary, highlighting the need for stronger territorial planning to ensure equitable access.
Peer support and mutual aid	GEMs; Advocacy Normandie; Tutti G.A.J.; Médiateurs de Santé-Pairs; Jeunes Ambassadeurs Santé Mentale	Peer-led and lived-experience-based initiatives support social connection, recovery, autonomy and destigmatisation. GEMs provide mutual aid without requiring a medical prescription, while peer health mediators are integrated into multidisciplinary teams.

Housing and social inclusion	Un Chez Soi d'Abord; Vivre et Devenir; Côté Cours; SAMSAH; S3A; Habitat Partagé; Clubhouse Rouen	Housing-first and inclusive housing initiatives support people with severe psychiatric disorders, homelessness histories or psychosocial disabilities. Clubhouse Rouen contributes to social and professional reintegration through a community-based recovery model.
Mobile and outreach services	EMAS; EMPEIC; Centre de Santé Mobile	Mobile teams support school inclusion, crisis intervention for children and adolescents, and psychiatric outreach in rural or underserved areas. These models help reduce reliance on hospital-based care and improve territorial access.
Youth and adolescent support	Maisons des Adolescents	MDA structures provide first-line listening, counselling and support for young people facing mental health challenges, helping to identify needs earlier and facilitate referral.
Coordination and advocacy	PTSM; CLSM; UNAFAM	PTSM and CLSM support coordination between psychiatric services, municipalities, health actors and community stakeholders. UNAFAM provides family support through multiple reception points in Normandy. However, user participation in governance remains uneven.
Community-based and inclusive models	GEMs; Médiateurs de Santé-Pairs; Clubhouse Rouen; Normandie REHAB; Housing First initiatives	Normandy is progressively adopting an “inclusive turn” in disability and mental health care, with stronger emphasis on recovery, autonomy, participation, empowerment and social inclusion.
Governance and data-driven planning	Santé publique France; Health Barometer 2024; Regional Delegation; local authorities	Public health governance is increasingly evidence-based and territorialised. The 2024 Health Barometer included around 1,700 Normandy residents within a national survey of 35,000, supporting more locally adapted prevention and intervention policies.
Governance gaps and fragmentation	Private clinics, NGOs, informal care actors and community organisations	Despite strong surveillance systems, the broader ecosystem is not fully captured in institutional datasets. This limits visibility of informal and community-based actors and may reinforce fragmented governance.
Innovative territorial governance	Normandy Vaping Model; coordinated regional action	Normandy demonstrates the potential of territorial coordination to respond to public health inequalities. The Normandy Vaping Model is highlighted as an example of targeted regional action reducing socio-economic disparities in nicotine product use.

Key findings

- The Évreux and Normandy mental health ecosystem includes a broad range of public, private, medico-social, community-based and peer-led services.
- Public services such as CMPs, CMPPs and the Nouvel Hôpital de Navarre provide essential psychiatric and psychological support, but waiting times and capacity constraints remain significant barriers.
- Psychosocial rehabilitation is underdeveloped and unevenly distributed, with only one rehabilitation unit serving the wider Évreux area.
- Community-based and recovery-oriented approaches are increasingly present through GEMs, Médiateurs de Santé-Pairs, Clubhouse Rouen, Normandie REHAB and Housing First initiatives.
- Housing, peer support, mobile outreach, school inclusion support and youth services play an important role in addressing needs beyond clinical treatment.
- Territorial inequalities remain a major challenge, particularly for rural and underserved populations with limited access to specialised care.
- Governance mechanisms such as PTSM and CLSM support coordination, but the ecosystem remains fragmented, and user involvement in decision-making is still limited.
- Data-driven planning is improving through Santé publique France and the Health Barometer, yet private, NGO and informal care actors are not fully visible in institutional monitoring systems.

Overall, the ecosystem shows strong potential for integrated, community-based and recovery-oriented support, but requires better coordination, improved territorial coverage and stronger continuity between hospital, community, social care and disability support services.

3.3.7 Service Exclusion Trends

The primary challenge in regional health strategy remains the profound discrepancy between population needs and service utilisation. Data from the 2024 Barometer indicates that while psychological distress is prevalent, affecting 1 in 7 adults in Normandy, a significant portion of the population remains outside the formal care circuit. This "non-recourse" phenomenon represents a critical loss of opportunity for early intervention and places an undue long-term burden on acute care infrastructure. [Table 13](#) below presents the main service exclusion trends affecting access to mental healthcare and psychosocial support in Normandy.

Table 13. Main service exclusion trends affecting access to mental healthcare and psychosocial support in Normandy.

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Financial	• Financial hardship remains strongly associated with mental health vulnerability and healthcare exclusion. • Individuals experiencing economic precarity demonstrate significantly higher rates of depressive episodes and anxiety disorders. • Unemployment often complicates access to treatment and long-term recovery. • Poverty and housing insecurity continue to reinforce exclusion from mental health services.
Geographical and Territorial	• Geographic inequalities create major barriers to accessing mental health support across the territory. Although the region has a relatively good number of healthcare professionals, services are largely concentrated in urban centres such as Rouen, Elbeuf, Barentin, and Yvetot.

	- Residents living in rural areas and disadvantaged neighbourhoods (QPV – Quartiers Prioritaires de la Politique de la Ville) experience more limited access to mental health services. - Limited mobility and transport accessibility often prevent vulnerable populations from reaching centralised care facilities. “Digital dead zones” in rural areas further restrict access to telemedicine and digital mental health services. - Publicly funded CMPs (Medico-Psychological Centres) are currently saturated, resulting in significant waiting times for mental health support. - These territorial and infrastructural inequalities contribute to uneven access to care and reinforce existing mental health disparities across the region.
Social and Cultural	- Social stigma and gendered perceptions of mental health continue to obstruct help-seeking behaviour. - The designation of mental health as a “Grande Cause Nationale 2025” specifically targets this stigma, which is particularly pronounced among male cohorts. - Currently, 55.6% of men experiencing a depressive episode do not seek care, compared to 28.5% of women, a disparity largely associated with gendered perceptions of help-seeking and risk behaviours. Social isolation and living alone are persistent factors associated with poor mental health outcomes and non-recourse to care.
Systemic and Policy-Related	- Significant “non-recourse” to care persists despite high levels of psychological distress within the population. - Lack of reliable and accessible information regarding available support structures remains a major barrier to entry. - High-risk groups such as homeless populations, undocumented migrants, and incarcerated individuals are frequently excluded from institutional surveys, resulting in an underestimation of the actual burden of mental health needs within the territory. - Complex institutional ecosystems and fragmented governance structures create additional barriers to care navigation.

The service exclusion trends identified in Normandy reveal a persistent gap between mental health needs and actual service utilisation. Although psychological distress affects a significant share of the adult population, many individuals remain outside formal care pathways due to financial hardship, territorial inequalities, stigma, limited mobility, fragmented governance and difficulties navigating available support. This pattern of “non-recourse” to care represents a major challenge for early intervention, as unmet needs may escalate into more severe conditions and increase pressure on already saturated acute and specialised services.

The analysis also shows that exclusion is multidimensional. Financial insecurity, unemployment and housing instability increase mental health vulnerability, while geographical concentration of services limits access for rural residents and disadvantaged neighbourhoods. Social stigma, particularly among men, continues to discourage help-seeking, and systemic data gaps mean that the needs of

high-risk groups such as homeless people, undocumented migrants and incarcerated individuals may remain underestimated.

Key Takeaways

- A significant mismatch exists between mental health needs and service use in Normandy, with many people experiencing distress remaining outside formal care pathways.
- Financial hardship, unemployment, poverty and housing insecurity reinforce both mental health vulnerability and exclusion from support services.
- Geographic inequalities remain a major access barrier, as services are concentrated in urban centres while rural areas and disadvantaged neighbourhoods face more limited availability.
- Saturation of publicly funded CMPs contributes to long waiting times and delays in accessing appropriate mental health support.
- Digital inequalities and limited mobility further restrict access to telemedicine, online support and centralised care facilities.
- Stigma and gendered perceptions of mental health strongly influence help-seeking behaviour, particularly among men experiencing depression.
- Social isolation and living alone remain important risk factors linked to poor mental health outcomes and non-recourse to care.
- Institutional surveys often exclude high-risk groups, leading to an underestimation of actual mental health needs across the territory.
- Fragmented governance and complex service pathways make it difficult for users and families to identify and access appropriate support.

Strengthening early intervention, service navigation, outreach, community-based support and integrated data systems should be considered key priorities for reducing service exclusion in Normandy.

3.3.8 Priority Areas for Investment within the Mental Health Care System in France

Table 14 below identifies key priority areas for investment and innovation within the mental health ecosystem in Évreux, France. Building on the ecosystem analysis, it highlights the main structural and service-related challenges currently affecting the provision of mental health care, including reactive and crisis-oriented service models, territorial inequalities in access to care, data gaps affecting vulnerable populations, and fragmented care pathways.

These challenges are particularly relevant in a territory characterised by significant urban-rural disparities, increasing demand for mental health services, and the presence of vulnerable groups whose needs are not always adequately captured by existing systems. The table links each identified system gap with potential areas for intervention and the expected outcomes.

Table 14. Priority Areas for Investment within the Mental Health Care System in Évreux, France

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment / Innovation Area	Expected Outcomes
Reactive and Crisis-Oriented Mental Health Systems	- Existing mental health systems remain largely reactive, with interventions often occurring only once mental health conditions reach acute stages. - Current approaches provide insufficient emphasis on prevention, proactive diagnostics, and early detection of psychological vulnerability.	- Strengthening early intervention and preventive care models; - Developing proactive diagnostics and “At-Risk Mental State” (ARMS) frameworks extending beyond psychosis prevention to depression and anxiety; - Reinforcing continuity-of-care pathways.	- Earlier identification of mental health vulnerabilities - Reduced long-term mental health deterioration; - Improved continuity of care and reduced crisis escalation.
Territorial Saturation and Centralised Care Models	- High-demand psychiatric centres, such as CH du Rouvray, are currently operating at or beyond capacity. - Rural populations, particularly older adults, remain significantly disconnected from specialised mental health services. - Existing hospital-centred care models are insufficient for addressing territorial inequalities in access to care.	- Developing decentralised and community-based mental health delivery systems; - Expanding proximity-based care hubs and outreach services; strengthening territorial accessibility and continuity of support.	- Improved territorial accessibility to care; - Reduced inequalities between urban and rural populations; - Strengthened community-based support systems.

Data Gaps and Invisible Vulnerabilities	• High-risk groups, including homeless populations, incarcerated individuals, and undocumented migrants, are frequently excluded from standard institutional data collection systems. • Existing datasets therefore, underestimate the actual burden of mental health needs across the territory.	• Developing inclusive data architectures and equity-sensitive monitoring systems capable of identifying “invisible” vulnerable populations; • Improving territorial mental health intelligence and evidence-based planning.	• Improved visibility of underserved populations; • More accurate identification of unmet mental health needs; • Better-targeted and evidence-based interventions.
Fragmented Care Pathways and Limited Community Engagement	• Existing mental health systems remain fragmented, while stigma and limited community engagement continue to discourage help-seeking behaviours. • Prevention-oriented and trauma-informed continuity-of-care approaches remain insufficiently integrated across the lifespan.	• Implementing digital wellbeing systems, remote mental health assistance, and diagnostic support tools; • Strengthening trauma-informed and community-based approaches; • Supporting vocational reintegration and social inclusion pathways.	• Improved continuity of care across the lifespan; • Reduced stigma and non-recourse to care; • Strengthened social inclusion and vocational reintegration outcomes.

3.3.9 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Évreux, France

Social economy actors represent a critical component in the EQUICARES local mental health ecosystems, particularly in contexts where formal health and social care systems face capacity constraints, accessibility barriers, or difficulties engaging PVS. Through community-based services, peer-support networks, social enterprises, cooperatives, employment initiatives, advocacy organisations, and grassroots structures, these actors often provide trusted, flexible, and person-centred responses that complement statutory mental health provision.

Within EQUICARES, social economy initiatives are considered key enablers of inclusion, empowerment, social participation, and service innovation. Their proximity to local communities, experience in supporting vulnerable populations, and ability to foster collaborative solutions make them particularly relevant partners for Smart Health Labs.

The following section identifies the most relevant social economy initiatives operating within the pilot ecosystem in Évreux, France and assesses their potential contribution to the co-creation, testing, sustainability, and future scaling of innovative community-based mental health solutions.

Table 15. Social Economy Initiatives to be prioritised by the Smart Health Lab in Évreux, France

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>Un chez-soi d'abord</u> (Housing First Programme)	Housing stability, homelessness prevention, psychosocial recovery, community inclusion	Provides immediate and unconditional access to stable housing through multi-sector cooperative structures. By reducing housing insecurity and survival-related anxiety, the initiative enables stronger recovery-oriented mental health support and promotes long-term social inclusion beyond crisis stabilisation approaches.
<u>Clubhouse Model</u>	Vocational recovery, psychosocial rehabilitation, community participation, social inclusion	Operates through non-medicalised and community-based environments where members co-manage activities alongside professional staff. The “work-ordered day” approach supports rebuilding social skills, confidence, and professional capabilities while promoting empowerment and recovery-oriented participation.
<u>Individual Placement and Support (IPS) Programmes</u>	Supported employment, vocational reintegration, recovery-oriented mental health support	Supports labour market reintegration for individuals with mental health conditions by focusing on capabilities, participation, and empowerment rather than illness and disability. Contributes to long-term socio-economic inclusion and recovery.
<u>Médiateurs de Santé-Pairs</u> (Peer Health Navigators)	Peer-support, lived-experience advocacy, mental health mediation, anti-stigma actions	Employs individuals with lived experience of mental health conditions to act as intermediaries between service users and healthcare professionals. Supports destigmatisation, improves trust in services, and strengthens engagement among individuals reluctant to access formal care pathways.
<u>Social Return on Investment</u>	Impact evaluation, sustainability	Supports the monitoring and evaluation of the social and economic value generated by community-

assessment, innovation measurement social based and recovery-oriented mental health initiatives. May contribute to the long-term scaling and sustainability of alternatives to acute hospital-centred care.

3.3.10 SWOT Analysis of the French Pilot Site and strategic directions for the design of the Smart Health Lab

The SWOT analysis presented below provides a strategic assessment of the mental health ecosystem in the Normandy pilot site, with a particular focus on people with intellectual, psychosocial, and physical disabilities, as well as other vulnerable groups experiencing social isolation, socio-economic precarity, or complex care needs. The analysis draws on the territorial, socio-economic, governance, service provision, and community support characteristics identified throughout the ecosystem profiling exercise.

By examining the internal strengths and weaknesses of the existing ecosystem alongside the external opportunities and threats that may influence future developments, the SWOT analysis identifies key factors that may facilitate or hinder the successful implementation of the Smart Health Lab. The findings provide a foundation for designing innovative, community-based, and person-centred interventions that strengthen psychosocial rehabilitation, social inclusion, continuity of care, and access to support services across the territory.

Table 16. SWOT Analysis of the French Pilot Site

Strengths	Weaknesses
Strong national and regional mental health governance framework, supported by ARS Normandie, PTSM, CLSM, and territorial psychiatric communities.	Significant fragmentation between health, social care, housing, employment, and disability support systems ("silo effect").
Well-developed ecosystem of community-based and recovery-oriented initiatives, including GEMs, Médiateurs de Santé-Pairs, Clubhouse Rouen, Normandie REHAB, and Housing First programmes.	Long waiting times and saturation of publicly funded mental health services, particularly CMPs and specialised psychiatric services.
Strong culture of territorial and evidence-based public health planning supported by Santé publique France and the Health Barometer.	Unequal territorial distribution of specialised services, with limited psychosocial rehabilitation capacity in the Évreux area.
Established psychosocial rehabilitation and supported employment approaches promoting autonomy and recovery.	Persistent ruptures in care pathways and insufficient continuity between hospital, community, and social care services.
Growing digital infrastructure supported by Eure Normandie Numérique and digital inclusion initiatives.	Digital exclusion remains significant, particularly among older adults and vulnerable populations.
Presence of specialised medico-social facilities and disability support structures across the region.	Complex institutional landscape makes navigation difficult for users and families.

Strong expertise of LADAPT Normandie in disability inclusion, psychosocial rehabilitation, and socio-professional integration.

Workforce shortages and limited availability of specialised mental health professionals.

Opportunities	Threats
Smart Health Lab activities can strengthen coordination across health, social, housing, and employment sectors.	Rising prevalence of mental health conditions and psychological distress may continue to increase demand beyond system capacity.
Digital cognitive remediation, e-coaching, tele-support, and AI-enabled tools can improve accessibility and autonomy for people with disabilities.	Normandy continues to experience suicide rates significantly above the national average, particularly among young men.
Expansion of community-based and recovery-oriented models can reduce dependence on hospital-centred care.	Persistent socio-economic inequalities, poverty, and housing insecurity may further exacerbate mental health vulnerabilities.
Increasing policy attention to mental health through Grande Cause Nationale, Mon Soutien Psy, and innovation funding mechanisms such as FIOP.	Social stigma and self-stigmatisation continue to discourage help-seeking behaviour and engagement with services.
Development of inclusive data systems can improve visibility of underserved groups and support more targeted interventions.	High levels of non-recourse to care mean many individuals with mental health needs remain outside formal support systems.
Strengthening peer-support, supported employment, and housing-first approaches can improve long-term recovery and social inclusion outcomes.	Financial instability of innovative community-based initiatives may threaten sustainability and continuity of support.
Expansion of mobile teams and proximity-based services can reduce territorial inequalities affecting rural populations.	Demographic ageing and increasing social isolation among older adults may place additional pressure on health and social care systems.

Strategic directions for the design of the Smart Health Lab in Évreux

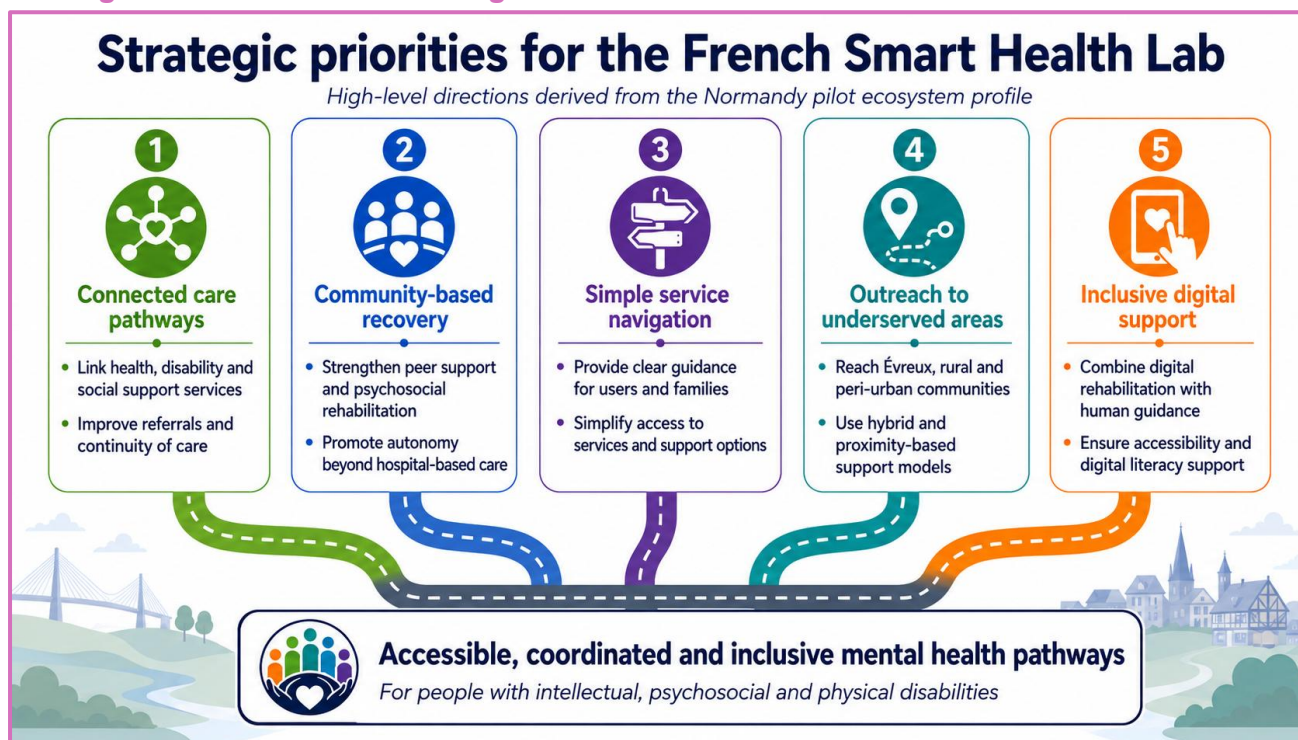


Figure 16. Strategic directions for the French Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the French Smart Health Lab could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The Normandy Smart Health Lab could be positioned as a locally grounded connector within a complex mental health, disability and social support ecosystem. Its role would not be to create parallel services, but to strengthen links between existing actors and make support pathways more understandable, inclusive and responsive to the everyday needs of people with intellectual, psychosocial and physical disabilities. The Lab might add value by bringing together health services, social care providers, disability support organisations, housing actors, employment services, peer-support initiatives, local authorities and community-based organisations around shared priorities.

Creating shared referral pathways between health, disability and social support actors

A key strategic direction could be to improve coordination across fragmented systems. Although Normandy benefits from strong institutional and community actors, services related to health, social care, housing, employment and disability often operate separately. The Smart Health Lab could therefore function as a collaborative space where LADAPT Normandie, psychiatric services, social care providers, local authorities and civil society actors can work jointly on access barriers, referral gaps and continuity of support. This might help reduce fragmentation and support more coherent pathways for users and families.

Expanding access to recovery-oriented support beyond hospital-based care

The Lab could also reinforce recovery-oriented and community-based approaches. Normandy already hosts promising initiatives such as GEMs, peer health mediators, Clubhouse Rouen, Normandie REHAB and Housing First. However, access to these approaches remains uneven, and hospital-centred care continues to play a prominent role. The Smart Health Lab could therefore

promote activities that support psychosocial rehabilitation, social participation, peer-led recovery, independent living and everyday autonomy in accessible and non-stigmatising community settings.

Developing practical navigation tools for users and families

Another important priority would be to simplify service navigation. People with disabilities and their families often face a complex service environment, with difficulties moving between hospital care, community services, disability support, housing, employment and social assistance. The Lab might help address this by developing practical navigation tools, simplified referral routes and accessible guidance materials. These tools could help people understand where to go, who to contact and how to access support at different stages of their care and recovery journey.

Reaching rural, peri-urban and underserved communities around Évreux

The Smart Health Lab could also pay particular attention to territorial inequalities. Specialised support might not be evenly distributed across Normandy, and the Évreux area has more limited psychosocial rehabilitation capacity compared with other urban centres. The Lab could therefore test outreach-based, hybrid and proximity-oriented activities that can reach people living in rural, peri-urban or underserved areas. This would help ensure that access to support does not depend solely on proximity to central service locations.

Combining digital rehabilitation tools with human and accessibility support

Digital solutions could be used carefully and inclusively. While fibre coverage and digital initiatives are expanding in Normandy, digital exclusion continues to affect older adults, people with disabilities and other vulnerable groups. Digital rehabilitation, e-coaching, remote support and AI-enabled tools should therefore be introduced only alongside human guidance, accessibility support and digital literacy assistance. This approach would allow the Lab to benefit from innovation while avoiding the risk of reinforcing exclusion.

Linking mental health support with employment, workplace adaptation and independent living

The Lab could also connect mental health support with employment, autonomy and social participation. LADAPT Normandie and supported employment actors provide a strong foundation for linking care and socio-professional inclusion. The Smart Health Lab might build on this by connecting mental health support with vocational pathways, workplace adaptation, assistive technologies and cooperation with France Travail, Cap Emploi and supported employment services. This would support recovery not only as a clinical process, but also as a pathway towards autonomy, inclusion and participation in everyday life.

Creating trusted community spaces to reduce stigma and non-recourse to care

Reducing stigma and encouraging earlier engagement could be another central objective. Stigma, self-stigma and non-recourse to care prevent many people from seeking support before their needs become more severe. The Lab could therefore create trusted community-based spaces where people with lived experience, families, professionals and local actors can exchange openly, challenge misconceptions and encourage earlier help-seeking.

Using participatory mapping to identify hidden needs and missing links

The French Smart Health Lab could also improve understanding of unmet needs. Formal institutional data do not always capture the contribution of NGOs, informal carers, peer networks or underserved groups. Through participatory mapping, user feedback and local evidence collection, the Lab could identify hidden needs, missing links and barriers that may not be visible in official datasets. This evidence might support more targeted and realistic local action.

Building evidence and partnerships to sustain promising local practices

Finally, sustainability should be considered from the beginning. Community-based initiatives in Normandy demonstrate strong value, but they may face unstable funding, workforce shortages and growing demand. The Lab could therefore help generate evidence on the added value of inclusive support models, strengthen partnerships between local actors and explore ways to maintain promising practices beyond short-term project activities.

In this direction, the French Smart Health Lab might become a practical experimentation and coordination space. Its added value would come from connecting existing services, making support easier to access, and testing inclusive solutions that strengthen autonomy, recovery, participation and continuity of care for people with disabilities across Évreux and the wider Normandy context. The Normandy Smart Health Lab could be designed as a practical connector within a complex mental health and disability support environment. Rather than creating parallel structures, the Lab might help link existing services, community initiatives and social support actors around the everyday needs of people with intellectual, psychosocial and physical disabilities.

3.3.11 Useful Resources

Table 17. Key Ecosystem Actors, Support Programmes, and Social Innovation Resources Contributing to Mental Health and Social Inclusion in Normandy

Resource / Initiative	Official Link
Eure Normandie Numérique	https://www.eurenormandienumerique.fr
Conseillers Numériques France Services	https://www.conseiller-numerique.gouv.fr
Mon soutien psy programme	https://www.ameli.fr/assure/sante/themes/sante-mentale-de-l-adulte/mon-soutien-psy
Assurance Maladie	https://www.ameli.fr
Nouvel Hôpital de Navarre	https://www.nh-navarre.fr
Contrôle général des lieux de privation de liberté (CGLPL)	https://www.cglpl.fr
Évreux Portes de Normandie	https://www.evreurportesenormandie.fr
Un Chez Soi d'Abord programme	https://www.gouvernement.fr/agir-pour/un-chez-soi-d-abord
French Public Health Code – Article L3221-2	https://www.legifrance.gouv.fr/codes/article_lc/LEGIArtI000006689787
Fonds pour l'Innovation Organisationnelle en Psychiatrie (FIOP)	https://sante.gouv.fr
Allocation aux Adultes Handicapés (AAH)	https://www.service-public.fr/particuliers/vosdroits/F12242
Aide Sociale à l'Enfance (ASE)	https://www.service-public.fr/particuliers/vosdroits/F3143
Agence Régionale de Santé (ARS) Normandie	https://www.normandie.ars.sante.fr
Contrats Locaux de Santé (CLS)	https://www.santepubliquefrance.fr
Projet Territorial de Santé Mentale (PTSM)	https://www.psycom.org
Seine-Maritime Departmental Council	https://www.seinemaritime.fr
Emploi Accompagné programme	https://travail-emploi.gouv.fr/emploi-et-insertion/emploi-et-handicap/article/l-emploi-accompagne

France Travail	https://www.francetravail.fr
Cap Emploi	https://www.capemploi.info
Haute Autorité de Santé (HAS)	https://www.has-sante.fr
Advocacy Normandie	https://www.advocacy-normandie.fr
Clubhouse Rouen	https://www.clubhousefrance.org/clubhouse-rouen
Normandie REHAB	https://www.normandie-rehab.fr
UNAFAM	https://www.unafam.org
Santé publique France	https://www.santepubliquefrance.fr
Health Behaviour in School-aged Children (HBSC) Study	https://hbosc.org

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3.4 Seville, Andalucía (Spain)

3.4.1 Geographical Context & Demographic Overview

Key territorial and demographic characteristics

The Sevilla pilot site is located in the province of Sevilla (ES618), within the Andalucía region (ES61) in south-western Spain. The territory lies in the lower Guadalquivir River valley and combines a diverse landscape of urban areas, agricultural plains and surrounding mountainous zones linked to the Sierra Morena. Its location in the south-west of the Iberian Peninsula positions Seville as a geographical bridge between the coastal plains of Huelva and Cádiz and the eastern Andalusian mountain ranges.

The province is characterised by a hot Mediterranean climate, with very hot and dry summers and mild winters. With approximately 1.98 million inhabitants in 2025, Seville is one of the most populous provinces in Spain. Population growth has remained modest but positive in recent years, mainly driven by migration, while the Spanish-born population remains stagnant or declining. Foreign residents account for around 8% of the provincial population. Despite its demographic importance, the territory continues to face structural socio-economic disadvantage and persistent territorial inequalities, which affect well-being, social inclusion and access to healthcare and mental health services. Further information is presented in [Figure 17](#) below.



Figure 17. Seville (Spain) Location and Demographic Overview

3.4.2 Techno-Economic Context

The techno-economic context of the Seville pilot site is shaped by a combination of strong digital and innovation capacity, persistent labour-market precarity, high poverty levels, and practical barriers to accessing mental health services. Andalucía has invested in digital health infrastructure and regional innovation strategies, creating favourable conditions for testing digital tools, e-health pathways and community-based mental health innovation. At the same time, these opportunities are unevenly accessible to people in vulnerable situations, particularly Roma communities, Latin American migrants, older adults, low-income groups and recently arrived migrants.

The main challenge is therefore not only the availability of digital systems or formal healthcare entitlement, but whether these resources can be used effectively by populations facing economic insecurity, low digital literacy, unstable employment, administrative complexity and limited system-navigation capacity. In addition to digital literacy, digital trust is also important. Concerns about privacy, data use, confidentiality and the reliability of online services may influence whether Roma communities, migrants and other vulnerable groups feel comfortable using digital mental health tools.

Digital Health Infrastructure and E-Health Readiness

Andalucía has developed a consolidated regional digital health architecture through the Estrategia de Salud Digital de Andalucía 2030. The regional healthcare system relies on digital tools such as the Diraya electronic health record system, e-prescription services, teleconsultation pathways and online appointment management platforms. Public healthcare access increasingly depends on online administrative procedures, digital identification systems and e-government platforms.

For users with strong digital skills, these tools can improve flexibility, procedural efficiency and access to healthcare services. However, digital competencies are unevenly distributed across the population. Older adults, low-income groups, Roma communities and recently arrived migrants may face barriers in using online platforms, digital identification tools and administrative procedures. As a result, digital-first models may create hidden exclusion for individuals who lack digital literacy, administrative knowledge or system-navigation skills.

For the Seville Smart Health Lab, this means that digital mental health tools should not be implemented as stand-alone solutions. They should be accompanied by assisted digital navigation, face-to-face support, culturally sensitive mediation and user-friendly access pathways.

Innovation Ecosystem and Research Capacity

Seville hosts a strong innovation ecosystem, including universities, biomedical research institutes integrated into the Andalusian Public Health System and technology parks such as Cartuja. Regional strategies also position research, innovation and digital transformation as important pillars for healthcare system sustainability.

This creates favourable conditions for piloting digital mental health tools, community-based innovation and culturally adapted solutions. The territory also benefits from multidisciplinary collaboration between health sciences, technology and social sciences. However, innovation ecosystems are not always connected to deprived neighbourhoods or to the everyday realities of Roma communities, migrants and other vulnerable groups.

Labour Market and Economic Stability

Andalucía consistently records unemployment rates above Spanish and EU averages. In Seville, employment is concentrated in services, agriculture, construction, logistics and tourism-related sectors. These sectors are often characterised by temporary contracts, seasonal employment, irregular schedules and limited employment stability.

Precarious work particularly affects young adults, low-skilled workers and migrant populations. Job insecurity and financial instability are recognised determinants of poor mental health outcomes, contributing to chronic stress, anxiety and reduced ability to attend appointments during working hours. Migrant populations may face additional stress linked to residence permits, contract renewals and administrative instability. Economic precarity therefore increases mental health vulnerability while also reducing the ability to access and maintain continuity of care.

Poverty, Affordability and Indirect Costs of Care

Spain provides universal public coverage for mental health services. However, Andalucía records some of the highest poverty and social exclusion rates in Spain. Poverty remains a structural driver of health inequalities and has a direct impact on mental health and service access.

Although public healthcare is legally free at the point of use, indirect costs continue to create barriers. These include transport, childcare, time off work, administrative procedures and the time needed to navigate appointments and referrals. For low-income households, these costs may delay help-seeking and reduce continuity of care.

Roma communities may experience cumulative disadvantage linked to concentrated deprivation, residential segregation and reduced institutional trust. Latin American migrants may experience downward social mobility and financial pressures linked to remittance obligations, increasing vulnerability to depression and anxiety.

The table below summarises the main techno-economic factors shaping access to mental health support in the Seville pilot site. It shows that Andalucía benefits from strong digital health infrastructure, innovation capacity and universal public healthcare coverage. However, these assets are unevenly accessible due to digital exclusion, administrative complexity, labour-market precarity, poverty, migrant economic vulnerability, Roma socio-economic disadvantage and mental health workforce shortages.

Table 18. Key Techno-Economic Factors Affecting Mental Health Access in Seville

Techno-Economic Dimension	Key Conditions	Main Access Challenges	Relevance for the Smart Health Lab
Digital health infrastructure	Andalucía has a consolidated digital health architecture, including Diraya, e-prescription, teleconsultation and online appointment platforms.	Digital access depends on digital literacy, identification systems and online administrative skills. Older adults, low-income groups, Roma communities and recently arrived migrants may be excluded.	Digital tools should be combined with assisted navigation, face-to-face support and accessible guidance.

E-government and administrative digitalisation	Public healthcare access increasingly relies on online procedures and e-government platforms.	Digital-first access can create hidden barriers for users lacking administrative knowledge or system-navigation capacity.	The Lab should support simplified pathways, digital literacy and human mediation.
Innovation ecosystem	Seville has universities, biomedical research institutes and technology parks such as Cartuja.	Innovation is not always embedded in deprived neighbourhoods or co-designed with vulnerable groups.	Innovation should be equity-oriented, participatory and connected to community organisations.
Labour market structure	Employment is concentrated in services, agriculture, construction, logistics and tourism-related sectors.	Temporary contracts, seasonal work, irregular schedules and limited job security increase stress and reduce appointment attendance.	Mental health actions should consider flexible schedules, outreach formats and links with employment support.
Unemployment and precarious work	Andalucía records unemployment rates above Spanish and EU averages.	Young adults, low-skilled workers and migrants are particularly exposed to job insecurity and financial stress.	The Lab should connect mental health support with social and labour-market inclusion pathways.
Poverty and affordability	Public mental healthcare is legally free at the point of use.	Indirect costs such as transport, childcare, time off work and administrative procedures limit practical access.	Low-threshold and locally accessible support models are needed.
Migrant economic vulnerability	Latin American migrants may face unstable work, administrative uncertainty and financial pressure linked to remittances.	These pressures may increase anxiety, depression and delayed help-seeking.	Support should include navigation, culturally sensitive outreach and flexible access routes.
Roma socio-economic disadvantage	Roma communities may face concentrated deprivation, residential segregation and lower institutional trust.	Economic hardship and mistrust can reduce engagement with formal mental health services.	The Lab should work with trusted Roma organisations and community mediators.
Workforce capacity in mental health	Andalucía has a public, tax-funded mental health system organised through	Shortages of clinical psychologists and psychiatrists contribute to	Digital and community-based tools should support early intervention

primary care, waiting times and limited and continuity, Community Mental psychotherapy access. without replacing Health Units and professional care. hospital care.

Overall Enabling and Hindering Dynamics

Seville combines universal public health coverage, strong digital infrastructure, and substantial research capacity with structural socioeconomic vulnerability and labour-market precarity.

Enabling conditions include universal entitlement, an established digital health architecture, a dense primary care network, and innovation capacity. Hindering conditions include unemployment and precarious employment, poverty and territorial deprivation, digital and administrative access barriers, workforce shortages, cultural mistrust, and low mental-health literacy among vulnerable groups.

The central equity challenge lies not in formal coverage, but in ensuring that digital transformation, innovation capacity, and universal entitlement translate into equitable, culturally responsive, and practically accessible mental-health services for populations in vulnerable situations.

3.4.3 Ecological and Environmental Factors

The Seville pilot site is also shaped by ecological and environmental determinants that affect mental health, well-being and access to support services. Environmental vulnerability in Seville is not limited to climate exposure; it is closely linked to spatial inequalities, housing instability, public space degradation, residential segregation and unequal access to services and infrastructure.

Spatial Inequalities and Environmental Accessibility

Health and social services remain concentrated in major urban centres, while rural and semi-urban areas experience more limited access to healthcare, public transport and community support structures. This spatial mismatch between service availability and population needs reinforces exclusion among geographically isolated populations and may reduce timely access to mental health and psychosocial support.

Urban Degradation and Public Space Quality

Certain deprived neighbourhoods experience deteriorated public infrastructure, poorly maintained public spaces, inadequate sanitation and waste accumulation. Community research highlights the normalisation of environmental neglect within socially excluded urban environments. Limited access to safe, clean and well-maintained public spaces negatively affects social interaction, well-being and perceptions of neighbourhood quality.

Climate-Related Stressors and Environmental Health Risks

Seville is among the European cities most exposed to extreme summer heat. Vulnerable neighbourhoods are particularly affected by urban heat exposure due to high building density, limited tree coverage and insufficient green infrastructure. Energy poverty and limited access to air conditioning increase thermal stress among low-income populations. Extreme heat events therefore constitute an important environmental and public health risk for vulnerable communities.

Gendered Environmental Vulnerability

Women experiencing poverty, precarious employment or housing insecurity face increased exposure to gender-based violence and greater difficulty leaving abusive environments. Intersectional

vulnerabilities linked to ethnicity, poverty and social exclusion further intensify exposure to violence and psychosocial stress. Energy poverty also disproportionately affects low-income women, increasing exposure to thermal stress and related health risks.

Housing Instability and Residential Segregation

Rising housing costs and limited affordable housing stock have increased homelessness and precarious housing conditions. Informal and substandard settlements, including chabolas, continue to disproportionately affect Roma populations and other marginalised groups. These settlements frequently lack basic infrastructure and remain highly vulnerable to environmental hazards such as extreme heat, cold and flooding. Residential segregation and environmental disadvantage are also reflected in deteriorated infrastructure, limited green spaces and insufficient municipal investment in vulnerable neighbourhoods.

Table 19 summarises the key ecological and environmental factors that affect mental health access in Seville.

Table 19. Ecological and Environmental Factors Affecting Mental Health and Service Access in Seville

Environmental Dimension	Main Challenges	Implications for People in Vulnerable Situations
Spatial inequalities and accessibility	Health and social services are concentrated in major urban centres, while rural and semi-urban areas have weaker access to healthcare, public transport and community support.	Geographically isolated populations may face delayed access to mental health services and reduced continuity of care.
Urban degradation and public space quality	Deprived neighbourhoods may experience deteriorated infrastructure, poorly maintained public spaces, inadequate sanitation and waste accumulation.	Poor-quality environments can reduce social interaction, weaken community well-being and reinforce perceptions of exclusion.
Climate-related stressors	Seville is highly exposed to extreme summer heat. Vulnerable neighbourhoods are affected by high building density, limited tree coverage and insufficient green infrastructure.	Low-income households face increased exposure to thermal stress, especially where energy poverty limits access to cooling.
Gendered environmental vulnerability	Women facing poverty, precarious employment or housing insecurity may experience greater exposure to gender-based violence and fewer options to leave unsafe environments.	Gender-based violence, poverty and environmental stressors can combine to increase psychosocial vulnerability and mental health risks.
Housing instability and residential segregation	Rising housing costs, limited affordable housing, homelessness, precarious housing and informal settlements affect marginalised groups, especially Roma communities.	Substandard housing and segregated settlements increase exposure to environmental hazards and reduce access to safe, stable living conditions.

Environmental disadvantage in vulnerable neighbourhoods	Limited green spaces, deteriorated infrastructure and insufficient municipal investment remain visible in disadvantaged areas.	Environmental neglect may reinforce territorial stigma, social exclusion and unequal health outcomes.
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3.4.4 Regulatory and Policy Landscape

Spain's current mental health regulatory framework is shaped by a clear transition towards community-based, person-centred and rights-based care. At national level, the Mental Health Strategy of the National Health System 2022–2026 promotes a holistic understanding of mental health, recognising the interaction between psychobiological vulnerability factors and psychosocial risk factors. It places strong emphasis on human rights, prevention, recovery, social inclusion and the progressive shift away from institutional models towards community-based support.

This direction is reinforced by the Primary and Community Care Action Plan 2025–2027, which positions primary care as the main entry point into the health system. The plan highlights the need to proactively identify vulnerable populations, including people affected by socioeconomic disadvantage, limited social support, functional limitations or additional barriers to healthcare access.

National policies also include targeted strategies for specific groups. The National Strategy on Addictions 2017–2024 addresses dual pathology, referring to the coexistence of mental health conditions and substance use disorders, and calls for more flexible and tailored treatment pathways for groups at higher risk of marginalisation, including women, ethnic minorities and migrants. Similarly, the National Strategy for Roma Equality, Inclusion and Participation 2021–2030 recognises that universal measures are not always sufficient to address structural disadvantage. It therefore promotes both mainstream and targeted actions to reduce inequalities in access to health, education, employment and social inclusion.

Employment and training are also recognised as important components of recovery and social participation. The Mental Health Strategy 2022–2026 highlights labour market access as a key factor for autonomy, while the Roma Equality Strategy and the Spanish Strategy for Active Support for Employment 2025–2028 promote education, reskilling and upskilling, particularly in relation to digital skills and green jobs. These measures are relevant for vulnerable groups whose mental health is affected by exclusion from employment, unstable work or limited access to training opportunities.

At regional level, Andalucía has adapted these national priorities through its own strategic frameworks. The Strategic Plan for Mental Health and Addictions of Andalucía (PESMA-A) emphasises the need for stronger coordination between mental health and addiction services and includes a specific focus on vulnerable populations. It also refers to community-based resources, including community treatment teams, as relevant mechanisms for reaching people with complex needs. In addition, FAISEM plays a central role in the Andalusian ecosystem by supporting social integration, housing, employment orientation and community-based support for people with mental health conditions.

The Andalusian Strategy for Immigration 2021–2025 further strengthens the regional focus on equity by promoting preventive action, intercultural mediation and proactive outreach to vulnerable migrant populations. This is particularly relevant for Seville, where migrant communities and Roma populations may face overlapping barriers linked to language, discrimination, poverty, administrative complexity and limited trust in formal institutions.

Despite this robust policy framework, important implementation gaps remain. Official strategies point to persistent organisational and cultural barriers rather than purely legal ones. Coordination between healthcare, social services and addiction networks remains insufficient, which can interrupt continuity of care and complicate access for people with complex or overlapping needs. PESMA-A also identifies bureaucratic difficulties in accessing mental health residential resources, which may disproportionately affect vulnerable groups.

Another key challenge concerns cultural competence and organisational flexibility. Existing services may not always be adequately adapted to the clinical, social and cultural needs of Roma communities, migrants and other marginalised groups. Structural stigma also remains a barrier to service access and engagement. Finally, a significant policy gap is the lack of disaggregated data by ethnic origin in official records. This “statistical invisibility” limits the ability of public authorities to measure structural discrimination, monitor inequalities and design policies that respond accurately to the needs of Roma communities, migrants and ethnic minorities.

3.4.5 Priority PVS and Current Mental Health Needs



Figure 18. Priority PVS and Current Mental Health Needs in Seville

The Seville Smart Health Lab will prioritise two groups experiencing persistent social and health inequalities: Roma communities and Latin American migrants. Both groups are well represented within the pilot territory and face multiple social determinants that increase their vulnerability to poor mental health outcomes and barriers to accessing appropriate support.

Roma communities in Seville are concentrated in several socioeconomically disadvantaged neighbourhoods, including Polígono Sur, Polígono Norte, Torreblanca, Tres Barrios-Amate, and El Vacie. They continue to experience high levels of poverty, discrimination, social exclusion, and residential segregation. These structural disadvantages are associated with elevated levels of anxiety, depression, substance use, and psychological distress. Despite significant mental health needs, access to preventive and community-based mental health support remains limited, while stigma and discrimination may discourage engagement with formal services.

Latin American migrants represent the largest foreign-national population group in Seville. Many experience migration-related stressors, including uncertainty, administrative difficulties, social isolation, precarious employment, and challenges navigating healthcare systems. Anxiety, mood disorders, sleep disturbances, and psychological distress are among the most commonly reported mental health concerns. Language, cultural, administrative, and information barriers may further limit access to timely and appropriate care.

Across both Roma communities and Latin American migrants, shared barriers include financial insecurity, anxiety and psychosocial distress, stigma, limited trust in formal institutions, difficulties navigating services, administrative complexity and reduced continuity of care.

3.4.6 Local Mental Health Ecosystem

The mental health ecosystem in Seville operates through a decentralised and community-based model within the Andalusian Public Health System (Servicio Andaluz de Salud – SAS). It combines hospital-based psychiatric care, outpatient mental health services, rehabilitation structures, primary care, municipal social services and community-based support. The system is territorially organised through Clinical Management Units (Unidades de Gestión Clínica – UGCs), which coordinate mental health services within defined catchment areas.

The ecosystem benefits from a broad public infrastructure, including regional hospitals, primary care centres, specialised mental health centres, psychiatric emergency services, municipal social support and civil society organisations. However, gaps remain in preventive care, mild-to-moderate psychological support, psychosocial counselling and coordination between regional, municipal and community-level actors.

The table below summarises the main components of the mental health and psychosocial support ecosystem in Seville. It shows how public healthcare services, specialised mental health structures, municipal support, community-based organisations and governance mechanisms interact within the wider local ecosystem.

Table 20. Overview of the Mental Health and Psychosocial Support Ecosystem in Seville

Ecosystem Component	Main Structures / Actors	Role in the Mental Health Ecosystem
Public mental health system	Andalusian Public Health System (SAS), regional hospitals, primary care centres, specialised mental	Provides the core public psychiatric and psychological care infrastructure

health centres and psychiatric emergency services through a decentralised and territorially organised model.

Clinical Management Units (UGCs)	UGC Virgen del Rocío, UGC Virgen Macarena, UGC Hospital Universitario de Valme	Coordinate specialised mental health services within defined territorial catchment areas, including outpatient, inpatient, rehabilitation and child and youth mental health services.
Primary care services	32 primary care centres	Act as the main entry points into the mental health system, managing first presentations of psychosocial distress and non-urgent referrals to Community Mental Health Units.
Specialised mental health services	Community Mental Health Units, acute inpatient units, rehabilitation units, day hospitals, therapeutic communities and child and youth mental health units	Provide specialised psychiatric, psychological, rehabilitative and community-based interventions.
Private mental health services	Private psychology and psychotherapy providers	Absorb part of the demand for anxiety, mild depression and psychosocial distress, especially where public services prioritise Severe Mental Illness.
Municipal social services	Seville City Council and services across the 11 municipal districts	Provide social support, family assistance, home help, social reintegration, dependency support, elderly support and emergency financial aid.
Community-based and social support	FAISEM, NGOs, civil society organisations, Roma and migrant organisations	Support social reintegration, anti-stigma actions, culturally responsive care, housing, occupational integration and community outreach.
Governance and coordination	Decree 77/2008, Clinical Management Agreements, RELAS and Local Health Plans	Provide the formal framework for service organisation, intersectoral coordination and district-level health planning.

Seville has a broad and multi-layered mental health ecosystem, but effective access depends on how well public healthcare, municipal services, community organisations and governance structures are connected. The key challenge is not only service availability, but coordination, accessibility and continuity across different parts of the system.

Public Mental Health System

The public mental health system in Seville is delivered through the Andalusian Public Health System. It includes hospital, outpatient, rehabilitation and community-based services. The system is structured around:

- 3 regional hospitals;
- 32 primary care centres;
- 22 specialised mental health centres;
- a centralised psychiatric emergency service.

Mental health services are organised territorially through Clinical Management Units (UGCs). These units manage specialised mental health facilities within their catchment areas and coordinate services such as Community Mental Health Units, acute inpatient psychiatric units, rehabilitation units, therapeutic communities, day hospitals and child and youth mental health services.

Table 21. Examples of Clinical Management Units in Seville, Andalucía

UGC / Mental Health Unit	Territorial Coverage	Main Mental Health Structures and Services
UGC Virgen del Rocío	• Covers high-density urban districts and the metropolitan Aljarafe region.	• Includes Community Mental Health Units (USMCs) in Nervión, Triana, Sevilla Este, Sevilla Sur, and Aljarafe; Acute inpatient psychiatric units (UHSM); Rehabilitation Units (URSM); Therapeutic Communities (CT); A Day Hospital (HDSM); • A centralised Child and Youth Mental Health Unit (USMI-J).
UGC Virgen Macarena	• Covers northern districts of Sevilla and surrounding rural/peri-urban municipalities such as Camas, Carmona, and Constantina.	• Includes 6 Community Mental Health Units (USMCs); a 44-bed acute psychiatric inpatient unit; rehabilitation and day-hospital structures; and an Intensive Community Treatment Team (ETIC) providing assertive home-based interventions for severe and non-adherent patients.
UGC Hospital Universitario de Valme (Área Sur)	• Covers southern municipalities and dispersed rural areas including Dos Hermanas, Alcalá de Guadaira, Utrera, Lebrija, and Morón de la Frontera.	• Includes Community Mental Health Units (USMCs); acute inpatient psychiatric services; rehabilitation units; day hospitals; and specialised Child and Youth Mental Health Units (USMI-J).

Private Mental Health Services

Private mental health services play an important complementary role in the Seville ecosystem. Due to the prioritisation of Severe Mental Illness within the public system, service gaps remain in preventive interventions, psychotherapy for mild-to-moderate mental health conditions and psychosocial counselling.

As a result, private psychology and psychotherapy providers absorb a substantial share of demand related to anxiety, mild depression and psychosocial distress as access to private care remains uneven, and affordability barriers limit its availability for people in vulnerable situations, including low-income groups, migrants and socially excluded communities.

Social and Community-Based Mental Health Support

Social interventions are coordinated through Seville's 11 municipal districts. Seville City Council provides a broad network of social support services, including:

- **Information, Assessment, Guidance and Advice Service;**
- **Home Help Service;**
- **Coexistence and Social Reintegration Service;**
- **Social Cooperation Service;**
- **Family Treatment Teams;**
- **dependency and elderly support services.**

Municipal services also support homeless people, minors and families, marginalised neighbourhoods, informal settlements, volunteers and community initiatives. Financial support mechanisms include family financial aid, complementary economic aid and emergency social funds.

FAISEM also plays an important role in supporting people with Severe Mental Illness. Its services include supervised housing, residential facilities and occupational integration programmes. These structures are especially relevant for promoting social inclusion, recovery and continuity of support beyond clinical care.

Governance and Inter-Agency Coordination

Mental health services are coordinated through Clinical Management Agreements governed by Decree 77/2008. UGCs manage all mental health facilities within their territorial catchment areas. Four-year Clinical Management Agreements regulate operational objectives, budget allocation, professional performance indicators, research standards and quality standards.

Intersectoral coordination is mainly supported through the Local Network for Health Action (RELAS). RELAS brings together public health infrastructure, municipal social services, civil society organisations, local authorities and community-based actors. Local Health Plans are implemented across Seville's 11 districts.

Despite these coordination mechanisms, governance remains partly fragmented. This is mainly due to the top-down relationship between regional ministries and local implementation systems, which may limit flexibility, local adaptation and systematic cooperation with community-based actors.

Role of Key Stakeholders

Table 22 below identifies the main stakeholder groups involved in the Seville mental health ecosystem and explains their contribution to people in vulnerable situations. It highlights the importance of combining clinical care with social, community-based and culturally responsive support.

Table 22. Main stakeholder groups contributing to mental health care, psychosocial support and social inclusion for people in vulnerable situations in Seville

Stakeholder Group	Main Role	Relevance for People in Vulnerable Situations
Primary care services	Act as the main entry point into the mental health system. General practitioners manage first presentations of psychosocial distress and non-urgent referrals to Community Mental Health Units.	Particularly relevant for people experiencing distress linked to unemployment, poverty, housing insecurity or social exclusion.
Specialised mental health services	Provide multidisciplinary care through psychiatrists, clinical psychologists, mental health nurses, social workers and occupational therapists.	Offer psychotherapy, psychoeducation, psychopharmacology, assertive community treatment, psychiatric nursing coordination, cognitive rehabilitation, psychosocial skills training and vocational guidance.
Municipal social services	Provide social assistance, family support, home help, reintegration services, dependency support and emergency financial aid.	Address social determinants of mental health, including poverty, homelessness, family vulnerability, dependency and marginalisation.
FAISEM	Provides supervised housing, residential facilities and occupational integration for people with Severe Mental Illness.	Supports recovery, social inclusion, housing stability and labour-market reintegration for people with complex needs.
NGOs and civil society organisations	Support social reintegration, anti-stigma interventions and culturally responsive care pathways.	Organisations such as En Primera Persona, Fundación Secretariado Gitano, FAKALI and AMURADI provide culturally competent support for Roma communities and socially excluded populations.
Community-based organisations	Provide outreach, trust-building, mediation and support in vulnerable neighbourhoods.	Help bridge the gap between formal services and communities that may experience mistrust, stigma or discrimination.

Key Findings

- Seville has a broad public mental health infrastructure combining hospitals, primary care, specialised mental health centres, rehabilitation structures and emergency psychiatric services.

- The system is territorially organised through Clinical Management Units, which coordinate specialised services across defined catchment areas.
- Primary care centres are the main entry points into the mental health system and play a key role in identifying psychosocial distress linked to poverty, unemployment and housing insecurity.
- Public services prioritise Severe Mental Illness, creating gaps in preventive care, mild-to-moderate psychological support, psychotherapy and psychosocial counselling.
- Private psychology and psychotherapy services respond to part of this unmet demand, but affordability limits access for vulnerable groups.
- Municipal social services provide important support for families, elderly people, homeless people, marginalised neighbourhoods, informal settlements and people facing social vulnerability.
- FAISEM contributes to recovery and social inclusion through supervised housing, residential support and occupational integration for people with Severe Mental Illness.
- RELAS and Local Health Plans provide a framework for intersectoral coordination, although governance remains partly fragmented between regional and local levels.
- NGOs and civil society organisations are essential for anti-stigma work, social reintegration, culturally responsive support and outreach to Roma communities and socially excluded populations.

3.4.7 Service Exclusion Trends

The priority populations in the Seville Lab, Roma communities and Latin American migrants, experience multiple and intersecting forms of service exclusion that affect their ability to access and benefit from mental health services. These barriers are presented in [Table 23](#) below and extend beyond healthcare provision itself. They are rooted in broader socioeconomic, cultural, administrative, and structural inequalities.

Table 23. Service exclusion trends affecting Roma communities and Latin American migrants in Seville, Andalucía, highlighting barriers to accessing mental healthcare and psychosocial support services.

Type of Service Exclusion	Roma Communities	Latin American Migrants
Financial	• Roma communities experience disproportionately high levels of poverty, socioeconomic disadvantage, and social exclusion. • Economic marginalisation reduces the ability to prioritise healthcare-related expenses and indirectly limits access to mental health support. • Financial precarity increases vulnerability to mental health difficulties while reducing continuity of care.	• Financial vulnerability remains a major indirect barrier despite theoretically free public mental healthcare. • Many migrants work in precarious employment conditions characterised by unstable contracts, informal work, long hours, and limited protections. • Fear of income loss discourages attendance at medical and psychological appointments.

Geographical	• Many Roma populations live in segregated or socioeconomically disadvantaged neighbourhoods. • Territorial inequalities may reduce accessibility to specialised healthcare services and preventive mental health support.	• Limited knowledge of healthcare entitlements may lead to delayed treatment and avoidable costs. • Geographical exclusion is linked more to unequal navigation of services than to physical distance. • Access to specialised mental healthcare frequently involves long waiting lists, administrative complexity, and additional travel requirements. • These barriers disproportionately affect migrants with unstable employment conditions or limited transport flexibility.
Social and Cultural	• Structural discrimination, anti-gypsyism, and racism contribute to institutional mistrust and reduced engagement with healthcare services. • Cultural stigma surrounding mental health discourages formal help-seeking. • Mental distress is often addressed within family or community environments rather than clinical settings. • Experiences of prejudice and discrimination during healthcare encounters reinforce exclusion. • Roma populations remain underrepresented in mental health research and data collection systems.	• Migrants frequently report discrimination and unequal treatment within healthcare settings. • Reported experiences include verbal abuse, dismissive communication, stereotyping, and lack of empathy. Communication barriers extend beyond language and include weak trust-building and insufficient active listening. • Perceived lack of dignity discourages future engagement with mental healthcare services. • Institutional fatigue and increased workload may contribute to subtle forms of exclusion within healthcare systems.
Legal and Policy	• Although universal healthcare is legally guaranteed, implementation gaps remain significant. • Existing policy frameworks insufficiently integrate culturally competent services, targeted outreach, cultural mediation, and anti-discrimination mechanisms. • Lack of Roma-inclusive mental health policies perpetuates structural inequalities.	• Administrative and legal barriers remain major determinants of healthcare exclusion. • Migrants frequently report insufficient information regarding legal entitlements and healthcare registration procedures. • Difficulties obtaining the National Individual Health Card (<i>Tarjeta Sanitaria Individual</i>) remain a major obstacle.

		• Irregular administrative status may restrict access due to residence and registration requirements. • Fear of deportation or data sharing with authorities discourages engagement with services.
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Overall, the table shows that Roma communities and Latin American migrants in Seville face overlapping but distinct forms of exclusion from mental healthcare and psychosocial support. For Roma communities, barriers are strongly linked to poverty, residential segregation, discrimination, institutional mistrust and insufficient culturally responsive policies. For Latin American migrants, exclusion is often shaped by precarious employment, administrative complexity, uncertainty around legal status, limited knowledge of entitlements and difficulties navigating the healthcare system.

Although public healthcare is formally available, these barriers limit effective access, delay help-seeking and reduce continuity of care. Addressing service exclusion therefore requires more than expanding service provision; it requires culturally competent outreach, simplified administrative pathways, trusted community mediation, anti-discrimination measures and stronger links between healthcare, social services and community organisations.

3.4.8 Priority Areas for Investment within the Mental Health Care System in Spain

The mental health ecosystem in Seville benefits from a well-developed public healthcare system, ongoing mental health reforms, and a growing emphasis on community-based care. Nevertheless, significant challenges continue to affect the accessibility, inclusiveness, and responsiveness of services, particularly for Roma communities and Latin American migrants. These challenges are not only related to service capacity but also to the way mental health care is organised, delivered, and experienced by people in vulnerable situations.

Current service provision remains largely reactive, with access to specialised mental health support often occurring primarily through primary care referrals or emergency pathways, often after psychological distress has already escalated. Long waiting times, limited integration of psychological care within primary care settings, and insufficient follow-up mechanisms can delay timely intervention and continuity of care. Administrative complexity, fragmented coordination between health and social services, and limited cultural competence further contribute to inequalities in access and service utilisation.

The ecosystem analysis also highlights a persistent gap between institutional service models and the lived realities of vulnerable communities. Roma and migrant populations may rely on family, community, spiritual, or informal support networks when experiencing psychological distress, while stigma, anticipated discrimination, and mistrust of institutions can discourage engagement with formal mental health services. In addition, weak intersectoral collaboration and limited participation of vulnerable groups in decision-making processes may reduce the effectiveness, acceptability, and sustainability of interventions.

Table 24 identifies the key priority areas for investment and innovation within the Seville mental health ecosystem and how these priorities could be capitalised. It links the main system gaps identified through the ecosystem profiling exercise with targeted investment and innovation opportunities and their expected outcomes. Particular emphasis is placed on strengthening early intervention, improving access to psychological care, reducing administrative and cultural barriers, enhancing coordination across sectors, promoting community participation, and developing more flexible, person-centred, and equity-oriented models of care.

Table 24. Priority Areas for Investment within the Mental Healthcare System in Seville, Spain

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment/ Innovation Area	Expected Outcomes
Reactive and Crisis-Oriented Access Model	Access to specialised mental health services is largely activated through primary care referrals or emergency pathways.	- Community-based early intervention teams - Strengthening Intensive Community Treatment Teams (ETIC)	- Earlier detection of distress - Reduced emergency admissions - Improved continuity of care - Increased engagement among populations reluctant

	• Early deterioration and psychosocial distress frequently remain unaddressed until crisis stages are reached. • Preventive outreach and home-based intervention remain limited.	• Home-based and neighbourhood outreach models • Partnerships with Roma associations, migrant NGOs, and trusted community actors	to access institutional services
Limited Integration of Psychological Care in Primary Care	• Clinical psychologists are not systematically embedded in primary care. • Mild-to-moderate cases are frequently managed pharmacologically, while access to structured psychotherapy remains limited and waiting times remain high.	• Embedding psychologists within primary care • Expanding short-term structured psychotherapy • Developing stepped-care models adapted to vulnerable populations	• More equitable access to psychotherapy • Reduced pharmacological over-reliance • Improved continuity and early support
Long Waiting Times and Insufficient Follow-Up	• Follow-up intervals may be insufficient for PVS requiring sustained psychosocial support. • Service demand has increased substantially after COVID-19.	• Increased workforce capacity • Hybrid (digital + face-to-face) follow-up models • Digitally supported continuity-of-care mechanisms	• Improved treatment continuity • Reduced drop-out rates • Better adherence and long-term engagement
Administrative and Bureaucratic Complexity	• Appointment systems, referral procedures, and documentation requirements operate as exclusionary filters, particularly for individuals with low health literacy or unstable administrative status.	• Simplified access pathways, • Assisted digital navigation • Case management models • User-friendly referral systems	• Reduced exclusion of low-literacy and administratively vulnerable populations • Improved system navigation capacity
Weak Intersectoral Coordination	• Coordination between healthcare, social services, employment agencies, NGOs, and community actors remains fragmented. Social entities often compensate for systemic gaps rather than functioning within integrated pathways.	• Formalised coordination protocols • Integrated health–social care case management • Shared referral and information systems	• Improved coordination across sectors • Better integration of social determinants into care pathways
Limited Cultural Competence and Diagnostic Oversimplification	• Lack of standardised cultural competence training contributes to variability in care quality. Migrant trauma and Roma-specific experiences may remain insufficiently explored during assessment processes.	• Accredited cultural competence training • Culturally adapted assessment tools	• Reduced misdiagnosis and stereotyping • Increased trust and therapeutic alliance

		Structured use of intercultural mediators	
Misalignment Between Biomedical Models and Community Understandings of Mental Health	Roma and migrant communities often rely on relational, family-based, spiritual, or community-centred understandings of distress. Public services insufficiently engage these trust networks.	- Partnerships with Roma associations, migrant NGOs, faith leaders, and peer mediators - Community-led and co-designed interventions	- Increased engagement among populations prioritising relational trust - Greater acceptability of interventions
Stigma and Anticipated Discrimination	Fear of discrimination linked to ethnicity, migration status, poverty, or gender discourages help-seeking and contributes to institutional mistrust.	- Anti-stigma strategies - Participatory governance - Safe feedback and complaint mechanisms - Peer-support initiatives	- Improved help-seeking behaviours - Reduced stigma - Strengthened institutional trust
Organisational Rigidity and Service Inflexibility	Mental health services are predominantly organised during weekday mornings and are poorly adapted to precarious employment, caregiving burdens, or unstable routines common in vulnerable communities.	- Flexible schedules - Outreach clinics in deprived neighbourhoods - Reminder systems - Drop-in and low-threshold consultation models	- Improved attendance rates - Reduced structural exclusion - Increased accessibility
Insufficient Holistic and Person-Centred Approaches	Residual biomedical approaches contribute to fragmentation between mental healthcare, physical healthcare, housing support, employment services, and social participation pathways.	- Integrated person-centred care pathways - Recovery-oriented and multidisciplinary approaches	Improved overall wellbeing and social recovery outcomes
Limited Evaluation and Equity-Sensitive Indicators	Existing monitoring systems insufficiently capture social determinants, cultural dimensions, intersectionality, and outcomes among vulnerable populations.	- Development of equity-sensitive indicators - Social determinant-adjusted evaluation frameworks - Implementation science approaches	- Improved evidence-based scaling of inclusive models - Better measurement of inequalities and outcomes

Top-Down Governance and Limited Participation	• Strategic decision-making processes remain largely top-down with limited participation of Roma communities, migrant representatives, or social organisations.	• Community advisory boards • Co-creation workshops within Smart Health Labs • Inclusion of lived-experience experts in governance and evaluation	• Better alignment between services and community realities • Increased sustainability and acceptability of interventions
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3.4.9 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Seville, Spain

The province of Seville hosts a consolidated network of community-based and social economy organisations working on:

- mental health,
- social inclusion,
- labour integration,
- anti-discrimination,
- migrant support,
- Roma community empowerment.

These organisations operate through community-driven and rights-based approaches that combine psychosocial support, advocacy, empowerment, and territorial outreach. Their long-term territorial presence and trusted community relationships position them as key actors for reaching PVS.

Their involvement is expected to strengthen both the individual-level activities of the Smart Health Lab, such as health promotion, mental health literacy, and co-creation actions, and the community-level activities focused on co-designing and testing innovative solutions that address persistent barriers to mental health service access.

The following table presents the social economy initiatives identified within the Seville ecosystem that are considered particularly relevant for the Smart Health Lab. These organisations and initiatives have been selected based on their experience in supporting PVS, their contribution to mental health, social inclusion, community engagement, and service innovation, and their potential to contribute to the sustainability, scalability, and long-term impact of Smart Health Lab activities.

Table 25. Social Economy Initiatives to be prioritised by the Smart Health Lab in Seville, Spain

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>FAKALI</u> <u>(Federation of Associations of Roma Women)</u>	Roma women empowerment, mediation, counselling, employment support, digital inclusion	Provides culturally competent outreach to Roma communities and operates innovative digital tools such as the <i>Virtual Health Centre</i> and <i>Empleakali</i> employment platform.
<u>ASAENES</u> <u>(Association of Mental Health in Seville)</u>	Mental health support, psychosocial rehabilitation, labour insertion, anti-stigma actions	Supports people with mental health conditions through empowerment and recovery-oriented initiatives such as the AVANZA+ programme.
<u>FAISEM</u>	Social integration of people with Severe Mental Illness (SMI), supported housing, and employment orientation	Provides residential support, occupational integration, and supported employment services for individuals with complex mental health needs.
<u>ACCEM</u>	Refugee and migrant support, psychosocial assistance, social inclusion	Delivers direct psychological support and safe spaces for migrants and refugees experiencing trauma, displacement, and adaptation difficulties.

En Primera Persona

Peer-support networks, lived-experience advocacy, anti-stigma actions

Promotes “experts by experience” models and meaningful participation of service users within mental health governance and recovery processes.

Areté / SURGE Network

Social rights, poverty reduction, labour integration, neighbourhood interventions

Develops personalised socio-labour insertion pathways in disadvantaged neighbourhoods such as Torreblanca and Polígono Sur.

3.4.10 SWOT Analysis of the Spanish Pilot Site and strategic directions for the design of the Smart Health Lab

The SWOT analysis presented below provides a strategic assessment of the Seville pilot site, focusing on the capacity of the local mental health ecosystem to address the needs of Roma communities and Latin American migrants, while supporting the implementation of the Smart Health Lab. The analysis draws on the territorial, socio-economic, governance, service provision, innovation, and community engagement characteristics identified throughout the ecosystem profiling exercise. It highlights both the assets that can facilitate the implementation of innovative and inclusive mental health solutions and the challenges that may hinder equitable access to care for people in vulnerable situations.

Table 26. SWOT Analysis of the Spanish Pilot Site

Strengths	Weaknesses
Universal public healthcare coverage and a well-established public mental health system organised through primary care, Community Mental Health Units (USMCs), specialised services, and rehabilitation structures.	Workforce shortages in clinical psychology and psychiatry contribute to long waiting times and reduced access to psychotherapy and psychosocial support.
Strong digital health infrastructure through the Andalusian Digital Health Strategy 2030, including Diraya electronic health records, teleconsultation services, and digital appointment systems.	Access to specialised mental health services remains largely reactive and crisis-driven, with limited emphasis on prevention and early intervention.
Robust innovation ecosystem supported by universities, biomedical research institutes, the Cartuja Science and Technology Park, and regional health innovation strategies.	Clinical psychologists are not systematically integrated within primary care, leading to an overreliance on pharmacological responses for mild-to-moderate conditions.
Extensive network of community-based organisations and social economy actors (FAKALI, ACCEM, ASAENES, FAISEM, En Primera Persona, Arété) with strong community legitimacy and outreach capacity.	Fragmented coordination between healthcare, social services, employment services, NGOs, and community actors.
Existing mechanisms for intersectoral collaboration through RELAS and Local Health Plans across Sevilla's districts.	Administrative complexity, referral procedures, and bureaucratic requirements create exclusionary barriers for vulnerable populations.

Presence of specialised programmes supporting severe mental illness, rehabilitation, supported housing, social inclusion, and labour market integration. Strong territorial presence of Roma and migrant organisations capable of supporting co-creation and community engagement activities.	Limited cultural competence and insufficient use of intercultural mediation can lead to misdiagnosis, mistrust, and reduced engagement among Roma and migrant populations. Top-down governance structures and limited participation of vulnerable communities in strategic decision-making processes.
Opportunities	Threats
Smart Health Lab activities can strengthen co-creation, community participation, and culturally responsive service design for Roma communities and Latin American migrants.	Persistent poverty, unemployment, precarious employment, and social exclusion continue to act as major determinants of poor mental health outcomes.
Expansion of community-based early intervention models, outreach teams, and neighbourhood-level services can improve accessibility and prevention.	Structural discrimination, anti-Gypsyism, racism, and stigma may continue to discourage help-seeking behaviours and engagement with services.
Greater use of intercultural mediators, culturally adapted assessment tools, and community navigators can reduce barriers for migrants and Roma populations.	Continued administrative barriers and legal uncertainty may discourage migrants, particularly those with irregular status, from accessing care.
Digital innovation, telehealth solutions, and assisted digital navigation can improve service access when combined with inclusion measures.	Digital transformation may unintentionally increase exclusion among people with low digital literacy, limited administrative skills, or low trust in institutions.
National and regional mental health reforms (PESMA-A, IV PISMA, Spain Mental Health Action Plan 2025–2027) provide a supportive policy environment for innovation and equity-focused interventions.	Rising demand for mental health services may continue to outpace workforce capacity and available resources.
Development of integrated health-social care pathways and shared referral systems can improve continuity of care and address social determinants of health.	Residential segregation, neighbourhood deprivation, and territorial inequalities may reinforce existing disparities in mental health outcomes and service access.
Strong social economy ecosystem creates opportunities for long-term sustainability and scaling of community-based interventions.	Climate-related stressors, extreme heat exposure, housing instability, and energy poverty may further increase vulnerability among already disadvantaged populations.

Strategic directions for the design of the Smart Health Lab in Seville



Figure 19. Strategic directions for the Spanish Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Spanish Smart Health Lab could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

Building on the SWOT analysis, the Seville Smart Health Lab could be developed as a community-based and equity-oriented platform that strengthens access to mental health support for Roma communities, Latin American migrants and other vulnerable groups facing intersecting forms of exclusion. Its role would be to connect existing public services, social economy actors, community organisations, primary care, municipal structures and lived-experience networks around practical actions that improve prevention, service navigation, early support and continuity of care.

Strategic positioning: establishing the Lab as an equity-driven access and coordination platform

The Seville Smart Health Lab could act as a local mechanism for translating existing ecosystem strengths into practical improvements in mental health access. Rather than duplicating existing services, the Lab could connect public healthcare capacity, municipal structures, social economy organisations, community-based actors and lived-experience networks around shared priorities. Its added value lies in creating a coordinated, inclusive and community-facing space that supports Roma communities, Latin American migrants and other vulnerable groups more effectively.

Advancing prevention and early intervention through neighbourhood-based outreach

A central strategic direction would be to reinforce prevention and early intervention at neighbourhood level. Access to specialised mental health services remains largely reactive, with support often provided only once needs have become more severe. The Lab could therefore promote outreach activities, early identification of distress and low-threshold psychosocial support in cooperation with Roma organisations, migrant NGOs, primary care providers and municipal services.

Improving culturally safe access for Roma communities and Latin American migrants

The Lab could improve culturally responsive access for Roma communities and Latin American migrants. Experiences of discrimination, anti-Gypsyism, racism, stigma and limited cultural competence can reduce trust in formal services and discourage engagement. To address this, the Lab could work with intercultural mediators, community navigators and trusted local organisations. Communication materials, outreach activities and referral support might be adapted to the cultural and social realities of the target groups, ensuring dignity, trust and continuity of care.

Reducing administrative burden through navigation, rights information and referral support

Another priority could be to simplify service navigation and reduce administrative barriers. Complex referral procedures, bureaucratic requirements, legal uncertainty and limited knowledge of rights can prevent people from accessing available support. The Smart Health Lab could provide practical guidance, user-friendly information and assisted referral pathways, helping people understand healthcare registration, available services, access entitlements and the steps needed to receive support.

Addressing social determinants of mental health through integrated local support

The Lab could connect mental health with the broader social determinants of vulnerability. Poverty, unemployment, precarious work, housing instability, residential segregation and social exclusion strongly influence mental health outcomes. For this reason, the Smart Health Lab could not address mental health in isolation, but would link its activities with social services, employment support, housing assistance, community organisations and social economy actors. This integrated approach might help respond to the wider conditions that shape distress and exclusion.

Strengthening cross-sector coordination between health, social care and community actors

Promoting integrated health–social care pathways could be another key direction. Coordination between healthcare providers, social services, employment structures, NGOs and community actors remains fragmented. The Lab could support shared referral routes, cross-sector working groups and coordinated case-management approaches involving both public services and community-based organisations. This might improve continuity of care and reduce the risk that vulnerable users move between disconnected services without sustained support.

Deploying digital mental health tools through inclusive and supported access models

Digital innovation could be introduced carefully and inclusively. Seville benefits from strong digital health infrastructure, but digital transformation may exclude people with low digital literacy, limited administrative skills or low trust in institutions. Telehealth, assisted digital navigation and digital mental health tools could therefore be tested only alongside face-to-face guidance, human support and digital inclusion measures.

Expanding low-threshold psychosocial support for mild-to-moderate distress

The Smart Health Lab could also support psychological care for mild-to-moderate distress. The limited integration of clinical psychologists in primary care contributes to restricted access to psychotherapy and may increase reliance on pharmacological responses. The Lab could pilot complementary community-based psychosocial support, mental health literacy actions, brief interventions and referral assistance for people experiencing anxiety, depression or psychosocial distress.

Leveraging social economy actors to strengthen outreach, empowerment and sustainability

A further strategic priority is to build on Seville's social economy and community ecosystem.

Organisations such as FAKALI, ACCEM, ASAENES, FAISEM, En Primera Persona and Areté bring strong outreach capacity, community legitimacy and experience in empowerment, peer support, social inclusion and anti-stigma work.

Embedding Roma and migrant participation in co-design, governance and evaluation

The Lab could increase the participation of vulnerable communities in decision-making. Mental health governance remains largely top-down, with limited involvement of Roma communities, migrant representatives and grassroots organisations. Participatory mechanisms such as community advisory groups, co-design workshops and structured feedback loops can ensure that the voices of Roma and migrant communities directly inform priorities, activities and evaluation.

Building trust, reducing stigma and integrating lived-experience expertise

Strengthening trust, reducing stigma and involving lived experience should remain central to the Lab's approach. Stigma, anticipated discrimination and previous negative encounters with services can discourage people from seeking help. The Lab could therefore create safe and trusted spaces where communities can discuss mental health without fear of judgement. Peer-support models, lived-experience expertise and anti-stigma campaigns might help normalise help-seeking and improve engagement.

3.4.11 Useful Resources

Table 27. Key policy, institutional, community and data resources relevant to the Seville / Andalucía pilot site, covering mental health, digital health, Roma inclusion, migration, social economy, public services and local ecosystem mapping

Resource / Initiative	Official Link
Estrategia de Salud Digital de Andalucía 2030	Estrategia de Salud Digital de Andalucía 2030
IV PISMA – Andalusian Comprehensive Mental Health Plan	IV PISMA
PESMA-A – Andalusian Strategic Plan for Mental Health and Addictions	PESMA-A
Spain Mental Health Action Plan 2025–2027	Spain Mental Health Action Plan 2025–2027
National Strategy for Roma Equality, Inclusion and Participation 2021–2030	National Strategy for Roma Equality, Inclusion and Participation 2021–2030
Servicio Andaluz de Salud (SAS)	Servicio Andaluz de Salud (SAS)
Diraya Electronic Health Record System	Diraya
RELAS – Local Network for Health Action	RELAS
Andalusian School of Public Health (EASP)	Andalusian School of Public Health (EASP)
Red iSir – Migration and Health Network	Red iSir
Cartuja Science and Technology Park	Cartuja Science and Technology Park
FAKALI – Federation of Associations of Roma Women	FAKALI

Fundación Secretariado Gitano	Fundación Secretariado Gitano
Empleakalí Platform	Empleakalí
ERACIS+ Andalucía	ERACIS+ Andalucía
ASAENES – Association of Mental Health in Seville	ASAENES
FAISEM – Andalusian Public Foundation for the Social Integration of People with Mental Illness	FAISEM
En Primera Persona	En Primera Persona
ACCEM	ACCEM
SURGE Network	SURGE Network
Sevilla City Council	Sevilla City Council
Sevilla Municipal Statistics Service	Sevilla Municipal Statistics Service
Instituto Nacional de Estadística (INE)	Instituto Nacional de Estadística (INE)
Eurostat	Eurostat
Spanish Ministry of Inclusion, Social Security and Migration	Spanish Ministry of Inclusion, Social Security and Migration
Spanish Ministry of Education and Vocational Training	Spanish Ministry of Education and Vocational Training
OECD – Social Economy and Innovation	OECD – Social Economy and Innovation

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3.5 Mannheim – Baden-Württemberg (Germany)

3.5.1 Geographical Context & Demographic Overview

The German pilot site is located in Mannheim (DE126), an independent city within the Karlsruhe administrative region (DE12) in Baden-Württemberg (DE1), south-western Germany. Mannheim is situated in the Upper Rhine Plain, at the confluence of the Rhine and Neckar rivers, and is characterised by a flat, non-mountainous and fully urban municipal environment. The pilot activities will therefore be implemented across the full urban territory of Mannheim, reflecting the city's role as a major urban centre in the Upper Rhine metropolitan region. In demographic terms, Mannheim had approximately 332,600 inhabitants in 2024 and presents a relatively dynamic urban profile. The city combines a large working-age population with significant proportions of children, adolescents and older adults, creating diverse mental health and social support needs across the life course. Mannheim demonstrates migration-driven population growth and demographic stabilisation.

A defining characteristic of Mannheim is its high migration-related diversity. Nearly half of the city's residents have a migration background, with large communities originating particularly from Türkiye, alongside more recent refugee and protection-related migration flows. Mannheim also hosts a state reception centre for asylum seekers (LEA), reinforcing its role within the regional migration and reception system. This demographic composition highlights the importance of culturally responsive, multilingual and inclusive mental health approaches. At the same time, the city combines an ageing long-term population with younger and more mobile migrant populations. High residential mobility and the increasing number of single-person households are important social trends that may affect wellbeing, social connectedness and mental health needs. These features underline the relevance of the Mannheim Smart Health Lab as a setting for addressing the intersection between migration, urban diversity, ageing, mobility and access to mental health support.

The infographic below ([Figure 20](#)) summarises the location and demographic profile of the Mannheim pilot site. It visually presents the city's geographical position within Germany and Baden-Württemberg, its urban setting at the Rhine-Neckar confluence, and the main population characteristics shaping local mental health needs, including migration diversity, age structure, residential mobility and demographic growth.

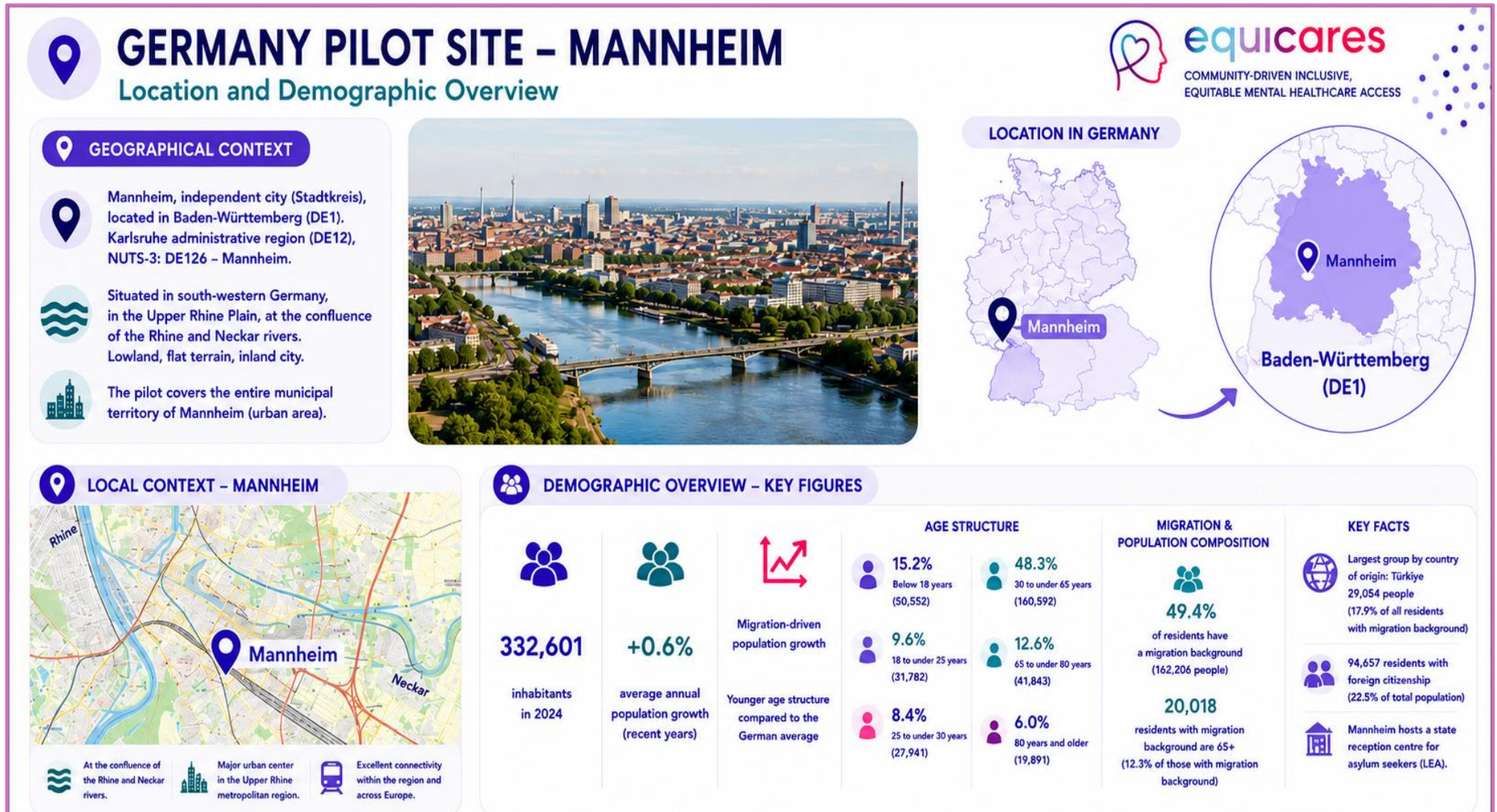


Figure 20. Mannheim (Germany) Location and Demographic Overview

3.5.2 Techno-Economic Context

Mannheim offers a favourable setting for digitally supported mental health and care solutions. As a large urban municipality in Baden-Württemberg, the city benefits from advanced broadband and mobile network coverage, a strong public administration infrastructure, and a healthcare environment where digital communication is increasingly common. Online appointment systems, electronic communication channels and digitally managed service information are becoming more relevant in both public administration and outpatient healthcare.

The city also forms part of the wider Rhine-Neckar academic and research environment, which provides a strong basis for developing specialised health, social care and digitally enabled support services. However, the local context also shows that digital and healthcare infrastructure alone do not guarantee equal access. Mannheim's diversified economy, including manufacturing, logistics, trade, healthcare and public administration, produces varied employment conditions and uneven socioeconomic situations. For some residents, unstable employment, fixed working hours, transport costs or limited flexibility may make it difficult to attend mental health appointments regularly.

Access is also shaped by education, language and digital literacy. People with lower formal education may be less familiar with the German healthcare system and may experience difficulties understanding written or digital information about mental health services. This is particularly relevant for some first-generation migrant populations, who may also face language barriers and lower utilisation of psychotherapy.

Germany's statutory health insurance system provides broad coverage for outpatient psychotherapy, psychiatric treatment and inpatient mental healthcare. Nevertheless, practical barriers remain. Long waiting times, complex entry routes into care, and limited structured interpreting provision can delay access, especially for migrants and refugees. Since mental healthcare is mainly delivered in German, language remains a central factor influencing whether people can understand services, express distress and build trust with professionals.

As shown in [Table 28](#) below, Mannheim has strong foundations for the Smart Health Lab, including advanced digital infrastructure, a strong research environment and broad statutory health coverage. The main challenge is to make these assets usable for groups facing language barriers, low digital literacy, unstable employment, transport costs or limited knowledge of the German healthcare system.

Table 28. Digital, economic and healthcare access conditions shaping mental health service utilisation and Smart Health Lab design priorities in Mannheim

Techno-Economic Dimension	Key Conditions	Main Access Challenges	Relevance for the Smart Health Lab
Digital infrastructure and connectivity	Mannheim benefits from widespread broadband and mobile network coverage within a highly developed urban region.	Access to services increasingly depends on the ability to use digital platforms, online information and electronic communication tools.	Smart Health Lab activities can build on strong digital infrastructure while ensuring that digital solutions remain accessible and user-friendly.

Digitalisation of healthcare and administration	Public administration and outpatient healthcare providers increasingly use online appointment booking and electronic communication systems.	People with limited digital literacy, language barriers or low familiarity with the healthcare system may struggle to navigate digital procedures.	The Lab should support assisted digital navigation, multilingual information and simple access pathways.
Research and innovation ecosystem	Mannheim is embedded in the Rhine-Neckar academic and research ecosystem, which supports specialised health, social and digitally supported care services.	Innovation capacity may not automatically reach vulnerable groups unless linked with community-based implementation and inclusive design.	The Lab can act as a bridge between research, digital innovation, service providers and communities in vulnerable situations.
Local economic structure	Mannheim has a diversified urban economy based on manufacturing, logistics, trade, healthcare and public administration.	Employment conditions vary across sectors, contributing to socioeconomic inequalities.	Mental health support should consider the diversity of working conditions and the needs of both stable and precarious workers.
Employment instability and practical access barriers	Working hours, unstable employment and transport-related costs may affect service access.	Individuals may find it difficult to attend regular appointments, especially when services are offered during standard working hours.	Flexible formats, hybrid support and outreach-based activities can improve continuity of care.
Education and digital literacy	Educational attainment and digital skills influence the ability to access written and digital healthcare information.	Lower levels of formal education may reduce familiarity with the healthcare system and limit psychotherapy utilisation.	The Lab should include health literacy, digital literacy and service navigation support.
Migration-related language and system barriers	Some first-generation migrant populations may face greater language barriers and reduced familiarity with the German healthcare system.	Written and digital healthcare information is often difficult to navigate without language support or system knowledge.	Multilingual communication, cultural mediation and community-based guidance will be important access enablers.
Healthcare coverage and service entitlement	Germany operates a statutory health insurance system with near-universal coverage,	Formal entitlement does not eliminate barriers such as long waiting times, complex	The Lab should focus on translating formal coverage into practical, timely and

	including psychotherapy, psychiatric treatment and inpatient mental healthcare.	entry pathways and limited interpreting services.	understandable access to care.
Language of mental healthcare provision	Mental healthcare services are primarily delivered in German.	Migrants and refugees may face difficulties expressing distress, understanding treatment options or building therapeutic trust.	Structured interpreting support, culturally responsive tools and referral guidance should be considered within Lab activities.

3.5.3 Ecological and Environmental Factors

Mannheim's ecological and environmental context is shaped by its position as a densely populated urban municipality within the Upper Rhine valley, one of Germany's major transport and industrial corridors. This urban and industrial setting creates important environmental pressures that may influence mental wellbeing, particularly in neighbourhoods exposed to higher levels of traffic-related air pollution, environmental noise and dense built environments.

Urban living conditions can contribute to psychological stress, especially where residents experience limited space, high population density, noise exposure or poor housing conditions. Research on urbanicity suggests that city environments may influence stress processing and increase vulnerability to mental health disorders, particularly when combined with social or economic disadvantage. In this context, environmental stressors should be understood not only as physical health risks, but also as factors that may affect sleep quality, emotional regulation, perceived safety and overall mental wellbeing.

Access to urban green spaces is therefore an important protective factor. Restorative green environments can support stress reduction, social interaction and mental wellbeing, especially in densely built neighbourhoods. Their availability, quality and accessibility are particularly relevant for people in vulnerable situations, including older adults, migrants, refugees, people living alone and residents facing socioeconomic hardship.

Overall, environmental factors such as noise, heat, air pollution, housing conditions and urban density may disproportionately affect vulnerable populations and interact with existing barriers to care. These conditions can also influence people's practical ability to seek support, attend appointments and maintain continuity of mental healthcare.

3.5.4 Regulatory and Policy Landscape

Mental healthcare in Mannheim is shaped by a multi-level regulatory framework combining federal legislation, statutory health insurance rules and Baden-Württemberg state-level planning. At federal level, access to medically necessary mental healthcare is mainly regulated through the statutory health insurance system, while specific legal frameworks define psychotherapy provision, coordinated care for severe mental illness, rehabilitation, youth support and professional qualification standards. At state level, Baden-Württemberg provides additional structures for community mental health support, crisis intervention and regional psychiatric planning.

This framework creates a strong legal basis for access to mental healthcare, psychotherapy, rehabilitation and social participation support. However, responsibilities are distributed across several systems, including healthcare, rehabilitation, youth welfare, employment support and community-based psychosocial care. As a result, effective access often depends on coordination between multiple institutions and on the ability of individuals to understand and navigate parallel entitlement systems.

The table below translates this multi-level regulatory landscape into a structured overview of the main legal and policy frameworks shaping mental healthcare access in Mannheim. It shows how federal health insurance rules, psychotherapy regulations, Baden-Württemberg state-level planning instruments, rehabilitation law, youth welfare provisions and employment support measures each contribute to the broader mental health and psychosocial support system.

Table 29. Regulatory and policy frameworks shaping mental healthcare access and psychosocial support in Mannheim, Germany

Regulatory / Policy Framework	Main Scope	Relevance for Mental Health Access in Mannheim
Statutory Health Insurance System – SGB V	Regulates access to healthcare under Germany's statutory health insurance system.	Provides insured persons with legal entitlement to medically necessary mental healthcare, including outpatient psychotherapy, psychiatric treatment and inpatient mental healthcare.
Psychotherapy Guideline	Defines outpatient psychotherapy access pathways, diagnostic procedures and eligible treatment methods.	Structures how individuals enter psychotherapy, which treatments are covered, and how outpatient psychotherapy is organised within statutory care.
KSVPsych Guideline	Supports coordinated and structured care for people with severe mental illness and complex psychiatric or psychotherapeutic needs.	Provides a framework for more integrated care pathways for people requiring intensive, multi-professional support.
Psychotherapists Act – PsychThG	Regulates professional qualification, training and licensure of psychotherapists.	Ensures professional standards and quality requirements for psychotherapeutic care provision.
Baden-Württemberg Psychisch-Kranken-Hilfe-Gesetz – PsychKHG	Regulates support and protection measures for people with mental illness at state level.	Provides the legal basis for community mental health support, crisis intervention and local psychiatric coordination structures in Baden-Württemberg.
Landesplan der Hilfen für psychisch kranke	Coordinates regional psychiatric and psychosocial care planning.	Supports strategic planning of mental health and psychosocial services across the state, including

Menschen in Baden-Württemberg		community-based support structures.
Social Code Book IX – SGB IX	Regulates rehabilitation, participation and psychosocial disability support.	Provides a legal basis for social participation, rehabilitation and support for people with psychosocial disabilities.
Social Code Book VIII – SGB VIII §35a	Regulates integration assistance for children and adolescents with mental health-related disabilities.	Provides children and adolescents with entitlement to support where mental health difficulties affect social participation and development.
Federal Employment Agency programmes	Provide employment support, vocational qualification and labour-market reintegration measures.	Relevant for people whose mental health needs intersect with unemployment, reduced work capacity, vocational exclusion or reintegration needs.

Policy gaps, fragmentation and implementation challenges

Although the regulatory framework provides broad entitlements, its complexity can create practical barriers for people in vulnerable situations. Responsibilities are distributed across different legal systems, including healthcare under SGB V, rehabilitation and participation under SGB IX, youth welfare under SGB VIII, and employment support through Federal Employment Agency programmes. This can create unclear responsibilities at the interface between medical care, psychosocial support, social participation and labour-market reintegration.

A further challenge concerns language mediation. Interpreting and language support are not systematically embedded as standard benefits within statutory healthcare provision. This may create significant barriers for migrants and refugees, particularly when mental healthcare depends on detailed communication, trust-building and the ability to describe emotional distress accurately.

The regulatory landscape also tends to organise support around single eligibility categories, such as age, disability status, migration status, employment status or severity of illness. However, many people in vulnerable situations experience overlapping needs. Older migrants, refugees with severe mental illness, or people with both psychosocial disability and labour-market exclusion may not fit neatly into one coordinated support pathway. This increases the need for cross-sector cooperation, practical navigation support and clearer referral mechanisms.

For the Mannheim Smart Health Lab, the policy landscape therefore provides both an enabling framework and an important design challenge. The Lab can build on strong statutory entitlements and existing state-level planning structures, while helping to address fragmentation through improved service navigation, multilingual information, cross-sector coordination and community-based support pathways.

3.5.5 Priority PVS and Current Mental Health Needs



Figure 21. Priority people in vulnerable situations and key mental health needs addressed by the Mannheim Smart Health Lab, focusing on older migrants, refugees and working-age migrants

The Mannheim Smart Health Lab will focus on people with a migration background, reflecting the city's high level of migration-related diversity and the documented barriers that migrant communities experience in accessing mental health support. The primary target group is older migrants aged 65 years and above, while working-age migrants, refugees and people with protection status will also be considered important priority groups.

Mannheim is one of Germany's most diverse urban areas. Approximately 49.4% of residents, corresponding to around 162,206 people, have a migration background. In some socioeconomically disadvantaged neighbourhoods, this proportion exceeds 70%. The city's migrant population includes long-settled labour migrant communities from Türkiye, Kurdistan, Southern Europe, Eastern Europe and other EU Member States, as well as more recent refugee and protection-related migration flows.

This demographic profile creates specific mental health and care needs. Migrants in Mannheim may experience depression, anxiety, psychosocial distress, stress-related disorders, loneliness and social isolation. For older migrants, these challenges often intersect with age-related vulnerabilities, including multimorbidity, bereavement, retirement-related loss of social networks, reduced mobility and growing dependence on formal care services. Refugees and people with protection status may face additional mental health risks linked to forced migration, displacement, traumatic experiences, family separation, legal uncertainty and labour market integration difficulties.

The coexistence of formal healthcare entitlement and lower use of psychotherapeutic services among people with a migration background indicates that access barriers are not only legal or financial. They are also linguistic, cultural, administrative and organisational. The Mannheim Smart Health Lab should therefore focus on transforming existing service availability into practical, understandable and trusted access pathways for migrants, older migrants and refugees.

Structural and Systemic Barriers to Access

Despite broad statutory health insurance coverage, people with a migration background may still face substantial difficulties entering and navigating mental health care pathways. Key barriers include language discordance between service users and providers, limited availability of professional interpreting, reliance on German-language written and digital information, complex administrative procedures for accessing psychotherapy, and fragmented responsibilities across healthcare, social services and community support structures.

National evidence indicates that people with a migration background make less use of psychotherapeutic services, with communication barriers and limited language mediation playing an important role. For refugees, studies in Germany show that access to mental healthcare remains limited despite high levels of need. Reported barriers include lack of information about available services, language difficulties and challenges navigating the healthcare system.

This suggests that exclusion in Mannheim is not primarily caused by the absence of services, but by difficulties in reaching, understanding and using them effectively. Access depends on the ability to identify the right entry point, communicate needs clearly, arrange appointments, understand referral procedures and move between different care and support systems.

Existing Support Structures

Mannheim already has several relevant support structures that can contribute to the Smart Health Lab. These include office-based psychotherapists and psychiatrists, hospital-based psychiatric services, social psychiatric services, counselling services, migrant self-organisations, welfare

organisations, refugee counselling services and support structures linked to reception facilities. These actors provide important contact points for migrants, older migrants and refugees, but they are distributed across different sectors and organisational responsibilities.

3.5.6 Local Mental Health Ecosystem

Organisation of mental health care

Mannheim has a comparatively strong mental health ecosystem, including outpatient psychiatrists and psychotherapists, hospital-based psychiatric care, counselling centres, community psychosocial services, welfare organisations, municipal structures and specialised services. The Central Institute of Mental Health is a major specialist actor and provides important clinical and research expertise, including culturally adapted services through its Transcultural Outpatient Clinic.

The local ecosystem also includes municipal coordination structures, welfare organisations, migration counselling services, refugee support actors, psychosocial centres, senior meeting points, migrant associations and religious communities. These actors are highly relevant because they operate close to everyday life contexts and can provide trusted entry points for people who may not initially approach formal mental health services.

Governance and coordination mechanisms

The Mannheim mental health ecosystem is supported by formal local coordination mechanisms, specialised psychiatric services, municipal structures, welfare organisations and community-based actors. Coordination at the local level is structured through the Gemeindepsychiatrischer Verbund (GPV) and municipal psychiatry coordination functions. The City of Mannheim also hosts an Arbeitskreis Psychiatrie, organised by the municipal psychiatry coordination unit within social planning. This body supports coordination tasks under §7 of the PsychKHG Baden-Württemberg and operates within the broader GPV framework.

The GPV model in Baden-Württemberg provides an important structure for cross-sector cooperation between healthcare, social care, psychosocial support and municipal actors. It enables regular exchange between institutions and supports the coordination of psychiatric and psychosocial services at the local level. However, the practical reach of these mechanisms depends on the participation of relevant actors and the extent to which statutory, welfare-based, clinical and community organisations are effectively connected.

Role of primary care, specialised services, NGOs, and informal actors

As presented in The Mannheim mental health ecosystem includes a combination of primary care providers, specialised psychiatric services, welfare organisations and informal community actors. These actors play complementary roles in identifying needs, supporting referrals, providing psychosocial assistance and helping vulnerable groups navigate the mental healthcare system. For migrants, refugees and older migrants, access often depends not only on the formal availability of services, but also on whether entry points are trusted, understandable and culturally accessible.

Table 30. Overview of the Mental Health and Psychosocial Support Ecosystem in Mannheim

Ecosystem component	Main structures	Role in the mental health ecosystem
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Primary care providers / GPs (Hausärztinnen*)

Primary care providers often act as the first point of contact for people experiencing mental health concerns. They can identify early signs of distress, provide initial guidance and refer individuals to specialised psychiatric, psychotherapeutic or hospital-based services when needed.

GPs can support early identification, signposting and referral, particularly for individuals who may not approach mental health services directly.

Specialised mental health services	The Central Institute of Mental Health (ZI) provides specialised psychiatric pathways, outpatient diagnostic services and consultation entry points. However, high demand and waiting times in some specialised outpatient services indicate capacity pressure within parts of the system.	ZI represents a key specialist actor for referral, clinical expertise and collaboration, while the Lab can help users navigate waiting periods and identify complementary support options.
NGOs and welfare organisations	Welfare organisations play an important role in psychosocial counselling, community-based support, social guidance and service navigation. This includes support provided through SpDi-related partnership structures and other welfare-based services.	These organisations can provide trusted, low-threshold access points and help connect vulnerable groups with formal mental health, social care and community support services.
Informal and community actors	Migrant self-organisations, faith communities and local community groups often function as trusted first-contact points. Although they may be less formally documented than statutory structures, they can strongly influence whether people seek help and how they enter formal care pathways.	These actors are essential for outreach, trust-building, stigma reduction and culturally sensitive engagement with migrants, refugees and older migrants.

Key system-level challenges in practice

- Fragmentation across sectors and responsibilities: The Mannheim ecosystem spans statutory outpatient care (e.g. psychotherapists), hospital psychiatry (e.g., ZI), and welfare/municipal psychosocial supports (e.g., SpDi, Caritas, Diakonie).
- Formal coordination mechanisms exist (e.g., GPV/Arbeitskreis Psychiatrie) to facilitate exchange between institutions. However, participation and reach vary across sectors, and not all relevant actors in local health and social care are consistently involved.
- Capacity constraints and waiting times: High demand is visible in specialist outpatient areas (with explicit references to longer waiting times in at least some ZI outpatient clinics), and outpatient psychotherapy capacity constraints are a well-known practical issue in urban Germany.
- Interface and navigation burden: Because entry points include practices, hospital services, SpDi, and other counselling structures, service users may need support to navigate pathways, especially when needs span medical treatment plus social participation support.

Overall, the Mannheim ecosystem benefits from a broad range of formal and informal actors, but effective access depends on how well these actors are connected.

3.5.7 Service Exclusion Trends

The target group in Mannheim consists mainly of long-settled migrants with statutory health insurance coverage rather than recently arrived refugees. Accordingly, barriers to access are less related to formal entitlement to care and more related to practical access pathways, communication and system navigation. Evidence from German and European studies shows that documented migrants predominantly face social and informational barriers rather than complete legal exclusion from services. At the same time, refugees and asylum seekers in Germany face additional barriers related to legal status, restricted entitlements and structural access conditions, which differ from those of long-settled migrants.

Table 31. Main service exclusion trends affecting migrants and refugees in Mannheim, Baden-Württemberg, including barriers influencing access to mental healthcare and psychosocial support services.

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Financial	- Most long-settled migrants in Mannheim are covered by statutory health insurance and therefore formally entitled to outpatient psychotherapy and psychiatric treatment. Direct treatment costs are generally not the main barrier for this population group. However, indirect financial pressures such as transportation costs, childcare responsibilities, or inability to take time off work may delay help-seeking and continuity of care. - For refugees and asylum seekers, financial barriers may be more pronounced due to restricted healthcare entitlements under the Asylbewerberleistungsgesetz (AsylbLG) and the lack of routine funding for interpreting services.
Geographical and Organisational	- Mannheim is a densely populated urban area with multiple healthcare providers, meaning physical distance to services is generally not the primary obstacle. However, navigating the healthcare system remains challenging, particularly in identifying the appropriate entry point to care (e.g., psychotherapist, GP, counselling service, or hospital). - Waiting times and transport-related difficulties may still affect service utilisation. Refugees living in collective accommodation may additionally experience mobility and accessibility challenges linked to housing conditions.
Social and Cultural	- Social barriers represent the most significant obstacles affecting access to mental healthcare among migrants and refugees. Language barriers strongly affect communication with healthcare providers, understanding of diagnoses, and treatment engagement. Limited access to professional interpreting services often results in reliance on family members for translation. Many migrants also experience limited familiarity with the German healthcare system and insufficient knowledge regarding available mental health services, referral pathways, and treatment options. - Cultural perceptions of mental illness, fear of stigma, and concerns regarding social exclusion may further delay help-seeking. Refugees may

additionally experience stress associated with uncertain legal status, family separation, and unstable living conditions.

Legal and Policy-Related

- Long-settled migrants with regular residence status generally possess legal entitlement to mental healthcare services. However, administrative procedures, written documentation requirements, and complex appointment systems may still function as indirect barriers. Refugees and asylum seekers face more substantial restrictions under the Asylbewerberleistungsgesetz (AsylbLG), which limits healthcare provision primarily to acute and emergency treatment during the initial residence period.
- Psychotherapeutic treatment often requires individual authorisation and is not routinely covered. Recent policy changes have further extended the restricted access period from 18 to 36 months before refugees can access benefits comparable to statutory health insurance coverage.
- Structural barriers are also reinforced by limited and insecure funding for refugee counselling and support services.

Key interpretation

Overall, the main exclusion mechanism in Mannheim is not exclusion from the system but exclusion within the system: People can theoretically access services, but cannot easily enter the care pathway.

The dominant barriers are therefore communication, lack of knowledge, stigma, orientation and system-navigation barriers rather than financial or legal restrictions.

For refugees in particular, exclusion may additionally occur at the level of formal entitlements and administrative procedures, indicating that both exclusion from and within the system can be relevant depending on legal status and stage of the asylum process.

3.5.8 Priority Areas for Investment within the Mental Health Care System in Mannheim

The mental health ecosystem in Mannheim benefits from a comparatively strong healthcare infrastructure, characterised by a broad network of outpatient mental health professionals, specialised psychiatric services, hospitals, counselling centres, and community-based support organisations. Germany's universal health insurance system further provides a favourable framework for access to mental healthcare. Nevertheless, the ecosystem analysis reveals that important barriers remain in transforming formal service availability into effective and equitable access for migrants, older migrants, and refugees.

While a wide range of services exists, navigating the mental health system can be challenging, particularly for people with limited familiarity with healthcare structures, language barriers, or reduced social support networks. Access pathways often require individuals to independently identify appropriate services, coordinate appointments, understand referral procedures, and move between different healthcare and social support providers. As a result, many people in vulnerable situations experience difficulties in accessing timely and appropriate support despite the overall availability of services.

The pilot contextual situation also highlights challenges related to communication, cultural accessibility, and continuity of care. Entry into mental healthcare frequently relies on written information, telephone communication, and increasingly digital systems that may not be equally accessible to all population groups. In addition, mental health services operate across multiple organisational and administrative structures, creating fragmented care pathways and placing a significant burden on individuals to coordinate their own support. Language discordance, limited access to interpreting services, and insufficient institutional support for intercultural communication further contribute to disparities in service utilisation and user experience.

At the same time, the ecosystem demonstrates opportunities for strengthening preventive, community-based, and digitally enabled approaches to mental healthcare. Existing service models remain predominantly oriented towards treatment after the onset of more severe mental health difficulties, while low-threshold prevention, early intervention, and community outreach initiatives remain comparatively limited.

Table 32 identifies the key priority areas for investment and innovation within Mannheim's mental health ecosystem. It links the main system gaps identified through the ecosystem profiling exercise with targeted opportunities for improvement and Smart Health Lab intervention.

Table 32. Priority Areas for Investment within the Mental Healthcare System in Mannheim, Germany

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment / Innovation Area	Expected Outcomes
Access and Navigation Barriers	- Mannheim has a comparatively dense network of outpatient providers, specialised psychiatric services, and community-based support structures. - Despite service availability, individuals must independently identify services, initiate contact,	- Structured orientation and navigation support - Clear and accessible information on available services	- Improved practical accessibility to care - Reduced service exclusion

	arrange appointments, and navigate fragmented pathways between medical, psychosocial, and counselling sectors. • For people in vulnerable situations, access pathways often remain unclear and difficult to navigate.	• Support mechanisms for identifying appropriate care pathways	• Improved system navigation among vulnerable populations
Communication and Orientation Gaps	• Entry into care frequently depends on written information, telephone communication, and digital appointment systems. • Information regarding referral pathways and treatment procedures may be difficult to understand or inaccessible through trusted channels. • Language barriers and limited familiarity with the healthcare system further restrict access.	• Culturally and linguistically accessible communication formats • Culturally sensitive outreach and mediation • Accessible information regarding mental health and available services	• Improved understanding of available services • Increased help-seeking behaviour • Reduced communication-related exclusion
Fragmented Coordination Between Services	• Mental healthcare providers operate across multiple organisational and administrative structures, including outpatient care, hospital services, municipal structures, and welfare organisations. • Individuals may move between counselling, social support, and medical care without structured referral or handover procedures.	• Integrated referral pathways • Improved coordination between healthcare, counselling, and community organisations • Cross-sector cooperation mechanisms	• Improved continuity of care • Reduced fragmentation between sectors • More integrated support pathways
Structural and Provider-Level Barriers	• Language discordance and lack of routine reimbursement for interpreting services may negatively affect communication quality and continuity of care. • Limited structural support for intercultural communication may contribute to disparities in utilisation and perceived quality of care.	• Structured intercultural communication support • Improved access to interpreting services • Strengthening intercultural competence within mental healthcare provision	• Reduced inequalities in treatment access • Improved communication quality • Strengthened trust in services
Limited Early Intervention and Preventive Support	• Mental healthcare is often accessed only once conditions become severe enough to require specialist intervention. • Low-threshold prevention, awareness-raising, and early engagement structures remain comparatively underdeveloped.	• Community-based prevention initiatives • Awareness-raising and early engagement activities • Low-threshold support models	• Earlier identification of mental health needs • Reduced crisis escalation • Improved preventive mental healthcare engagement

Need for Community-Based and Culturally Accessible Approaches	- Existing services may not always operate within familiar or trusted environments for vulnerable and migrant populations. - Traditional institutional settings may discourage initial contact and engagement with care.	- Low-threshold and community-based engagement structures - Partnerships with trusted community actors and NGOs - Culturally adapted support approaches	- Increased service engagement - Reduced stigma and mistrust - Improved accessibility for migrant and vulnerable populations
Digital Innovation and Hybrid Support Models	- Digital systems are increasingly used for appointment booking and communication, but may create additional barriers when not combined with personal support. - PVS may require support navigating digital health systems.	- Hybrid support models combining digital tools with face-to-face support - Digital tools for appointment preparation and service navigation - Community-supported digital engagement	- Improved accessibility and flexibility of support - Enhanced service navigation - Strengthened continuity of care
Alignment with Smart Health Labs Objectives	- Existing services often operate in parallel rather than through integrated community-based ecosystems. - People in vulnerable situations may remain excluded despite formal service availability.	- Development of hybrid community-based hubs - Co-creation activities involving service providers, community actors, and vulnerable populations - Awareness-raising, prevention, and stakeholder coordination activities	- Transformation of formal service availability into practical accessibility - Improved cooperation across the local mental health ecosystem - Increased inclusiveness and sustainability of mental healthcare pathways

3.5.9 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Mannheim

Mannheim has a range of social economy actors that interact with residents in everyday settings. These organisations are not part of the medical care system but provide social support, counselling, community activities and participation opportunities. For migrants, older migrants and refugees, they represent accessible and trust-based contact points embedded in daily life contexts.

Table 33. Social Economy Initiatives to be prioritised by the Smart Health Lab in Mannheim

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>Caritas Mannheim</u>	Migration counselling, refugee support, family and social counselling, housing and administrative support	Provides accessible and trust-based contact points for migrants and vulnerable populations, supporting orientation, referral pathways, and connection with mental health and psychosocial services.
<u>Diakonie Mannheim</u>	Social counselling, refugee and migration support, psychosocial assistance, social participation	Supports vulnerable populations through low-threshold counselling and guidance services that may facilitate earlier engagement with mental health support systems.
<u>NIFA plus</u>	Labour market integration, employment support for migrants and refugees, vocational orientation	Contributes to social stability and inclusion through employment-oriented support pathways that may indirectly strengthen psychosocial wellbeing and social participation.
<u>Netzwerk Unternehmen integrieren Flüchtlinge</u>	Refugee employment integration, employer support, labour market inclusion	Supports integration and participation of refugees through workplace inclusion initiatives and social orientation structures linked to long-term wellbeing and stability.
<u>Migrant Community Associations</u>	Community activities, cultural support, informal social networks, social participation	Operate as trusted and culturally familiar environments where information about support services can circulate informally and stigma related to mental health may be reduced.
<u>Religious Communities</u>	Community support, social cohesion, informal guidance and support networks	Provide accessible and trusted community-based environments where vulnerable individuals may seek orientation and support prior to engaging with formal healthcare services.
<u>Senior Meeting Points and Community Encounter Centres</u>	Social participation, neighbourhood engagement, support for	Function as low-threshold community-based structures where social isolation and support needs

older adults, and informal orientation services

may be identified and referral to counselling or healthcare services facilitated.

<u>Sozialpsychiatrischer Dienst (SpDi) Mannheim</u>	Low-threshold psychosocial support, counselling, crisis support, and coordination for people with severe mental illness	Acts as an important interface between formal mental healthcare services and community-based psychosocial support structures, supporting coordination and accessibility within the local ecosystem.
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Supporting these initiatives complements existing services rather than replacing them. The Smart Health Lab in Mannheim could help structure cooperation and facilitate earlier and more appropriate contact with mental health services.

3.5.10 SWOT Analysis of the German Pilot Site and strategic directions for the design of the Smart Health Lab

Mannheim combines a highly developed healthcare and research environment with one of the most diverse urban populations in Germany. The city benefits from extensive mental health service provision, strong academic expertise, and an established network of welfare and community organisations. At the same time, the ecosystem faces challenges associated with care pathway complexity, communication barriers, service fragmentation, and unequal utilisation of mental health services among migrant populations. These factors influence both the accessibility of care and the ability of vulnerable groups to engage effectively with available support structures.

The SWOT analysis identifies the ecosystem features that can facilitate the co-creation and implementation of innovative mental health solutions, while also highlighting structural vulnerabilities and external risks that may affect the long-term sustainability and impact of Smart Health Lab activities. Particular emphasis is placed on opportunities to strengthen community engagement, improve cultural responsiveness, enhance coordination across sectors, and develop more accessible pathways into mental health care. The findings provide a strategic foundation for designing interventions that can contribute to a more inclusive, equitable, and person-centred mental health ecosystem in Mannheim.

Table 34. SWOT Analysis of the German Pilot Site

Strengths	Weaknesses
Universal statutory health insurance system providing broad legal entitlement to outpatient psychotherapy, psychiatric treatment, and specialised mental healthcare services.	Access to mental healthcare remains difficult despite formal entitlement, with complex care pathways requiring individuals to navigate multiple providers and administrative procedures independently.
Well-developed mental health ecosystem including outpatient psychiatrists, psychotherapists, hospital-based services, counselling centres, and community psychosocial support structures.	Long waiting times for psychotherapy and specialised mental health services continue to affect timely access to care.

Presence of the Central Institute of Mental Health (ZI), a nationally recognised specialist provider offering specialised psychiatric services and culturally adapted support through the Transcultural Outpatient Clinic.

Strong governance and coordination mechanisms, including the Gemeindepsychiatrischer Verbund (GPV), municipal psychiatry coordination structures, and established welfare partnerships.

Extensive network of welfare organisations, migrant support services, refugee counselling initiatives, and community-based psychosocial support structures.

High migration-related diversity and the presence of well-established migrant communities, creating opportunities for community engagement and co-creation activities.

Strong research, innovation, and academic ecosystem within the Rhine-Neckar region, supporting the development and evaluation of innovative health interventions.

Mental healthcare information, appointment systems, and administrative procedures rely heavily on written, digital, and German-language communication, creating barriers for migrants and refugees.

Limited availability and reimbursement of interpreting services within routine mental healthcare provision restrict communication and continuity of care.

Fragmentation between healthcare, social services, migration support, and community organisations can result in discontinuities in care and navigation difficulties.

Prevention, early intervention, and low-threshold mental health promotion activities remain less developed than specialist treatment services.

Migrants and refugees continue to underutilise mental health services despite documented needs and formal access rights.

Opportunities

Smart Health Lab activities can strengthen community participation, co-creation, and culturally responsive service design for migrants, older migrants, and refugees.

Development of structured navigation support, community-based outreach, and culturally adapted communication approaches can improve practical accessibility to care.

Expansion of community-based prevention, mental health literacy, and early intervention initiatives can support earlier identification of mental health needs.

Greater collaboration between healthcare providers, welfare organisations, migrant associations, religious communities, and social economy actors can strengthen integrated support pathways.

Threats

Growing demand for mental healthcare may continue to increase waiting times and place additional pressure on existing services.

Persistent language barriers, stigma surrounding mental health, and mistrust of institutions may continue to discourage help-seeking behaviours.

Socioeconomic inequalities, precarious employment conditions, social isolation, and housing challenges may continue to negatively affect mental wellbeing among vulnerable populations.

Legal and administrative restrictions affecting refugees and asylum seekers may continue to create inequalities in access to mental healthcare and psychosocial support.

Hybrid digital and face-to-face support models can improve service navigation, communication, and continuity of care when combined with personalised assistance.

Digitalisation of healthcare services may unintentionally increase exclusion among individuals with limited digital literacy or limited familiarity with healthcare systems.

Mannheim's strong research and innovation capacity provides opportunities to pilot and evaluate scalable models for equitable mental healthcare.

Insufficient funding for interpretation, cultural mediation, and refugee support services may limit efforts to improve accessibility and inclusion.

The city's extensive network of migrant organisations, welfare providers, and community actors creates favourable conditions for long-term sustainability and scaling of Smart Health Lab interventions.

Demographic ageing, increasing single-person households, and social isolation may further increase demand for mental health and social support services in the coming years.

Strategic directions for the design of the Smart Health Lab in Mannheim

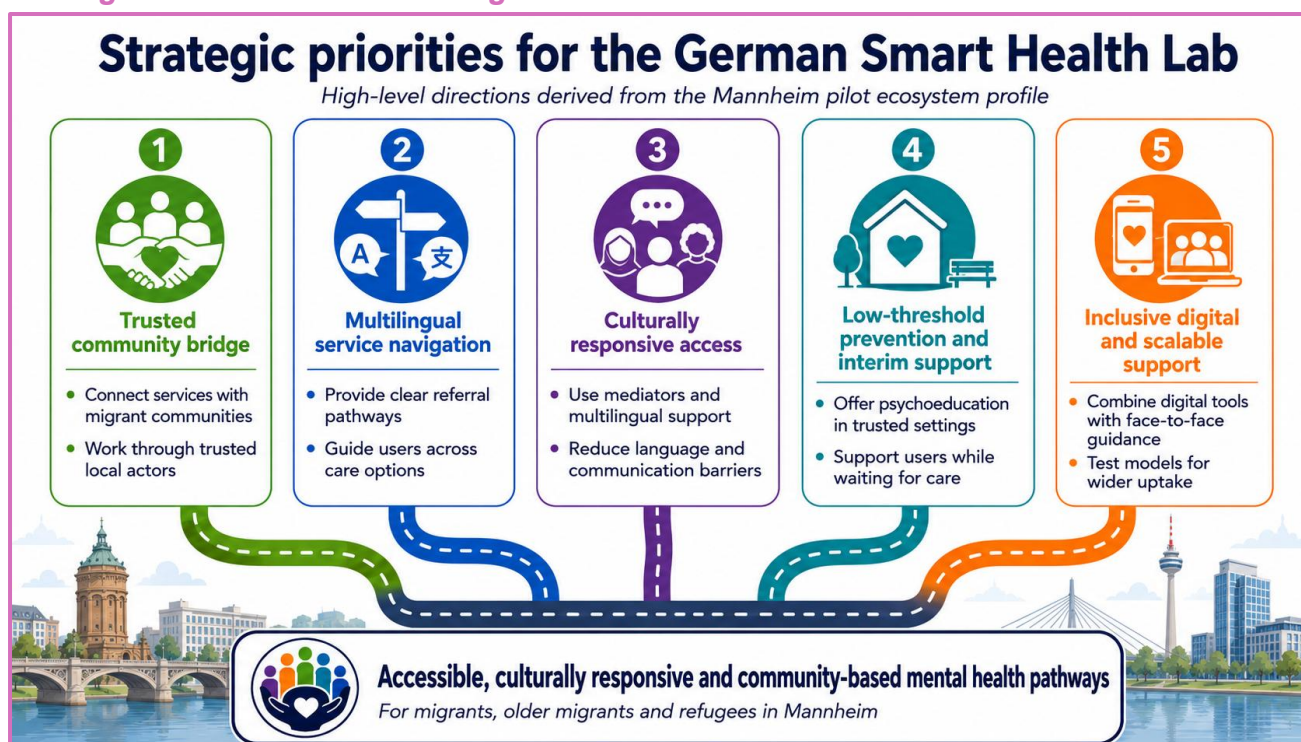


Figure 22. Strategic directions for the German Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the German Smart Health Lab could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The SWOT analysis in Table 34 indicates that the Mannheim Smart Health Lab could build on the city's strong healthcare, research and community infrastructure while addressing the practical barriers that prevent migrants, older migrants and refugees from accessing mental health support effectively. Although Mannheim benefits from a well-developed mental health ecosystem, universal health insurance coverage, specialised services such as ZI, and established coordination mechanisms

through the GPV and municipal psychiatry structures, access remains uneven in practice. Complex referral pathways, long waiting times, language barriers, limited interpreting support, fragmented responsibilities and low utilisation of mental health services among migrant populations point to the need for a stronger bridge between formal service provision and community-level access.

Strategic positioning: establishing the Mannheim Smart Health Lab as a trusted bridge between formal services and migrant communities

The Lab could function as a trusted interface between the formal mental health system and the everyday community environments where migrants, refugees and older migrants seek information, support and guidance. Its role should not be to duplicate existing services, but to strengthen links between healthcare providers, welfare organisations, migrant associations, community actors and people in vulnerable situations. By combining co-creation, outreach, mental health literacy, service navigation and hybrid digital support, the Lab might contribute to a more inclusive and person-centred model of mental health access in Mannheim.

Embedding migrants, older migrants and refugees in co-creation and validation processes

A central strategic direction could be to strengthen community-based co-creation with migrants, older migrants and refugees. Mannheim's high migration-related diversity and long-established migrant communities create favourable conditions for participatory engagement, but migrant and refugee populations continue to underuse mental health services. The Lab could therefore involve migrants, older migrants, refugees and community representatives directly in identifying needs, designing activities, testing tools and validating outputs. This might help ensure that Lab activities are grounded in lived experience and respond to real access barriers.

Improving service navigation through multilingual and user-friendly pathways

Access remains difficult despite formal entitlement to healthcare, as individuals often need to navigate multiple providers, administrative procedures and referral routes independently. The Lab could therefore develop accessible, multilingual and user-friendly information on available mental health, psychosocial and community support services. Clear signposting and referral pathways might help users understand where to go, who to contact and how to move between GPs, outpatient services, specialised care, welfare organisations and community-based support.

Strengthening culturally responsive communication and guided access support

Mental healthcare information, appointment systems and administrative procedures often rely heavily on German-language, written and digital communication. At the same time, interpreting services remain limited and are not always systematically available. The Smart Health Lab could promote culturally adapted communication, multilingual outreach, guided access support and cooperation with cultural mediators or trusted community intermediaries. This might help reduce communication barriers, build confidence in the system and improve the ability of migrants and refugees to access appropriate support.

Connecting specialised mental health services with welfare, migration and community actors

Fragmentation between healthcare, social services, migration support and community organisations can create discontinuities in care and increase the burden on users to navigate the system alone. The Smart Health Lab could therefore act as a bridging mechanism between ZI, outpatient mental health services, GPs, SpDi, welfare organisations, migrant associations, religious communities and municipal structures. This cross-sector role might support more coherent pathways and improve continuity between clinical, psychosocial and community-based forms of support.

Expanding low-threshold prevention, psychoeducation and early signposting in trusted settings

Prevention, early intervention and mental health promotion remain less developed than specialist treatment services, while stigma and mistrust may discourage help-seeking among migrant communities. The Lab could organise community-based awareness-raising, psychoeducation, peer exchange and early signposting activities in trusted local settings. These activities might help earlier recognition of distress, reduce stigma and create accessible entry points before needs become more severe.

Deploying hybrid and digital support without increasing exclusion among older migrants

Digital and hybrid tools can improve service navigation, continuity of care and access to information, but digitalisation may exclude older migrants and people with limited digital literacy. The Smart Health Lab should therefore combine digital tools, including the AI Assistant, with face-to-face support, guided use and offline participation options. This supported model can help ensure that digital innovation expands access rather than reinforcing existing inequalities.

Providing early orientation and interim support while users wait for specialised care

Long waiting times for psychotherapy and specialised services might delay access to care, increase distress and lead to disengagement. The Smart Health Lab could provide early orientation, interim psychosocial support, self-management resources and referrals to complementary community-based services while users wait for specialised care. This approach might help reduce the negative effects of waiting times and maintain user engagement with the care pathway.

Leveraging Mannheim's research and innovation ecosystem to test scalable access models

The presence of ZI and the broader Rhine-Neckar research ecosystem creates strong conditions for piloting and evaluating innovative approaches. The Smart Health Lab should use this local capacity to test, document and assess inclusive access models that can be adapted or scaled in other urban contexts. This evidence-generation role will be important for demonstrating what works in improving mental health access for migrant and refugee populations.

Aligning Lab activities with existing governance and coordination structures

Mannheim already has strong coordination mechanisms, including the GPV, municipal psychiatry coordination and the Arbeitskreis Psychiatrie. However, participation and reach may vary across sectors, particularly for community, migrant and social economy actors. The Smart Health Lab should align its activities with these existing structures while broadening participation to include actors that may be less represented in formal coordination mechanisms. This can strengthen policy relevance, avoid duplication and support more inclusive local governance.

Building sustainability through welfare, social economy and community partnerships

Mannheim's extensive network of welfare providers, migrant organisations and community actors creates favourable conditions for sustainability beyond the project period. The Smart Health Lab should develop partnerships with welfare organisations, community groups and social economy actors to support continuity, ownership and long-term embedding of Lab activities. Sustainability planning should be integrated from the beginning, ensuring that successful approaches can continue beyond project-based implementation.

3.5.11 Useful Resources

Table 35. Key institutional, healthcare, social service, migration and labour market resources relevant to the Mannheim / Baden-Württemberg pilot site, including public authorities, mental health service providers, community support organisations and data sources

Resource / Initiative	Official Link
Arbeiterwohlfahrt (AWO) Mannheim	AWO Mannheim
Bundesagentur für Arbeit	Bundesagentur für Arbeit
Bundesministerium der Justiz	Bundesministerium der Justiz
Caritas Mannheim	Caritas Mannheim
Diakonie Mannheim	Diakonie Mannheim
Gemeindepsychiatrischer Verbund Baden-Württemberg (GPV)	Gemeindepsychiatrischer Verbund Baden-Württemberg
Gemeinsamer Bundesausschuss (G-BA)	Gemeinsamer Bundesausschuss
Kassenärztliche Vereinigung Baden-Württemberg (KVBW)	KVBW
Landeserstaufnahmeeinrichtung Baden-Württemberg (LEA)	Landeserstaufnahmeeinrichtung Baden-Württemberg
Ministerium für Soziales, Gesundheit und Integration Baden-Württemberg	Ministerium für Soziales, Gesundheit und Integration Baden-Württemberg
Netzwerk Unternehmen integrieren Flüchtlinge	Netzwerk Unternehmen integrieren Flüchtlinge
NIFA plus	NIFA plus
Robert Koch-Institut (RKI)	Robert Koch-Institut
Sozialpsychiatrischer Dienst (SpDi) Mannheim	SpDi Mannheim
Stadt Mannheim	Stadt Mannheim
Stadt Mannheim – Senior Services and Community Centres	Senior Services Mannheim
Zentralinstitut für Seelische Gesundheit (ZI Mannheim)	ZI Mannheim

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3.6 Thessaloniki – Region of Central Macedonia (Greece)

3.6.1 Geographical Context & Demographic Overview

The Thessaloniki pilot site is situated in northern Greece, within the Municipality of Thessaloniki (EL522), which forms part of the wider Region of Central Macedonia (EL52). As Greece's second-largest metropolitan area and the administrative centre of Central Macedonia, Thessaloniki plays a

central role in the region's social, economic, educational and health-related landscape. The wider Regional Unit of Thessaloniki is the most densely urbanised part of Central Macedonia and includes 14 municipalities, such as Thessaloniki, Kordelio-Evosmo, Pavlos Melas, Kalamaria, Neapoli-Sykies and Themi.

As shown in the figure below, according to the 2021 Census, the Regional Unit of Thessaloniki counted 1,092,919 residents, showing a slight population decline of 1.6% compared with 2011. Within this wider area, the Municipality of Thessaloniki remains the largest local authority, with 319,045 inhabitants in 2021. This corresponds to roughly one-third of the regional unit's population. The municipality also followed the broader demographic trend of decline, recording a population reduction of around 1.9% over the 2011–2021 period.

The demographic profile of Central Macedonia is also shaped by migration. In 2021, migrants accounted for approximately 5.9% of the regional population, corresponding to 106,701 people. This figure should be interpreted with caution, as official statistics do not capture undocumented migrants or foreign-born residents who have since acquired Greek citizenship. The Albanian community represents by far the largest migrant group in the region, accounting for approximately 56% of the migrant population, while additional migrant groups originate from Asian countries, EU Member States and African countries.

Thessaloniki has also been an important point of arrival, transit and settlement for refugees and asylum seekers. Its role became particularly visible during the 2015–2016 refugee movements, when the city hosted approximately 16,000 refugees in 2016. The refugee and migrant population includes people from Syria, Afghanistan, Iraq and other countries affected by conflict, displacement or instability. This migration-related diversity is a defining characteristic of the local context and is highly relevant for understanding mental health needs, service accessibility, community engagement and the design of inclusive Smart Health Lab activities.

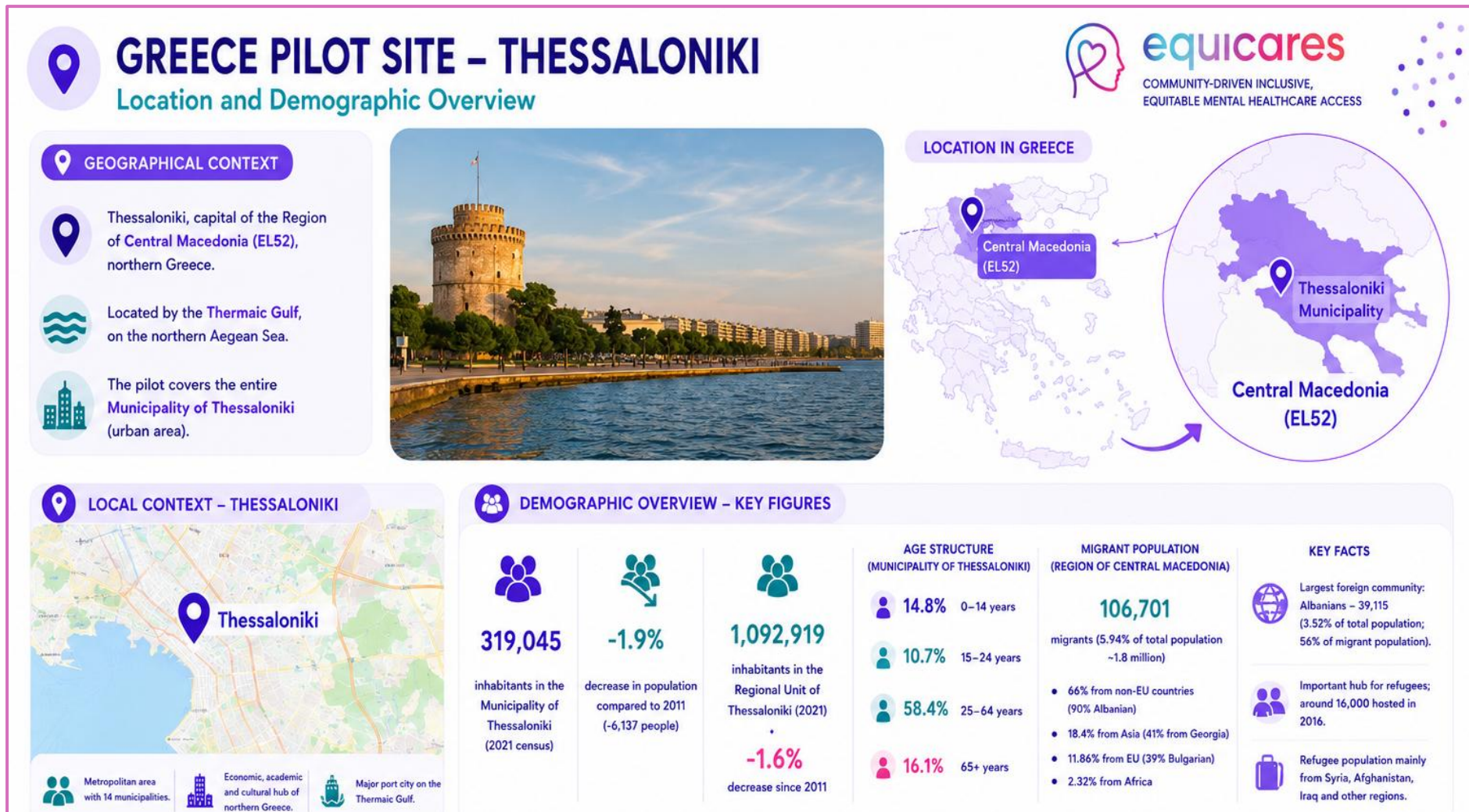


Figure 23. Thessaloniki (Greece) Pilot Site Location and Demographic Overview

3.6.2 Techno-Economic Context

Thessaloniki's techno-economic context is shaped by three intersecting dynamics: Greece's rapidly ageing population, the country's accelerated digital transformation, and the persistence of digital exclusion risks among older adults, migrants and other vulnerable groups. These dynamics are particularly relevant for the Thessaloniki Smart Health Lab, as digital tools and e-health services can improve access to mental health information and support, but may also reinforce inequalities when users lack digital skills, language access or trust in online systems.

Current Digital Literacy Standing

- Greece has reached a 52.4% coverage rate for basic digital skills.
- This score sits below the European Union average of 55.6% and shows a slight stagnation, dipping just below the country's 2023 result of 52.5%.

National digital transformation and digital skills

Greece is undergoing a rapid digital transformation across public administration, healthcare and service delivery. The national "Digital Transformation Bible", adopted in 2021, provides the strategic framework for the digitalisation of public and private services. This is further supported by the Digital Transformation Programme 2021–2027, which aims to promote a "Digital Greece" through upgraded public digital services, system interoperability, digital local governance, ultra-high-speed connectivity, digital skills development and the integration of advanced technologies.

The programme has a budget exceeding €943 million and supports the expansion of digital infrastructure and digital public services across the country. However, digital literacy remains a challenge. In 2024, Greece reached 52.4% coverage for basic digital skills, slightly below the EU average of 55.6% and marginally lower than the country's 2023 performance. This indicates that, while Greece is progressing rapidly in digital service provision, the population's capacity to use these services remains uneven.

Rapid digitalisation in Greece creates important opportunities to improve access to healthcare and mental health support, particularly through remote healthcare delivery, telepsychology, improved coordination of services, social connectivity and community-based forms of support.

Digital infrastructure and e-health services

Digitalisation is increasingly visible in the Greek healthcare system. The national myHealth application enables citizens to manage medical appointments, prescriptions, diagnoses and health-related information digitally. In addition, Greece has introduced the Healthcare Coordination, Navigation and Multichannel Assistance Mechanism through the national "1566" helpline, which operates 24/7 and supports appointment scheduling and healthcare navigation across primary healthcare units, hospitals, EOPYY-affiliated doctors and mental health structures.

Further reforms are also underway to improve digital health governance and service monitoring. In March 2026, the Greek Ministry of Health launched the "Quality-for-All" digital platform under the HEALTH-IQ programme. The platform aims to support real-time monitoring of healthcare quality, inequalities, patient safety and regional service performance. It also includes indicators related to mental health and prevention services, supporting more evidence-based allocation of healthcare resources.

At the same time, Greece is advancing the National e-Health Interoperability Framework and the introduction of an Individual Electronic Mental Health Record system. However, important gaps remain in the integration of digital mental health data systems and interoperability across services. These gaps may limit continuity of care, coordination between providers and the ability to monitor inequalities in access to mental health support.

Private digital mental health and telepsychology platforms have also increased significantly in recent years, including services such as **Doctoranytime**, **ClicktoTherapy**, **MyTherapist**, **TherapySpace**, and the free, anonymous support platform **MilaMou**.

Population ageing and social interaction patterns

Greece has one of the oldest populations worldwide, with almost one quarter of its residents aged over 65. This demographic structure has important implications for mental health, social care and digital inclusion. Older adults may face higher risks of loneliness, reduced mobility, chronic health problems and difficulties navigating increasingly digitalised public services.

The Greek social context has also traditionally been shaped by collectivist social norms, where access to information, services and support often relies on personal contact, family networks, local community ties and face-to-face communication. This is particularly important for older adults, who may feel more comfortable using in-person service channels than digital platforms. Although digital technology use among older people has increased in recent years, younger generations remain significantly more digitally engaged, creating a persistent intergenerational digital divide.

Migration, geography and digital exclusion risks

Greece's geographical position at the crossroads of Europe, the Middle East, Asia and Africa has contributed to long-standing migration and refugee movements. In Thessaloniki, this context is particularly relevant because the city has historically served as a reception, transit and settlement hub for migrants and refugees. Digital access barriers may therefore affect not only older adults, but also migrant and refugee populations who face language barriers, limited familiarity with Greek public systems and reduced access to culturally adapted information.

Rapid digitalisation can therefore have both positive and negative effects on wellbeing. On the one hand, digital tools can support remote therapeutic interventions, access to information, appointment management and communication with family or community networks. This can be especially valuable for older adults experiencing isolation or for people who face mobility barriers. On the other hand, digitalised services may create stress, anxiety and exclusion when they become the main route to essential healthcare, social care, banking or administrative services. Older adults may also face increased exposure to online fraud, while migrants and refugees may struggle with language barriers and unfamiliar digital procedures.

Innovation ecosystem (tech incubators, digital hubs, research centres)

Thessaloniki benefits from a dynamic innovation ecosystem, that can support the development of inclusive, digitally enabled and community-based approaches to mental health care. The city hosts a range of actors, including startup incubators, research centres, universities, digital hubs and technology organisations, which together create favourable conditions for experimentation, co-creation, prototyping and the testing of new health-related solutions. **Table 36** lists the key innovation actors of the area and benefits from a dynamic innovation ecosystem that can support the development of inclusive, digitally enabled and community-based approaches to mental health care.

Table 36. Innovation Ecosystem in Thessaloniki

Innovation Ecosystem Actor	Brief Description
OK!Thess	Supports innovation, co-creation, and digital health startups.
i4G	Supports investment and scaling of innovative projects.
EIT Digital	Connects local actors with European digital innovation initiatives.
CERTH	Provides expertise in digital health, AI, and smart technologies.
Thessaloniki Tech Lab (TLab)	Supports experimentation, prototyping, and participatory innovation.
Cisco Thessaloniki	Contributes to digital transformation and smart-city initiatives.
Aristotle University of Thessaloniki (AUTH)	Provides academic and health research expertise.
International Hellenic University (IHU)	Supports digital skills and interdisciplinary health innovation.
University of Macedonia (UoM)	Contributes expertise in policy, governance, and social innovation.

This digital transformation also carries a significant risk of reinforcing existing inequalities. Older adults, migrants, refugees, rural populations and uninsured individuals may be particularly exposed to digital exclusion due to limited digital literacy, language barriers, affordability constraints, lack of familiarity with digital public services and fragmented health information systems.

Therefore, digital inclusion should be treated as a core condition for equitable mental health access rather than as a secondary technical issue. Digital mental health tools and e-health services should be accompanied by face-to-face support, multilingual guidance, digital skills assistance and community-based intermediaries to enhance equitable and accessible access to care.

3.6.3 Ecological and Environmental Factors

Access to mental healthcare in Greece is shaped not only by the organisation of the health system, but also by broader territorial, environmental and socioeconomic conditions. Rural and island communities face persistent service gaps, while climate-related stressors and housing insecurity increasingly contribute to psychological distress, social exclusion and unmet care needs. These factors are particularly relevant for people in vulnerable situations, including refugees and asylum seekers, low-income households, older adults, homeless populations, and residents of remote or underserved areas.

Urban vs. rural disparities in access to services

Significant disparities exist between urban and rural areas in access to mental healthcare services across Greece. Mental health services and specialised professionals remain highly concentrated in major urban centres such as Athens and Thessaloniki.

Rural and island communities in Greece continue to face significant barriers in accessing mental healthcare services. These areas are affected by a combination of geographic isolation, shortages of specialised professionals, higher poverty levels, ageing populations and limited availability of specialised mental health services. Although psychiatric reform efforts have promoted the transition towards community-based care, they have not fully addressed territorial inequalities in the distribution of services and professionals.

These disparities are clearly reflected in the uneven distribution of the mental health workforce. For child and adolescent psychiatry, Attica has 35.21 specialists per 100,000 youth, while the North Aegean has only 2.72 and Western Macedonia 4.44. Similar inequalities are observed in adult psychiatry, with Attica recording 23.39 psychiatrists per 100,000 population, compared with 5.11 in Western Macedonia and 5.80 in the South Aegean.

As a result, rural residents are often required to:

- travel long distances to access care;
- cover significant transportation costs;
- depend on irregular specialist availability;
- delay treatment or forgo it entirely.

Delayed access to mental healthcare contributes to high levels of unmet needs, late diagnosis and worsening mental health outcomes. These challenges place rural and island populations at a clear disadvantage compared with residents of major urban centres, where services and specialised professionals remain more concentrated.

In response to these disparities, Greece has developed a network of Mobile Mental Health Units (MMHUs) as a pragmatic, low-cost model to deliver community-based care in remote and deprived areas. These interdisciplinary teams collaborate with primary healthcare centers and local social services, providing treatment for severe mental illness and demonstrating effectiveness in reducing hospitalisations and length of stay. The Council of Europe has recognised this model as an effective community-based initiative. However, MMHUs face critical challenges, including difficulties in recruiting and retaining specialised personnel, particularly those run by public hospitals, and limitations in serving child and adolescent populations. Furthermore, the persistent stigma surrounding mental illness in small, close-knit rural communities often leads families to seek private care in distant cities to preserve anonymity, a solution that becomes financially unsustainable for follow-up care.

Recent initiatives, such as the INTRINSIC telehealth program for older adults in low-resource areas, offer promising evidence that integrated telepsychiatry services can significantly reduce travel burdens and improve access, with pilot data showing dramatic reductions in distance traveled and time spent accessing care. Nevertheless, without systematic performance monitoring, coordinated patient pathways, and sustained investment in both workforce and infrastructure, the urban-rural divide in Greek mental healthcare will persist, leaving rural populations at a distinct disadvantage.

Pollution, climate-related stressors, or environmental risks

In a recent survey with 406 people from Greece, it was reported that climate change has adversely affected the health of people variously, either a moderate amount or a great deal, including physical or mental harm from forest fires (90%), physical or mental harm from storms and floods (87%), heat-related illnesses (82%), illness due to reduced outdoor air quality (70%) and loss of housing for residents displaced by extreme weather events (70%).

Based on the EIB climate survey in 2024, it was found that 94% of Greek respondents (14 points above the EU average) have experienced at least one extreme weather event in the last five years. 61% (6 points above the EU average) have suffered from extreme heat and heatwaves, 46% (25 points above the EU average) have faced wildfires, and 34% (similar to the EU average) have experienced droughts.

Lastly, a study examining the future health burden of air pollution in Greece reported that despite projected declines in pollutant concentrations, the associated excess mortality is projected to increase primarily due to population ageing. The study reported that Attica and Central Macedonia — which together host more than half of Greece's population - showed some of the largest projected increases in air pollution-linked deaths.

Housing instability, overcrowding, or poor living conditions

Housing insecurity and financial hardship have become major social determinants of mental health vulnerability in Greece, particularly among PVS, including refugees, asylum seekers, low-income households, older adults, and homeless populations.

Increasing homelessness and housing precarity are linked to:

- rising rental costs
- evictions and foreclosures
- unstable employment
- insufficient social protection mechanisms.

Refugees and asylum seekers face additional barriers due to:

- overcrowded accommodation systems
- limited housing availability
- lengthy administrative procedures
- dependence on temporary hosting structures.

Requests for integration into supported housing and hosting structures continue to increase, while available places remain limited and access processes are often slow and bureaucratically complex.

The mental health of PVS in Greece is increasingly affected by a convergence of environmental, housing, and geographic stressors that compound and reinforce one another. Climate-related disasters have emerged as a potent source of psychological trauma, with the vast majority of the population reporting mental harm from forest fires, floods, and heatwaves, events that generate PTSD, chronic anxiety, and the existential fear of displacement. This environmental precarity is compounded by profound housing instability, as rising evictions, homelessness, and the inability to cover basic living expenses create a state of relentless stress and hopelessness, while simultaneously blocking access to care through bureaucratic and digital exclusion.

For those in rural and island communities, these burdens are met with a stark geographic disparity in services, where severe workforce shortages and the persistent stigma of seeking help lead to years of delayed or foregone treatment. Thus, vulnerable populations are trapped in a vicious cycle: environmental and housing crises generate profound mental health needs, while a fragmented and urban-centric system ensures that for the rural poor, the displaced, and the homeless, those needs go overwhelmingly unmet.

3.6.4 Regulatory and Policy Landscape

This section summarises the national, regional and local regulatory and policy context shaping the organisation, accessibility, rights and inclusion of mental health services in Thessaloniki. Particular attention is given to how existing frameworks facilitate or hinder access for older adults aged 65+, migrants and refugees, who may face intersecting barriers related to age, language, legal status, socioeconomic vulnerability, disability, digital exclusion and limited knowledge of available services.

National Action Plan for Mental Health (2021–2030)

The National Action Plan for Mental Health 2021–2030 constitutes the main national framework guiding mental health reform and service development in Greece. It sets a strategic direction towards a more accessible, community-oriented and prevention-focused mental health system and aims to:

- ensure universal access to mental health services;
- strengthen community-based care;
- reduce stigma and social exclusion;
- integrate mental health into primary healthcare;
- improve prevention, early intervention and crisis response systems.

The framework places particular emphasis on PVS and seeks to reduce barriers affecting populations at higher risk of exclusion. Key priorities include deinstitutionalisation, the development of community mental health networks, workplace mental health, community resilience and the reduction of involuntary admissions.

However, despite its strategic importance, several implementation gaps remain. At regional and local levels, the operationalisation of the Action Plan is still uneven, and major challenges include insufficient monitoring mechanisms, limited implementation resources, weak coordination across services, and the lack of fully developed culturally adapted services for migrants, refugees and older adults. Overall, the National Action Plan provides an important regulatory anchor for mental health reform in Greece, but its impact depends on stronger implementation, financing and coordination mechanisms.

The key regulatory policies and initiatives relevant to mental health access in Greece are presented in [Table 37](#) below:

Table 37. Key Regulatory Policies and Initiatives Relevant to Mental Health Access

Policy / Initiative	Main Focus
National Action Plan for Mental Health 2021–2030	National framework for mental health reform, community-based care, prevention, deinstitutionalisation and stigma reduction.

National eHealth Interoperability Framework	Developed in 2019 with European Commission support to establish standardised communication protocols and interoperability across eHealth systems in Greece.
Guidelines for the Management of Depression and Anxiety in Primary Healthcare, 2017	National guidelines supporting General Practitioners and family doctors in managing depression and anxiety in primary healthcare settings.
National Strategy for Quality of Care and Patient Safety 2025–2030	Strategy to improve healthcare quality, patient safety, governance, evidence-based practice and patient-centred care.
Law 4368/2016 – Free Access to Healthcare for Vulnerable Populations	Provides free access to the Greek public healthcare system for refugees, asylum seekers, beneficiaries of international protection and other vulnerable groups.
National Strategy for Social Integration, 2019	Promotes social integration, diversity, social cohesion and inclusion of migrants and beneficiaries of international protection.
General Secretariat for Vulnerable Persons and Institutional Protection	Government body established under Presidential Decision 77/2023 responsible for policies and protection measures for vulnerable populations and unaccompanied minors.
National Emergency Response Mechanism (NERM)	Institutionalised in 2022 to identify and provide emergency accommodation and protection services for unaccompanied minors in precarious conditions.
Mental Health at Work Initiative	Developed in collaboration with WHO guidance and Thalpos Mental Health to support workplace mental wellbeing and psychosocial support.
Child and Adolescent Mental Health Initiative (CAMHI)	Five-year national initiative launched in 2021 and formalised through Law 5015/2023 to strengthen prevention, assessment and treatment of child and adolescent mental health conditions.
Primary Healthcare Reform and TOMY Implementation	Reform of primary healthcare structures, including the intended integration of mental health components.
Disability and Social Inclusion Legislation, including Law 4443/2016	Recognises mental health conditions as disabilities when they hinder daily functioning and provides anti-discrimination protections, disability benefits and employment pathways.

Overall, Greece has developed an important policy and legal framework supporting mental health reform, universal access, social inclusion and protection of vulnerable groups. The main challenge lies in translating these frameworks into effective local practice. The policy landscape shows a growing recognition that mental health access is closely linked to social protection, migration status, legal entitlements, digital systems and inclusive care pathways. Policies such as Law 4368/2016, the National Strategy for Social Integration, the General Secretariat for Vulnerable Persons and Institutional Protection, and NERM create an important basis for protecting refugees, asylum seekers, unaccompanied minors and other vulnerable groups.

3.6.5 Priority PVS and Current Mental Health Needs



Figure 24. Priority PVS and their Current Mental Health Needs in Thessaloniki, Greece

The Thessaloniki Smart Health Lab will prioritise older adults (60+) and migrants and refugees, reflecting the demographic, social, and health challenges identified within the metropolitan area. Older adults constitute the primary target group due to the rapid ageing of the population and their increased vulnerability to social isolation, chronic illness, cognitive decline, and mental health conditions such as depression and anxiety. Migrants and refugees represent a second priority group due to the multiple barriers they face in accessing mental health and psychosocial support, including language barriers, stigma, discrimination, limited mental health literacy, and difficulties navigating complex service systems.

The Thessaloniki metropolitan area is one of Greece's largest urban centres and hosts both long-established migrant communities and more recent refugee populations. According to local data, the wider Regional Unit of Thessaloniki includes almost 295,000 older adults aged 60 years and above, while the municipality itself hosts nearly 96,000 older residents. At the same time, Thessaloniki remains an important destination and transit area for migrants and refugees, contributing to a culturally diverse population with varying social, economic, and health-related needs.

The mental health needs of older adults are primarily associated with depression, anxiety, loneliness, social isolation, cognitive decline, chronic illness, caregiving responsibilities, and reduced social participation. Among migrants and refugees, mental health challenges are often linked to trauma, displacement, acculturation stress, socioeconomic insecurity, discrimination, and uncertainty regarding the future. Across both target groups, stigma surrounding mental health, low awareness of available services, and limited access to culturally sensitive and continuous support can further exacerbate mental health difficulties.

Older adults were prioritised due to their growing share of the population and their increased reliance on public health and social care services. Migrants and refugees were prioritised because they experience disproportionately high barriers to accessing mental health care despite significant psychosocial needs. Addressing the needs of these groups is expected to contribute to reducing health inequalities, strengthening social inclusion, and improving the responsiveness of the local mental health ecosystem.

3.6.6 Local Mental Health Ecosystem

The mental health ecosystem in Thessaloniki operates through a mixed and partially decentralised model, where public hospitals handle acute and severe cases, community mental health centres provide follow-up, NGOs fill intercultural and accessibility gaps, and families remain primary caregivers, especially for older adults. Despite progress in psychiatric reform and deinstitutionalisation, the system remains under-resourced, fragmented, and unevenly accessible, particularly for older adults and migrant/refugee populations. Public services in Greece are free at the point of use for insured individuals and vulnerable populations. However, long waiting times, serious understaffing, and very limited geriatric or transcultural specialisation constrain access and create barriers. Although psychiatric reform has promoted deinstitutionalisation and community care, coordination remains fragmented.

Mental health services in Thessaloniki operate under the Greek National Health System (ESY), coordinated by the Ministry of Health and the 3rd and 4th Regional Health Authorities (YPE) covering Northern Greece.

However, the system remains fragmented, with weak coordination mechanisms, limited interoperability, and insufficient integration between healthcare, social care, and community actors. NGOs frequently compensate for structural gaps, particularly regarding interpretation, cultural mediation, trauma-informed care, and migrant support, although these services remain highly dependent on project-based funding.

Structure of Mental Health Service Delivery

The structure of mental health service delivery in Greece includes both public and private providers. Primary and community-based mental healthcare is delivered through hospital-based services, outpatient psychiatric clinics, mental health centres, private psychiatrists and private psychologists. Public outpatient services may require a small fee, while emergency psychiatric services are provided free of charge.

In practice, access to timely outpatient care remains limited. Low-income populations often rely on emergency psychiatric services because of affordability barriers, long waiting times and difficulties accessing private care. In Thessaloniki, five out of seven hospitals include psychiatric departments or clinics, providing an important base for specialised mental healthcare. However, demand remains high, and waiting times for outpatient psychiatric appointments may exceed two months.

In rural and peri-urban areas, access pathways are more limited and depend heavily on Health Centres. General practitioners often act as the first point of contact, providing initial assessment, diagnosis and referral to specialised mental health services. This makes primary care an important entry point into the mental health system, but also highlights the need for stronger integration of mental health expertise, referral coordination and community-based support.

The Thessaloniki mental health ecosystem is presented in [Table 38](#), which combines public psychiatric services, community-based structures, private providers, and a strong NGO sector. However, the system remains fragmented, with weak coordination mechanisms, limited interoperability, and insufficient integration between healthcare, social care, and community actors. NGOs frequently compensate for structural gaps, particularly regarding interpretation, cultural mediation, trauma-informed care, and migrant support, although these services remain highly dependent on project-based funding.

Table 38. Mental Health Ecosystem Actors in Thessaloniki, Greece

Mental Health Ecosystem Component	Main Actors / Structures	Main Functions
Public Community-Based Mental Health Services	Community Mental Health Centres	
	Day Centres;	Outpatient psychiatric care, counselling, follow-up support, psychosocial rehabilitation, multidisciplinary community-based services
	Mobile Mental Health Units;	
	Psychosocial Rehabilitation Facilities	

Hospital-Based Psychiatric Services	AHEPA University Hospital; Papageorgiou General Hospital; Ippokrateio General Hospital; Psychiatric Hospital of Thessaloniki	Acute psychiatric care, inpatient treatment, emergency psychiatric support, specialised consultations
Psychiatric Reform and Decentralised Care	Former Psychiatric Hospital of Thessaloniki and decentralised community units	Transition from institutional psychiatric care towards community-based mental healthcare
Digital and Care Coordination Systems	National e-health services; Local healthcare providers	Appointment management, digital records, healthcare navigation
Private Mental Health Sector	Private psychiatrists; Psychologists contracted with EOPYY; Private clinics; counselling centres	Outpatient psychotherapy, psychiatric consultations, inpatient private care
NGO and Community-Based Ecosystem	MSF; Greek Council for Refugees; SolidarityNow; ARSIS; PRAKSIS; METAdrasi; Naomi; Irida; Red Cross; Action for Refugees; Migrants' Social Centre	Psychosocial support, legal aid, trauma-informed care, interpretation, cultural mediation, refugee and migrant support
Municipal and Social Care Services	Help at Home programmes; municipal social services	Psychosocial support and social assistance for older adults and vulnerable populations

Overall, access to mental healthcare in Thessaloniki remains strongly shaped by insurance status, economic vulnerability, migration and refugee status, with uninsured individuals, migrants and refugees often relying on targeted programmes or NGO-supported services, while structural inequalities continue to limit equitable access for people in vulnerable situations

3.6.7 Service Exclusion Trends

The mental health ecosystem includes several interconnected barriers that affect access to mental healthcare and psychosocial support for young people and unaccompanied children in Athens. These barriers extend beyond the availability of services and include financial, organisational, social, cultural, digital, and administrative factors that influence individuals' ability to seek, reach, and receive appropriate care. [Table 39](#) summarises the main service exclusion trends affecting the two

priority groups and highlights the key challenges that the Smart Health Lab will seek to address through more accessible, coordinated, and person-centred approaches to mental healthcare.

Table 39. Main service exclusion trends affecting older adults, migrants and refugees in Thessaloniki, Greece including barriers influencing access to mental healthcare and psychosocial support services.

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Financial	Older adults in Thessaloniki often face financial barriers linked to the high cost of private specialised mental health services, particularly due to the limited structural role of primary healthcare and the reliance on hospital-based and private providers as first points of contact. Limited pensions and reduced disposable income may discourage long-term engagement with mental health support. Migrants and refugees similarly experience financial insecurity, unemployment, and unstable socioeconomic conditions that limit access to private mental healthcare. Many rely on NGO-supported services, which are frequently dependent on temporary project-based funding rather than stable public provision.
Geographical and Organisational	Mobility limitations associated with chronic illness, disability, and physical frailty may reduce older adults' ability to access specialised mental health facilities, particularly when services are not community-based. Although Thessaloniki is a major urban centre, specialised mental health services remain concentrated in specific locations, creating accessibility challenges for vulnerable populations living in deprived neighbourhoods. Migrants and refugees may additionally experience unequal access to specialised services and fragmented referral pathways across healthcare and social care systems.
Social, Cultural, and Digital	Low mental health literacy, stigma associated with mental illness, and loneliness remain important barriers affecting older adults' willingness and ability to seek mental healthcare. Low digital literacy additionally creates exclusion from increasingly digitalised appointment systems and telehealth services. Among migrants and refugees, language barriers and lack of interpretation services significantly hinder communication with healthcare providers and understanding of available services. Cultural perceptions of mental illness, fear of stigma, and unmet trauma-related psychosocial needs further discourage engagement with formal mental healthcare systems.
Legal and Policy-Related	Fragmented referral pathways and limited coordination between primary care and specialist mental health services continue to create delays and confusion in accessing appropriate care for older adults. Preventive mental health strategies targeting ageing populations remain limited. Migrants and refugees additionally face uncertainty regarding legal status, administrative complexity, and limited awareness of healthcare rights. Public mental health services often lack trauma-informed and culturally appropriate approaches, further reinforcing exclusion from care.

Access to mental health support in Thessaloniki is shaped by a combination of socioeconomic, administrative, cultural and service-related factors. Older adults may experience difficulties in receiving timely and continuous care due to limited income, mobility constraints, loneliness, low digital literacy and the insufficient connection between specialised mental health services, primary care and community-based support. Migrants and refugees face additional barriers linked to unstable living conditions, limited financial resources, language difficulties, lack of interpretation, unfamiliarity with the healthcare system and uncertainty around administrative procedures or legal entitlements. Across both groups, stigma and limited awareness of available support can delay help-seeking and reduce engagement with formal services. NGOs and community organisations play an important role in bridging these gaps, particularly for migrant and refugee communities, but their contribution is often dependent on temporary funding and remains insufficiently integrated with public services.

3.6.8 Priority Areas for Investment within the Mental Health Care System in Thessaloniki, Greece

The mental health landscape in Thessaloniki is supported by a broad range of public health services, specialised mental health facilities, municipal programmes, civil society organisations, and community initiatives. In recent years, efforts to modernise healthcare delivery and expand community-based services have created opportunities to improve mental health support for vulnerable populations. Despite these positive developments, important gaps remain in ensuring that older adults, migrants, and refugees can access timely, appropriate, and continuous mental healthcare.

One of the most significant challenges relates to the limited availability of proactive mental health support within the community. Existing services are often concentrated on responding to established mental health conditions, while initiatives that promote emotional wellbeing, social connectedness, and early identification of mental health concerns remain relatively scarce. This is particularly relevant for older adults, who face increased risks of loneliness, isolation, and declining psychosocial wellbeing, yet often have limited access to structured preventive support.

The ecosystem assessment also points to persistent inequalities affecting migrant and refugee populations. Although a variety of services exist, many are not fully adapted to the cultural, linguistic, and trauma-related needs of diverse communities. Insufficient access to interpretation, limited intercultural support mechanisms, and weak links between public services and community organisations can create obstacles to care and reduce trust in formal support systems.

At the same time, the growing use of digital technologies within healthcare introduces new considerations for accessibility and inclusion. While digital platforms can facilitate service delivery and communication, many older adults and newly arrived migrants may encounter difficulties in using online systems due to language barriers, limited digital skills, or lack of confidence with technology. Ensuring that digital innovation remains inclusive will therefore be an important consideration for future service development. Another area requiring attention is the role of primary care in supporting mental health needs. Current pathways often rely heavily on specialist services, while opportunities for mental health promotion, screening, and support within frontline healthcare settings remain underutilised.

Table 40 outlines the main areas where investment and innovation could strengthen the Thessaloniki mental health ecosystem. The identified priorities focus on expanding community-based support for older adults and improving culturally responsive and trauma-informed care for migrants and refugees.

Table 40. Priority system gaps, investment needs, and Smart Health Labs alignment for older adults, migrant and refugee populations in Thessaloniki, Greece.

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment / Innovation Area	Expected Outcomes
Limited Preventive and Community-	Older adults experience inadequate preventive mental health services	Development of structured community-based preventive mental health services, including	Earlier detection of mental health needs;

Based Mental Health Support for Older Adults	- targeting loneliness, social isolation, and psychosocial wellbeing. - Community-based psychosocial interventions remain limited, while coordination between primary care and mental health services is fragmented.	psychosocial support, early detection, social participation activities, and outreach interventions.	- Reduced loneliness and isolation; - Improved psychosocial wellbeing and continuity of care among older adults.
Lack of Culturally Appropriate and Trauma-Informed Mental Health Services for Migrants	- Migrants and refugees face limited access to culturally appropriate and trauma-informed mental healthcare. - Public mental health services often lack interpretation services and intercultural mediation, while collaboration between NGOs and public structures remains fragmented.	Investment in trauma-informed care training, culturally sensitive therapeutic models, interpretation services, and stronger coordination between NGOs and public mental health services.	- Improved accessibility and quality of care for migrants and refugees; - Strengthened trust in mental health services; - Reduced exclusion and unmet trauma-related needs.
Digital Exclusion and Unequal Access to E-Health Services	- Older adults and migrants experience low levels of digital inclusion, limiting their ability to use e-health platforms, telemedicine systems, and digital appointment services. - Rapid digitalisation risks reinforcing exclusion from healthcare access.	Development of digital literacy programmes, assisted digital access models, simplified e-health platforms, and hybrid service models combining in-person and digital support.	- Improved accessibility to digital healthcare services; - Reduced digital exclusion; increased engagement with e-health and telehealth systems.
Weak Primary Mental Health Care Pathways and Over-Reliance on Specialist Care	- Fragmented referral systems and insufficient integration of support within primary healthcare contribute to over-reliance on private services. - Frontline providers often lack mental health training and structured referral mechanisms.	Strengthening primary mental healthcare pathways via integrated care models, capacity building for frontline professionals, and improved coordination for primary care and specialised mental health services.	- Improved continuity of care; earlier intervention; - Reduced pressure on specialist and hospital-based mental health services; More equitable access pathways.

3.6.9 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Thessaloniki

The Thessaloniki mental health ecosystem is supported not only by formal healthcare and social care services, but also by a diverse network of civil society organisations, humanitarian actors, community initiatives, and municipal support structures that play a crucial role in addressing the needs of people in vulnerable situations. These organisations often serve as trusted intermediaries between vulnerable populations and formal services, providing psychosocial support, social inclusion activities, legal assistance, community outreach, and practical support that complement public mental healthcare provision. Their close connections with older adults, migrants, refugees, and other socially excluded groups enable them to identify unmet needs, facilitate service access, and strengthen community engagement.

Table 41 presents the key social economy and community-based organisations operating within the Thessaloniki ecosystem and highlights their potential contribution to Smart Health Lab activities. The table illustrates how these actors can support outreach, co-creation processes, community participation, referral pathways, awareness-raising initiatives, and the development of more inclusive, person-centred, and community-oriented mental health solutions for older adults, migrants, and refugees.

Table 41. Social Economy Initiatives to be prioritised by the Smart Health Lab in Thessaloniki

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
Irida Women Center	Women's empowerment, psychosocial support, social inclusion, migrant and refugee support	Supports women, including migrant and refugee women, through community-based activities, psychosocial support, empowerment and social inclusion actions. It can contribute to trusted outreach and engagement with women in vulnerable situations.
Pnoi Zois	Social support, psychosocial assistance, refugee and migrant integration	Supports vulnerable groups, including migrants and refugees, through psychosocial assistance, social support and community integration activities.
<u>SolidarityNow</u>	Community centres, integration services, social inclusion	Provides integrated support services and community-based assistance for vulnerable and migrant populations.
<u>ARSIS</u>	Youth support, migrant assistance, social inclusion	Delivers social support and protection services for vulnerable youth, migrants, and refugees.
<u>Municipal Social Services and "Help at Home" Programmes</u>	Psychosocial support for older adults, home-based care, social assistance	Supports older adults through community-based psychosocial services and home-care interventions aimed at reducing isolation and improving wellbeing.
NGO and Community-Based Ecosystem	Cultural mediation, interpretation, trauma-informed care, case management	NGO services frequently compensate for structural gaps within the public mental healthcare system, particularly regarding accessibility and inclusion for vulnerable populations. However, sustainability remains challenging due to dependence on project-based and donor funding.

3.6.10 SWOT Analysis of the Greek Pilot Site (Thessaloniki) and strategic directions for the design of the Smart Health Lab

The SWOT analysis in [Table 42](#) synthesises the ecosystem profiling findings and identifies the main internal and external factors that may influence the implementation and sustainability of the Thessaloniki Smart Health Lab, focusing on older adults (60+) and migrants/refugees.

Table 42. SWOT Analysis of the Greek Pilot Site

Strengths	Weaknesses
Strong concentration of mental health services and specialised psychiatric facilities.	Fragmented coordination between healthcare, social care, and community services.
Presence of leading research centres, universities, and innovation actors.	Long waiting times and workforce shortages in public mental health services.
Well-established NGO ecosystem supporting migrants, refugees, and vulnerable populations.	Limited availability of culturally adapted and trauma-informed care.
Active digital health and innovation environment.	Weak integration of mental health within primary healthcare.
Extensive experience working with diverse migrant and refugee communities.	Limited interoperability and integrated referral systems across services.
Existing municipal programmes supporting older adults and community wellbeing.	Low digital literacy among many older adults and migrants.
Growing national investment in digital health infrastructure and e-health services.	Persistent mental health stigma and low mental health literacy among target groups.
Opportunities	Threats
National Mental Health Action Plan promotes community-based and preventive care.	Population ageing is expected to increase demand for mental health and social care services.
Expansion of telehealth and digital mental health services can improve accessibility.	Economic pressures and cost-of-living challenges may worsen mental health outcomes.
Smart Health Lab can leverage local innovation and research expertise.	Digitalisation may increase exclusion for digitally disadvantaged populations.
Strong potential for collaboration between healthcare, academia, municipalities, and NGOs.	Continued dependence of NGO services on short-term project funding threatens sustainability.
Growing policy focus on healthcare quality, interoperability, and person-centred care.	Climate-related events may increase psychological distress and service demand.
Digital literacy initiatives can enhance access to healthcare and wellbeing services.	Persistent workforce shortages may limit service capacity and reform efforts.
Community-based and social prescribing approaches are gaining recognition.	Housing insecurity, social exclusion, and poverty continue to affect vulnerable groups.
Increasing awareness of mental health and wellbeing creates favourable conditions for innovation.	Administrative barriers and language difficulties may continue to restrict access for migrants and refugees.

Strategic directions for the design of the Smart Health Lab in Thessaloniki

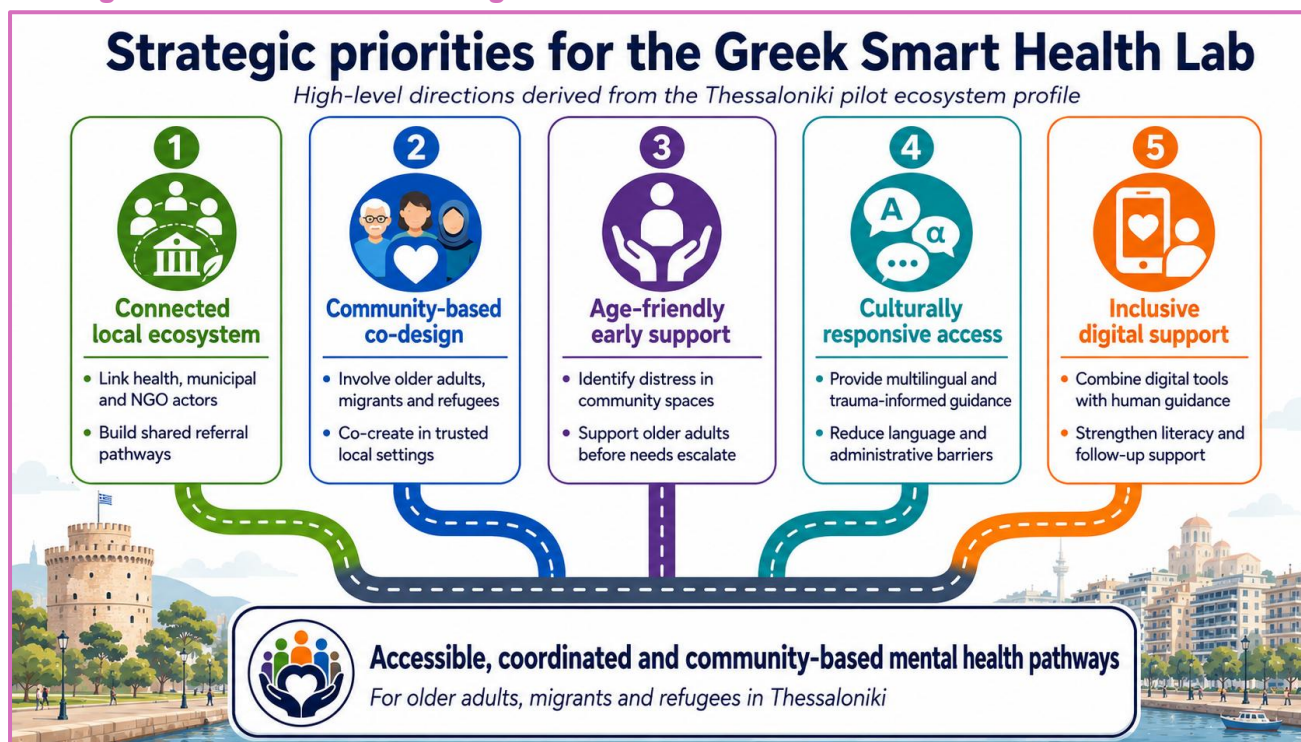


Figure 25. Strategic directions for the design of the Greek Smart Health Lab in Thessaloniki

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Greek Smart Health Lab in Thessaloniki could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The SWOT analysis in Table 42 highlights that the Thessaloniki Smart Health Lab could capitalise on the city's strong concentration of health, research, municipal and civil society actors, while addressing persistent gaps in coordination, accessibility and continuity of care. The local ecosystem includes important assets, such as specialised psychiatric services, universities, innovation actors, municipal programmes and NGOs with extensive experience in supporting migrants, refugees and other vulnerable groups. However, these resources are not yet sufficiently connected through stable referral pathways, shared operational mechanisms or integrated service models.

Strategic positioning: operationalising a Smart Health Lab as a physical and virtual hub for inclusive mental health access

The Thessaloniki Smart Health Lab could be positioned as a physical and virtual hub that brings together health service providers, care workers, service users, intermediaries, municipal actors, NGOs, academic partners and community representatives. Its purpose would not be to establish parallel services, but to create a multi-actor environment where existing resources can be better connected and adapted to the needs of people in vulnerable situations. Through this role, the Lab could support more user-centred, accessible and integrated mental health and care pathways for older adults, migrants and refugees.

Enabling multi-actor engagement across health, social care, municipal and community ecosystems

A core strategic direction would be to strengthen multi-actor engagement between public mental health services, primary care, social services, municipalities, NGOs, universities, innovation actors

and community representatives. The Lab could provide a structured space for these actors to identify shared challenges, clarify access barriers and develop practical responses through joint problem-solving. This is particularly important in Thessaloniki, where a wide range of actors exist, but cooperation is often based on informal or project-based relationships rather than stable operational pathways.

Putting older adults, migrants and refugees at the centre of co-design and validation activities

The Lab could ensure that older adults, migrants and refugees are not only consulted, but actively involved in the co-design, testing and validation of Lab activities. This reflects the EQUICARES objective of empowering PVS as active contributors to innovation rather than passive beneficiaries. Co-creation activities could be organised in familiar, safe and inclusive local settings, with the support of community intermediaries, cultural mediators and trusted organisations. This would help ensure that the Lab's outputs are grounded in lived experience and respond to real-world barriers in accessing mental health and care services.

Developing age-friendly prevention and early support pathways in community settings

For older adults, the Smart Health Lab could prioritise prevention, early identification and community-based support. Loneliness, social isolation, reduced mobility, digital exclusion and age-related mental health needs require approaches that are close to everyday community environments. Cooperation with municipal services, older-adult programmes, primary care actors and local community spaces could support earlier recognition of distress and more timely connection to appropriate support. Activities would combine face-to-face engagement with supported digital options where relevant, ensuring that older people are not excluded from innovation due to limited digital confidence or access.

Reducing cultural, linguistic and administrative barriers for migrants and refugees

For migrants and refugees, the Lab could address barriers that limit the ability to perceive, seek, reach and engage with mental health and care services. These include language difficulties, limited knowledge of the healthcare system, administrative complexity, stigma, lack of interpretation and previous experiences of trauma or exclusion. The Lab could therefore work closely with NGOs, intercultural mediators, migrant associations and trusted community organisations to provide multilingual information, culturally adapted communication and trauma-informed guidance. This approach might strengthen trust, improve service navigation and support earlier help-seeking.

Creating accessible entry points between community actors and formal services

The Lab would help create practical entry points into the mental health ecosystem by connecting formal services with the places where people in vulnerable situations already seek information and support. Municipal venues, NGOs, community centres, migrant organisations, older-adult structures and informal support networks can serve as important access points into care. By linking these environments with public mental health services, primary care and psychosocial support providers, the Lab could reduce the distance between service users and the formal care system.

Fostering health and digital literacy through supported hybrid engagement

In line with the EQUICARES emphasis on health and digital literacy, the Thessaloniki Smart Health Lab could use digital tools in a supported and inclusive way. Thessaloniki's innovation environment and wider e-health developments offer opportunities for digital service navigation, online information, telehealth and the AI Assistant. However, these tools could be combined with human guidance, offline participation options and practical digital support. This might help ensure that digital innovation

improves accessibility without reinforcing exclusion among older adults, migrants or refugees with limited digital skills.

Launching awareness-raising actions to address stigma and knowledge gaps

The Lab could contribute to awareness raising around mental health, help-seeking and available support. Activities would be adapted to the needs of both target groups and service-side actors, including professionals, care workers and community intermediaries. Awareness-raising actions could use accessible, age-friendly and multilingual formats and could be delivered through trusted local channels.

Supporting continuity of care through clearer referral and follow-up mechanisms

The Lab could help address discontinuities between public mental health services, municipal support, NGOs and community-based organisations. Fragmented responsibilities and unclear referral processes might delay access and weaken follow-up, particularly for people who need support across health, social care, legal, housing or integration services. The Smart Health Lab could support the development of clearer referral pathways, shared signposting tools and community-based follow-up practices that help users remain connected to support throughout their care journey.

Embedding Lab activities in existing infrastructures and local partnerships

Sustainability could be addressed from the outset by grounding Lab activities in existing infrastructures, resources and partnerships. Many NGO and community-based services depend on short-term funding, which creates risks for continuity. The Smart Health Lab could therefore explore how successful practices can be integrated into municipal programmes, public health structures, community organisations and local networks. This approach might support ownership, reduce duplication and increase the likelihood that effective actions continue beyond the project period.

Generating local evidence to inform scale-up, replication and policy uptake

The Thessaloniki Smart Health Lab could also contribute to evidence generation by documenting access barriers, engagement outcomes, user experiences and promising practices. This evidence might support the assessment of what works in improving access to mental health and care services for older adults, migrants and refugees. By producing locally grounded insights, the Lab could contribute to future policy recommendations, replication opportunities and wider EQUICARES outputs on inclusive and sustainable mental health access.

Expected strategic contribution: translating ecosystem capacity into user-centred, community-based access solutions

Overall, the Thessaloniki Smart Health Lab could help convert the city's strong but fragmented ecosystem into more accessible, coordinated and person-centred pathways for people in vulnerable situations. Its added value lies in bringing service users, providers, care workers, intermediaries and policy-relevant actors into a shared process of co-creation, awareness raising, digital inclusion and community-based innovation. By strengthening practical access, cultural responsiveness, service navigation and continuity of care, the Lab could contribute to the EQUICARES objective of improving access to innovative and sustainable mental health and care services for people in vulnerable situations.

3.6.11 Useful Resources

Table 43. Key Healthcare, Social Service and Community Resources for the Thessaloniki / Central Macedonia Pilot Site

Resource / Initiative	Official Link
1566 National Healthcare Helpline	1566 National Healthcare Helpline

Action for Refugees	Action for Refugees
ARSIS – Association for the Social Support of Youth	ARSIS – Association for the Social Support of Youth
AHEPA University Hospital	AHEPA University Hospital
Central Macedonia Region	Central Macedonia Region
ClicktoTherapy	ClicktoTherapy
Community Mental Health Centres	Community Mental Health Centres
Doctoranytime	Doctoranytime
EOPYY – National Organisation for Healthcare Services Provision	EOPYY – National Organisation for Healthcare Services Provision
Greek Council for Refugees (GCR)	Greek Council for Refugees (GCR)
Help at Home Programme (Βοήθεια στο Σπίτι)	Help at Home Programme
ifightdepression / ifightwellbeing (MENTBEST Project)	ifightdepression / ifightwellbeing (MENTBEST Project)
International Organization for Migration (IOM Greece)	International Organization for Migration (IOM Greece)
Ippokrateio General Hospital of Thessaloniki	Ippokrateio General Hospital of Thessaloniki
Irida Women's Center	Irida Women's Center
KAPI – Open Care Centres for Older Adults	KAPI – Open Care Centres for Older Adults
KIFI – Daily Care Centres for Older Adults	KIFI – Daily Care Centres for Older Adults
METAdrasi	METAdrasi
Médecins Sans Frontières (MSF Greece)	Médecins Sans Frontières (MSF Greece)
MilaMou	MilaMou
Mobile Mental Health Units	Mobile Mental Health Units
Municipality of Thessaloniki	Municipality of Thessaloniki
myHealth Application	myHealth Application
MyTherapist	MyTherapist
National e-Health Interoperability Framework	National e-Health Interoperability Framework
Papageorgiou General Hospital	Papageorgiou General Hospital
PRAXIS	PRAXIS
Psychiatric Hospital of Thessaloniki	Psychiatric Hospital of Thessaloniki
Quality-for-All Platform (HEALTH-IQ)	Quality-for-All Platform (HEALTH-IQ)
Red Cross Multidisciplinary Centre for Refugees	Red Cross Multidisciplinary Centre for Refugees
Social Centre of Migrants of Thessaloniki	Social Centre of Migrants of Thessaloniki
SolidarityNow	SolidarityNow
Thessaloniki Municipality Social Services	Thessaloniki Municipality Social Services
TherapySpace	TherapySpace
The Hellenic Red Cross	The Hellenic Red Cross
Wave Center	Wave Center

3.6.12 References & Data sources

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3.7 Athens – Attica region (Greece)

3.7.1 Geographical Context and Demographic Overview

The Attica pilot site is located in the Region of Attica (EL30), centred around the Athens metropolitan area. As the most populous region in Greece, Attica concentrates almost one third of the national population and functions as the country's main administrative, economic, educational and healthcare hub. According to the 2021 Population and Housing Census, the region had approximately 3,814,064 residents.

The territory combines a dense urban core with suburban areas, mountainous landscapes and extensive coastal zones along the Saronic Gulf and the South Euboean Gulf. The Athens basin is surrounded by major mountain ranges, including Mount Parnitha, Mount Pentelicus, Mount Hymettus and Mount Aigaleo, creating territorial differences between central, peripheral, coastal and semi-rural areas.

Attica's demographic profile is shaped by population ageing, declining birth rates, youth vulnerability and significant migration-related diversity. The region hosts large migrant and refugee communities, alongside a substantial urban youth population facing pressures linked to employment instability, educational transitions, housing affordability and economic insecurity. These combined dynamics contribute to social and territorial inequalities that may affect access to mental health and

psychosocial support services, particularly for young people, migrants, refugees, unemployed young adults and people experiencing economic hardship.

The infographic below ([Figure 26](#)) provides a concise visual overview of the Attica pilot site, highlighting its geographical location, territorial characteristics, population size, demographic trends and key social vulnerabilities.

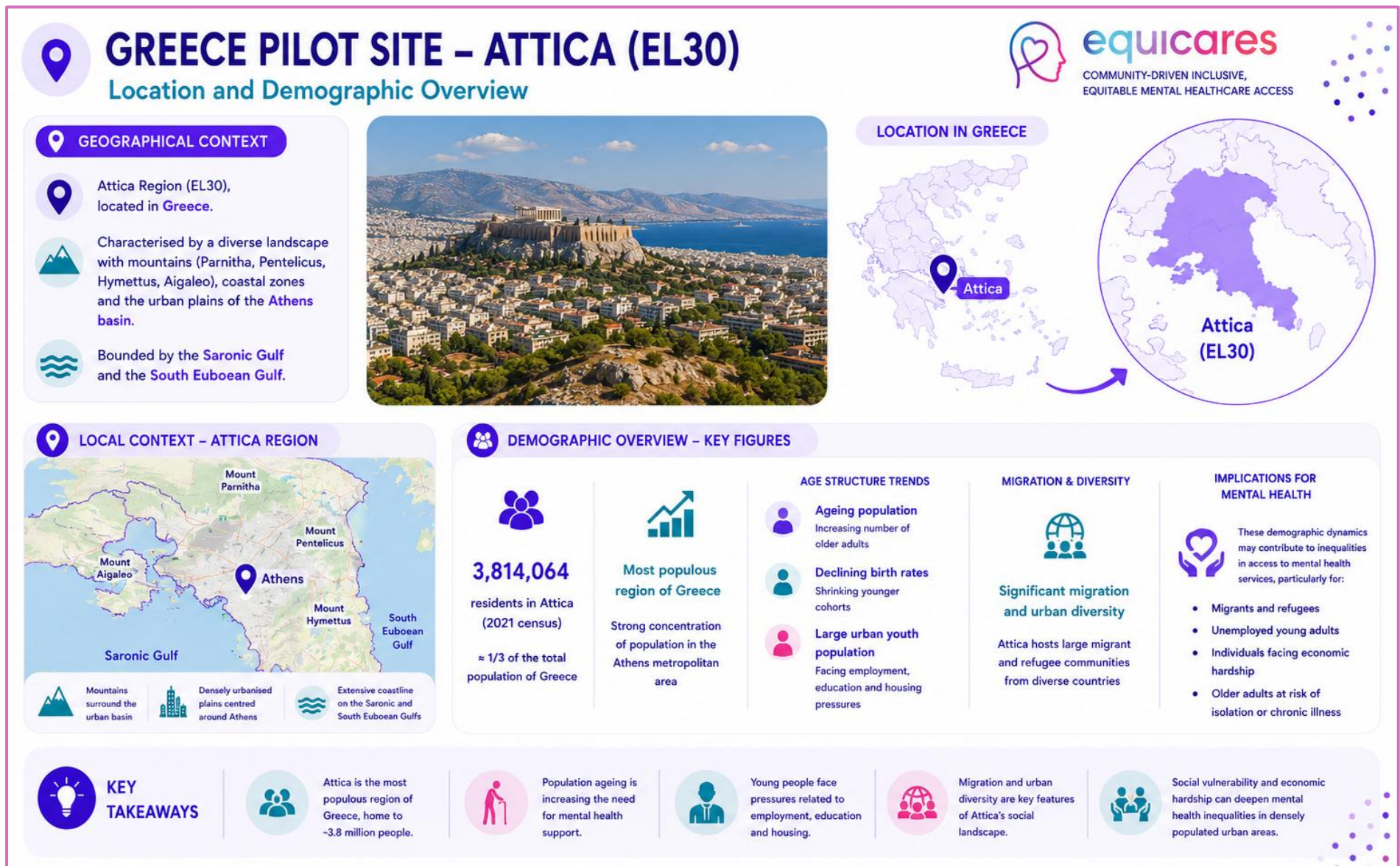


Figure 26. Athens (Greece) Pilot Site Location and Demographic Overview

3.7.2 Techno-Economic Context

Attica's techno-economic profile reflects its position as Greece's main metropolitan, administrative, academic and economic centre. The region benefits from relatively advanced digital infrastructure, a strong concentration of innovation actors and the presence of major healthcare and research institutions. At the same time, persistent socio-economic pressures, unequal digital literacy and high demand for mental health services continue to shape access to care, particularly for young people, migrants, refugees and economically vulnerable groups.

Digital infrastructure and innovation capacity

Attica has comparatively strong digital infrastructure, including widespread broadband connectivity, high smartphone penetration, national e-government platforms such as gov.gr and established digital health tools, including e-prescription services. These assets create favourable conditions for the development of digital health solutions, service navigation tools and hybrid models of mental health support.

The region also hosts a dynamic innovation ecosystem, supported by universities, research centres, technology incubators and digital innovation hubs. Institutions such as the National Technical University of Athens and the Athens University of Economics and Business, together with research organisations and technology-oriented initiatives, provide expertise in digital transformation, public administration, entrepreneurship, applied innovation and data-driven solutions.

Digital literacy and accessibility gaps

Despite this strong technological environment, the translation of digital capacity into accessible mental health support remains uneven. Older adults, low-income groups and migrant communities may face difficulties using online healthcare services, digital public administration platforms and remote mental health tools. These barriers are linked to limited digital literacy, language differences, affordability constraints and lack of familiarity with digital systems.

For these groups, digitalisation can only improve access when it is supported by inclusive design and complementary non-digital options. For young people and unaccompanied children, digital tools may support access to information and service navigation, but only when language, safeguarding, digital literacy, trust and access to devices are considered. Digital tools should therefore be accompanied by multilingual information, assisted access, community-based guidance and face-to-face alternatives, ensuring that innovation does not deepen existing inequalities.

Socio-economic vulnerability and urban pressures

Attica continues to experience significant socio-economic pressures linked to the long-term effects of the financial crisis, inflation, housing insecurity, rising living costs and labour market precarity. Young adults and migrants are particularly exposed to unemployment, underemployment, unstable work and housing affordability challenges. These conditions may contribute to stress, anxiety, depression and reduced capacity to seek timely mental health support.

Urban poverty and social exclusion remain visible in densely populated neighbourhoods, especially in areas with high migrant populations, ageing residents and limited access to community-based resources. These socio-economic conditions create a strong need for locally accessible, low-threshold and community-oriented mental health support.

Labour market characteristics and psychosocial stress

The regional economy is strongly service-oriented, with employment concentrated in tourism, retail, public administration, small enterprises and personal services. These sectors are often associated with seasonal work, low wages, unstable contracts and limited social protection, particularly following the COVID-19 pandemic and ongoing cost-of-living pressures.

Such labour market conditions can intensify psychosocial stress and increase demand for accessible mental health and social support services. For young people transitioning from education to employment, as well as for migrants working in precarious sectors, employment insecurity may become a key determinant of mental wellbeing.

Healthcare capacity and access inequalities

Greece provides universal healthcare coverage through the National Organisation for Healthcare Services Provision (EOPYY), including access to mental health services. Attica also concentrates major psychiatric hospitals and specialised mental health facilities, including Attikon University Hospital and Eginition Hospital, alongside community mental health centres, NGOs and private practitioners.

However, the concentration of services does not guarantee timely or equitable access. Demand continues to exceed service capacity, particularly in child and adolescent psychiatry, trauma-informed care and culturally adapted support for migrants and refugees. Waiting times in public services, uneven availability of professionals and out-of-pocket payments for private care continue to create significant barriers for vulnerable groups.

Mental health literacy, stigma and prevention gaps

Although educational attainment levels in Attica are comparatively high, mental health literacy remains uneven across population groups. Stigma continues to influence help-seeking behaviour, particularly among older adults, migrants and certain cultural communities. As a result, people may delay seeking support until needs become more severe.

Preventive and community-based mental health services remain underdeveloped in relation to population needs. This contributes to delayed access, unmet psychosocial needs and overreliance on specialised or crisis-oriented services. Strengthening prevention, early intervention and community-based support should therefore be a key priority for the Athens Smart Health Lab.

3.7.3 Ecological and Environmental Factors

Environmental conditions in Attica represent an important set of determinants influencing mental health and psychosocial wellbeing. As Greece's largest metropolitan region, Attica is exposed to multiple urban and climate-related stressors, including air pollution, heat exposure, wildfires, traffic congestion, noise and housing pressures. These factors do not affect all residents equally and may have stronger impacts on children, adolescents, older adults, migrants, low-income households and people living in overcrowded or poor-quality housing.

Air pollution and urban concentration

The Athens metropolitan area is particularly affected by air pollution linked to traffic density, urban concentration and high levels of daily mobility. Prolonged exposure to poor air quality has been associated with increased risks of anxiety, depression, stress and cognitive impacts, with children and adolescents considered especially vulnerable. In densely populated urban areas, environmental

exposure may therefore contribute to cumulative mental health risks, particularly when combined with poverty, limited access to green spaces and other social stressors.

Climate-related risks and psychological distress

Climate-related hazards have also become increasingly relevant across the Attica Region. Extreme heat events and wildfires have intensified in recent years, creating both direct and indirect psychosocial impacts. Exposure to climate-related emergencies may contribute to psychological distress, trauma, chronic stress and long-term anxiety, especially among people who have experienced displacement, property loss, health insecurity or repeated exposure to environmental threats.

Urban heat island effects

Urban heat island effects are particularly pronounced in densely built parts of Athens, where limited vegetation, high building density and traffic congestion increase heat exposure. Heat stress can affect mental wellbeing through sleep disruption, irritability, emotional distress, reduced concentration and increased risk of acute mental health episodes. Vulnerable groups living in overcrowded, poorly insulated or energy-poor housing may be disproportionately exposed to these impacts, especially during prolonged heatwaves.

Noise exposure and everyday stress

Noise pollution is another important environmental stressor in the Athens metropolitan area. Chronic exposure to transport and urban noise can contribute to sleep disturbance, fatigue, anxiety, emotional dysregulation and reduced quality of life. These effects may be more severe for residents living near high-traffic roads or in lower-quality housing where sound insulation is limited.

Housing conditions and mental health

Housing conditions further influence mental health outcomes in Attica. Overcrowding, poor housing quality, insufficient privacy and inadequate thermal comfort can contribute to stress, sleep disruption, family tensions, anxiety and depression. These challenges are especially relevant in densely populated neighbourhoods and among low-income households, migrants, refugees and young people facing housing insecurity.

3.7.4 Regulatory and Policy Landscape

The regulatory and policy landscape in Greece provides an important framework for improving access to mental health services and promoting social inclusion for people in vulnerable situations. Over the last decade, a series of reforms and policy initiatives have sought to strengthen community-based mental healthcare, expand healthcare coverage for vulnerable populations, improve service quality, and support the digital transformation of healthcare systems. Particular attention has been given to reducing barriers faced by migrants, refugees, older adults, people with disabilities, and other socially excluded groups through measures that enhance healthcare rights, social protection, patient safety, and care coordination.

Table 44 **Error! Reference source not found.** presents the most relevant national policies, strategies, and regulatory initiatives shaping the mental health ecosystem in Greece. Together, these frameworks create an enabling environment for more equitable, accessible, and person-centred mental healthcare by supporting universal healthcare coverage, promoting community-based approaches, strengthening digital health infrastructure, and improving the integration of mental health

services within broader health and social care systems. While implementation challenges remain, these policies provide important foundations upon which the Thessaloniki Smart Health Lab can build to develop innovative, inclusive, and sustainable mental health solutions for older adults, migrants, and refugees.

Table 44. Regulatory and policy frameworks supporting mental health access and inclusion in Greece

Policy / Strategy Area	Key Policies and Initiatives	Main Challenges
Mental health governance and psychiatric reform	Law 2716/1999 provides the foundation for psychiatric reform, patient rights, deinstitutionalisation and community-based mental healthcare. Law 5129/2024 introduces further restructuring of mental health institutions and rehabilitation services.	Psychiatric reform remains unevenly implemented, and community-based services are still under-resourced, especially for children, adolescents and people in vulnerable situations.
Patient rights and access to care	The national patient rights framework guarantees access to healthcare, informed consent, confidentiality and non-discrimination. Law 4368/2016 ensures free healthcare access for beneficiaries of international protection under the same conditions as Greek nationals.	Migrants and vulnerable groups may still face language, administrative and information barriers that limit effective access to rights and services.
National mental health strategies	The National Action Plan for Mental Health 2021–2030 prioritises prevention, community-based care, stigma reduction and improved access for vulnerable populations. The National Strategy for Quality of Care and Patient Safety 2025–2030 strengthens healthcare quality and governance.	Workforce shortages, funding limitations and fragmented public service coverage continue to delay implementation, particularly in youth mental health and community-based care.
Digital health and service modernisation	Greece 2.0 and national digital health tools, including e-prescription and gov.gr services, support healthcare modernisation and easier service navigation.	Rapid digitalisation may exclude older adults, migrants and people with limited digital skills or digital access.
Social inclusion and child protection	The National Strategy for Social Inclusion and Poverty Reduction 2021–2027 addresses poverty and exclusion as key social determinants of health.	Links between social inclusion policies and mental healthcare remain weak, while poverty and housing insecurity continue to create barriers to care.

The Child Guarantee National Action Plan supports access to healthcare, education and protection services for vulnerable children and youth.

Disability and psychosocial inclusion	The National Disability Strategy 2024–2030 promotes accessibility, participation and rights protection for persons with disabilities, including psychosocial disabilities.	Coordination between disability policy, employment support and mental healthcare delivery remains incomplete.
Local social protection and housing	Municipal initiatives such as KYADA and ACCMR support vulnerable populations, migrants and homeless individuals through psychosocial support, homelessness services and service navigation.	Limited long-term housing protection contributes to chronic stress, trauma exposure and social exclusion.
Employment and economic inclusion	DYPA programmes and the EU Youth Guarantee support vocational training, digital skills, employment integration and opportunities for young people and NEETs.	Employment insecurity and limited integration of mental health support into employment programmes continue to affect psychosocial wellbeing.

3.7.5 Priority PVS and Current Mental Health Needs



Figure 27. Priority PVS and their Current Mental Health Needs in Attica, Greece

Figure 27 presented an overview of the two target groups, their key mental health needs, and the expected contribution of the Smart Health Lab in addressing existing service gaps and promoting equitable access to care.

The Athens Smart Health Lab will prioritise young people aged 18–25 and unaccompanied children, reflecting both the project objectives and the significant mental health challenges experienced by these population groups. Both groups face heightened vulnerability due to social, economic, developmental, and structural factors that can affect their mental wellbeing and their ability to access appropriate mental healthcare services.

Young people aged 18–25 constitute a large population group within the Attica region. Although official census data are not available specifically for this age category, demographic estimates suggest that approximately 350,000–400,000 young people aged 18–25 reside within the region. This life stage is often characterised by important transitions related to education, employment, independent living, and social relationships, which may increase exposure to stress, anxiety, and uncertainty. Mental health challenges commonly reported among young people include symptoms of anxiety and depression, loneliness, social isolation, sleep disturbances, and substance use associated with coping mechanisms. The highly urbanised environment of Athens may further contribute to psychological stress through factors such as overcrowding, economic insecurity, and social pressures.

Unaccompanied children represent a second priority group for the Athens Smart Health Lab. Greece currently hosts approximately 1,900 unaccompanied children, with the majority of accommodation and support structures located within the Attica region, including shelters, Supported Independent Living (SIL) apartments, and emergency accommodation facilities. While precise figures for the city of Athens are not available, Attica remains the primary hub for protection and support services targeting this population.

The mental health needs of unaccompanied children are often associated with experiences of displacement, family separation, exposure to violence, traumatic journeys, and uncertainty regarding their future. Common mental health challenges include anxiety, depression, post-traumatic stress symptoms, sleep disturbances, grief, emotional distress, and difficulties related to attachment and psychosocial development. These vulnerabilities are often exacerbated by ongoing legal and administrative procedures, uncertainty regarding asylum outcomes, and frequent transitions between accommodation settings.

Access to mental healthcare for unaccompanied children is further complicated by guardianship requirements, administrative complexity, language barriers, and shortages in specialised child and adolescent mental health services. Frequent relocation between facilities may disrupt continuity of care, educational participation, and therapeutic relationships. Nevertheless, a number of specialised organisations provide essential support to this population. These include METAdrasi, which offers guardianship services, interpretation, intercultural mediation, educational support, and accommodation programmes, and PRAKSIS, which delivers healthcare, psychosocial support, legal assistance, and social integration services for vulnerable children and young refugees. National protection mechanisms coordinated by the Ministry of Migration and Asylum further support referral, accommodation, and emergency response activities.

The prioritisation of young people and unaccompanied children is consistent with the objectives of the EQUICARES project and reflects the substantial unmet mental health needs identified within these groups. Through the Smart Health Lab, both target populations will benefit from co-created and community-based solutions designed to improve accessibility, responsiveness, and inclusiveness of mental healthcare pathways.

3.7.6 Local Mental Health Ecosystem

Organisation of mental health care

Mental health care in Attica is delivered through a mixed system that combines services within the Greek National Health System (NHS), community-based mental health structures, private providers and civil society organisations. Public services form the backbone of care and include psychiatric

hospitals, psychiatric departments in general hospitals and outpatient clinics that provide diagnosis, crisis intervention and specialist follow-up. Alongside hospital services, Athens has developed a network of community-based services such as Community Mental Health Centres, day centres, mobile mental health units and residential psychosocial rehabilitation structures. These community services are intended to provide treatment, follow up and social reintegration within the community, although their availability and distribution remain uneven and do not fully meet demand.

The private sector also plays a major role in the organisation of mental health care in Attica. Because of waiting times in public services and limited capacity in community units, many residents access private psychiatrists and psychologists for outpatient care and psychotherapy. As a result, in practice a pattern has emerged where public services are often used for acute or complex cases while private providers deliver a large share of ongoing outpatient care.

Governance and coordination mechanisms

Mental health governance in Greece historically relied on sectorisation, introduced through Law 2716/1999, which organised services into geographic mental health sectors intended to coordinate hospitals, community services and rehabilitation structures within the ESY framework. Recent reforms have sought to reorganise this system. In 2024, Law 5129 introduced a new administrative model that centralises the management of psychiatric services through regional mental health service networks within the Health Regions. Although this reform aims to improve coordination and planning, the operational integration of services in Athens remains uneven and coordination between providers is still limited in practice.

Role of primary care, specialised services, NGOs and informal actors

Primary care structures such as the Local Health Units (TOMYs), introduced nationally in 2017, were designed to function as community-based entry points to the ESY system (ESY: National Health System) and to coordinate referrals to specialised services. Evaluations of TOMYs show high patient satisfaction and strong interpersonal quality of care, although accessibility and waiting times remain important challenges. Because mental health services are not consistently integrated into primary care, many residents in Attica still access specialised services directly through hospital outpatient clinics, psychiatric hospitals or private providers.

Non-governmental organisations also represent an important component of the mental health ecosystem in Athens. NGOs operate psychosocial rehabilitation units, supported housing, counselling services and community programmes, often focusing on socially vulnerable populations. Organisations such as EPAPSY are among the largest non-profit providers of community mental health services in Greece, while coordination platforms such as the Athens Coordination Center for Migrant and Refugee Issues facilitate collaboration between the municipality, civil society, international organisations and public authorities. Informal actors including families, peer networks and community organisations also play a role in supporting individuals with mental health needs and often influence pathways into formal care.

Overall, the mental health ecosystem in Attica operates as a complex multi-actor system in which ESY public services provide the core clinical infrastructure, NGOs and community organisations contribute psychosocial support, and the private sector absorbs a substantial share of outpatient demand. While this diversity of actors expands service availability, it also creates system level challenges including fragmentation between providers, uneven distribution of services and limited coordination across health and social care sectors.

3.7.7 Service Exclusion Trends

Despite the extensive network of mental health services available in Athens, significant barriers continue to affect equitable access to care for young people and unaccompanied children. These barriers are not only related to service availability but also to financial constraints, organisational complexity, social and cultural factors, and challenges in the implementation of existing policy frameworks. Understanding these forms of service exclusion is essential for identifying gaps within the mental health ecosystem and informing the development of targeted interventions through the Smart Health Lab. The table below summarises the main exclusion trends that influence access to mental healthcare and psychosocial support services among the priority target groups in Attica.

Table 45 below presents the main service exclusion trends affecting young people and unaccompanied children in Athens. It summarises the key financial, organisational, social, cultural, legal, and policy-related barriers that influence access to mental healthcare and psychosocial support services. These barriers highlight the multiple factors that can affect timely access to care, continuity of support, and engagement with mental health services among vulnerable population groups.

Table 45. Main service exclusion trends affecting youth and unaccompanied children in Attica, Athens, including barriers influencing access to mental healthcare and psychosocial support services.

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Financial	Financial barriers remain an important obstacle despite the existence of mental health services within the Greek National Health System (ESY). Although public mental healthcare is formally available, limited capacity and long waiting times frequently lead families and young adults to seek support from private psychiatrists and psychologists.
	For youth aged 18–26, outpatient psychotherapy and psychiatric follow-up often take place within the private sector, creating significant out-of-pocket costs that may be difficult to afford for students and young adults experiencing unstable employment or limited income.
	For unaccompanied children, direct treatment costs are not usually borne by the child, but access to specialised care may still depend on the resources and operational capacity of NGOs, accommodation facilities, or externally funded programmes when public services are unavailable or delayed.
Geographical and Organisational	In Athens, geographical barriers are linked less to physical distance from services and more to the uneven distribution and limited availability of specialised mental health structures.
	Young people often experience delays in obtaining appointments within public services and may rely on whichever provider has immediate availability rather than following stable and continuous care pathways. For unaccompanied children, geographical barriers may emerge when accommodation facilities are located far from specialised mental health services.
	Frequent relocation of unaccompanied minors within the protection system may additionally disrupt continuity of care and stable therapeutic relationships with mental health professionals.

Social stigma and concerns regarding social judgement continue to discourage early help-seeking among young people, particularly when mental health difficulties are associated with weakness or may negatively affect educational and employment opportunities.

Social and Cultural

Limited awareness regarding available services and uncertainty about referral pathways may further delay contact with mental health professionals.

For unaccompanied children, language barriers, cultural perceptions of mental illness, mistrust towards institutions, and trauma associated with displacement and forced migration may significantly hinder engagement with mental health services.

Legal and Policy-Related

Greece has established formal legal and policy frameworks guaranteeing access to healthcare and protection mechanisms for both youth and unaccompanied children. However, important implementation gaps remain.

For youth, fragmented coordination between primary care, specialised mental health services, and social support systems often creates complex and difficult-to-navigate care pathways. For unaccompanied children, access to care depends on coordination between multiple institutions, including healthcare providers, accommodation structures, guardianship systems, and child protection authorities. Although operational guidelines and training programmes exist, inconsistencies in implementation and continuity of care remain significant challenges.

The Athens mental health ecosystem offers a wide range of services, yet young people and unaccompanied children still face significant obstacles in accessing timely and appropriate care. The main barriers relate to affordability, long waiting times, fragmented referral pathways, limited service visibility, stigma, language difficulties and inconsistent coordination between healthcare, social care and protection actors.

For young people, exclusion is mainly linked to delays in public services, dependence on private care, and limited knowledge of available support options. For unaccompanied children, access is further complicated by trauma, cultural and language barriers, frequent relocation, and reliance on multiple institutions and NGOs.

3.7.8 Priority Areas for Investment within the Mental Health Care System in Attica, Greece

The mapping of the mental health ecosystem in Athens indicates that the main challenges in accessing services are linked less to the absence of mental health structures and more to weaknesses in how the system operates and communicates across institutions. Athens hosts a wide range of psychiatric hospitals, outpatient services, community mental health units and NGO programmes operating within the National Health System (ESY) and the broader social support ecosystem. However, information about available services is not always clearly communicated or easily accessible, making it difficult for individuals to identify where to seek support. As a result, the pathway from recognising a mental health need to actually accessing appropriate care often depends

on personal knowledge, informal recommendations or support from professionals already working within the system.

A second important gap concerns coordination between the multiple actors involved in mental health care. Although formal governance frameworks exist, collaboration between public health services, community structures, social services and non-governmental organisations is not always structured or consistent. In practice, referrals and coordination frequently rely on individual professional networks rather than standardised procedures, which can create variability in how services are accessed and delivered, especially when a need occurs and should be addressed on time. This fragmentation can slow down access to care and make the system difficult to navigate, particularly for vulnerable populations interacting with several institutions simultaneously.

Table 46 below synthesises the key systemic gaps identified within the Athens mental health ecosystem and translates them into priority areas for investment, innovation, and future intervention. Building upon the ecosystem profiling findings, the analysis highlights structural and operational challenges that continue to affect equitable access to mental health support, particularly for vulnerable groups such as young people and unaccompanied children.

Table 46. Priority system gaps, investment needs, and Smart Health Lab alignment for young people and unaccompanied children in Athens, Greece.

System Gap Identified	Current Challenges within the Mental Health Ecosystem	Priority Investment / Innovation Area	Expected Outcomes
Limited Accessibility and Visibility of Mental Health Services	- Although Athens hosts a broad range of mental health providers, information on available services, eligibility criteria, and referral pathways remains fragmented and difficult to navigate. - Young people and unaccompanied children often struggle to identify appropriate support services and available resources.	Development of accessible service directories, digital navigation tools, awareness-raising activities, and targeted mental health information campaigns.	Improved service visibility and accessibility; reduced delays in accessing care; strengthened mental health and digital literacy.
Fragmented Coordination Between Mental Health Actors	- Collaboration between public healthcare providers, municipalities, NGOs, educational institutions, accommodation facilities, and social services remains inconsistent. - Referral mechanisms are often informal, resulting in fragmented care pathways and discontinuity of support.	Strengthening cross-sector collaboration, integrated referral mechanisms, case management approaches, and structured coordination between ecosystem actors.	Improved continuity of care; more efficient referrals; stronger collaboration between ecosystem actors; smoother care pathways for vulnerable populations.
Difficult Navigation of the Mental Health Ecosystem	- The complexity of the mental health, social care, protection, and accommodation systems creates significant barriers for vulnerable groups. - Young people and unaccompanied children may experience difficulties understanding procedures, accessing support, and maintaining continuity of care across multiple services.	Development of person-centred navigation and guidance mechanisms, community-based support models, and user-friendly referral pathways.	Easier navigation of mental health services; earlier access to appropriate support; reduced exclusion and administrative burden for vulnerable groups.
Limited Mental Health and Digital Literacy	Mental health literacy remains uneven, particularly regarding recognition of	Delivery of mental health literacy programmes, digital inclusion initiatives, peer-support activities,	Increased mental health and digital literacy; improved self-navigation

	mental health needs, available support options, and help-seeking pathways. Digital literacy gaps may further limit the ability of vulnerable groups to access online information, digital services, and telehealth solutions.	and community-based awareness actions.	capacities; enhanced accessibility and inclusion within the mental health ecosystem.
Limited Trauma-Informed and Youth-Friendly Mental Health Support	- Young people and unaccompanied children often require specialised support that addresses trauma, displacement experiences, developmental needs, and social integration challenges. - Existing services may not always be sufficiently tailored to these specific needs.	Development of trauma-informed, culturally sensitive, and youth-friendly support approaches, including participatory and co-created interventions.	Improved responsiveness of services to target-group needs; strengthened trust in mental health services; increased engagement and wellbeing among vulnerable young people.

3.7.9 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Athens

In Athens, several actors from the social and solidarity economy contribute to supporting people with mental health needs, particularly through community services, employment integration and psychosocial support initiatives. Initiatives play a central role in this ecosystem, such as Diaplous - The Social Cooperatives of Limited Liability, which consists of the first institutionally recognised legal form of social enterprises in Greece.

The organisations presented in the table below illustrate how social economy actors can contribute to the co-creation, testing, and scaling of innovative mental health solutions while strengthening community-based support pathways within the Athens pilot site.

Table 47. Social Economy Initiatives to be prioritised by the Smart Health Lab in Attica

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>Diaplous Social Cooperatives of Limited Liability (KoiSPE)</u>	Socio-economic inclusion, vocational rehabilitation, therapeutic rehabilitation, employment reintegration for people with psychosocial difficulties	Supports recovery-oriented and community-based mental health approaches through employment inclusion and social participation. Provides opportunities for collaboration on psychosocial rehabilitation and inclusive innovation models.
<u>Galene Neuropsychiatric Clinic</u>	Mental healthcare services, psychiatric treatment, psychosocial support	Provides specialised mental healthcare services and contributes to the broader mental health support ecosystem in Athens.
<u>Social and Solidarity Economy Ecosystem in Athens</u>	Community-based support, psychosocial inclusion, empowerment, service innovation	Social economy initiatives contribute to reducing exclusion and improving accessibility for vulnerable populations through flexible and community-oriented support models. Their strong local presence and collaborative approaches make them suitable partners for Smart Health Labs activities, including digital service visibility, community engagement, and innovative mental health support pathways.

3.7.10 SWOT Analysis of the Greek Pilot Site (Athens) and strategic directions for the design of the Smart Health Lab

Attica combines significant healthcare, research, and digital assets with a strong network of mental health and social support actors. However, fragmentation, capacity constraints, and persistent inequalities continue to hinder equitable access to care. The Smart Health Lab represents an important opportunity to leverage existing strengths while addressing coordination, navigation, literacy, and accessibility challenges for young people and unaccompanied children.

Table 48. SWOT Analysis for the Greek Pilot Site

Strengths	Weaknesses
Extensive network of mental health providers, including psychiatric hospitals, university hospitals, community mental health centres, NGOs, and private practitioners.	Mental health services are fragmented, with limited coordination between healthcare, social services, municipalities, NGOs, and educational institutions.
Strong digital infrastructure, including e-prescription services, gov.gr platforms, and widespread broadband connectivity.	Long waiting times in public mental health services and insufficient capacity, particularly for child and adolescent psychiatry and trauma-informed care.
Presence of major universities, research centres, innovation hubs, and a dynamic digital health ecosystem.	Difficult system navigation due to complex referral pathways and fragmented information on available services.
Universal healthcare coverage through EOPYY, providing formal access to mental health services.	Persistent mental health literacy gaps and stigma, particularly among vulnerable populations and certain cultural communities.
Strong presence of NGOs and specialised organisations supporting migrants, refugees, young people, and unaccompanied children.	Preventive and community-based mental health services remain underdeveloped relative to population needs.
Large concentration of specialised expertise and professional resources compared to other Greek regions.	Digital exclusion persists among older adults, migrants, and low-income groups despite overall digital advancement.
Opportunities	Threats
Development of the EQUICARES Smart Health Lab to improve service navigation, coordination, digital inclusion, and mental health literacy.	Growing demand for mental health services may continue to exceed available capacity.
National Mental Health Action Plan and ongoing psychiatric reform promoting community-based care and service integration.	Economic pressures, housing insecurity, inflation, and employment precarity increase psychosocial distress among young people and vulnerable groups.
Greece 2.0 Recovery and Resilience Plan supports healthcare digitalisation and service modernisation.	Persistent workforce shortages and funding constraints may delay implementation of reforms and service expansion.
Expansion of digital mental health tools, service directories, AI-supported navigation, and telehealth solutions.	Digital transformation may unintentionally widen inequalities if vulnerable groups are not adequately supported.
Strengthening collaboration among public services, municipalities, NGOs, universities, and community organisations.	Climate-related risks, including heatwaves and wildfires, are increasingly associated with psychological distress and trauma.
Availability of EU and national funding streams focused on social inclusion, youth support, digital health, and community mental healthcare.	Urban stressors such as air pollution, noise, overcrowding, and poor housing conditions continue to negatively affect mental wellbeing.

Strategic directions for the design of the Smart Health Lab in Athens

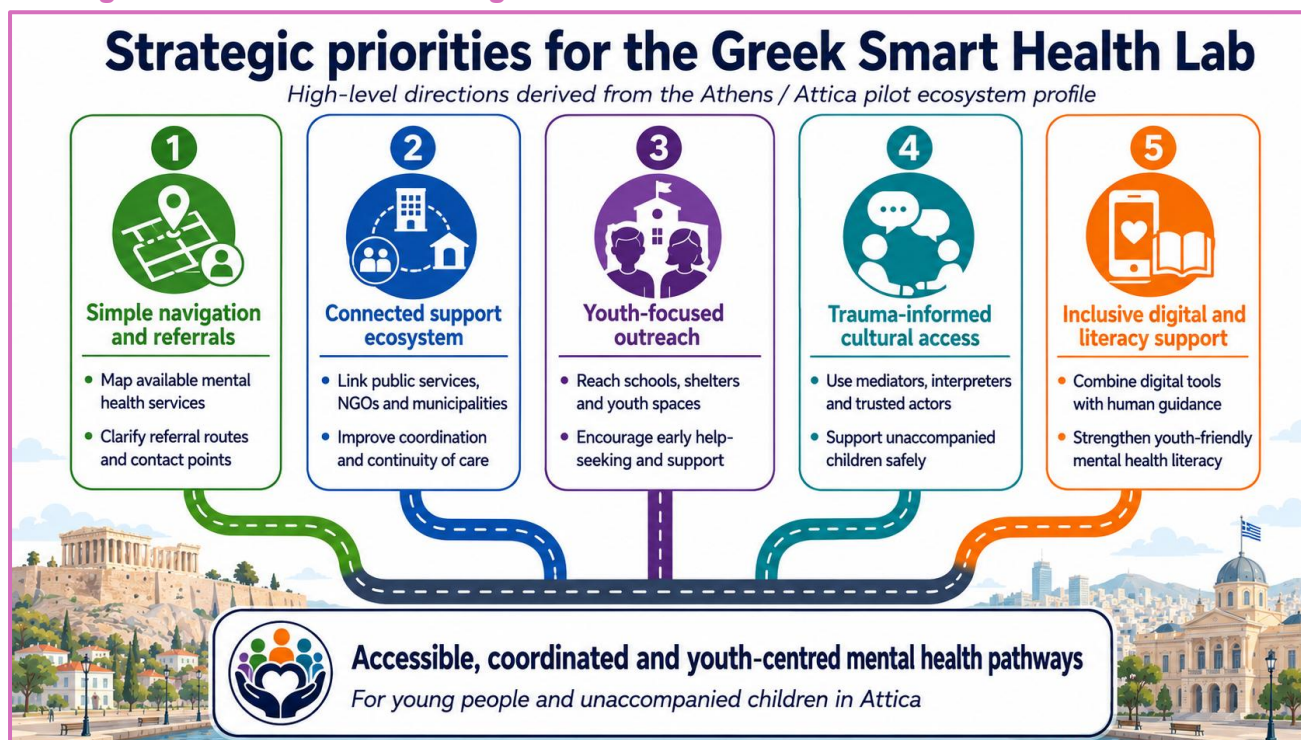


Figure 28. Strategic directions for the design of the Greek Smart Health Lab in Athens

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Greek Smart Health Lab in Athens could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

Based on the SWOT analysis, the Athens Smart Health Lab could be designed as a practical access, coordination and co-creation mechanism for young people and unaccompanied children in Attica. Its main purpose would be to make the existing mental health ecosystem easier to navigate, more responsive to vulnerable groups, and better connected across public services, NGOs, municipalities, educational actors, child protection structures and digital health initiatives.

Establish a local mental health navigation and referral mechanism

The Lab could address the difficulty of navigating Athens' fragmented mental health system by creating a practical navigation mechanism for young people, unaccompanied children and frontline professionals. This could include a regularly updated map of available public, municipal, NGO and community-based services; clear referral information; contact points; eligibility criteria; language availability; and guidance on where to seek support depending on the level of need. This direction might respond directly to the weaknesses of fragmented information, unclear referral pathways and uneven access to specialised services.

Create a multi-actor coordination space for public services and NGOs

The Lab could bring together key actors that currently operate in parallel, including public mental health services, municipal social services, NGOs supporting migrants and refugees, youth organisations, accommodation facilities, schools, universities and child protection actors. Regular coordination meetings or working groups could be used to identify bottlenecks, improve referral practices, avoid duplication and strengthen continuity of care. This would help transform Athens' strong institutional and civil society presence into a more connected support ecosystem.

Prioritise outreach to young people and unaccompanied children

The Lab could not rely only on service users actively seeking support. It would develop outreach activities in places where young people and unaccompanied children already interact with support systems, such as schools, universities, youth centres, shelters, accommodation facilities, NGO premises and municipal structures. Outreach could focus on early identification of psychosocial needs, awareness of available services, reduction of stigma and encouragement of timely help-seeking.

Develop trauma-informed and culturally sensitive access pathways

For unaccompanied children, the Lab could work with cultural mediators, interpreters, guardianship actors, accommodation staff and specialised NGOs to make mental health support more accessible and trusted. Activities could take into account trauma, displacement, language barriers, cultural perceptions of mental illness and mistrust towards institutions. This direction could include guidance for frontline professionals on how to communicate mental health support in a safe, non-stigmatising and age-appropriate way.

Strengthen youth-friendly mental health literacy actions

The Lab could develop targeted mental health literacy activities for young people aged 18–26, including students, unemployed youth and young adults facing economic insecurity. These activities could explain common mental health difficulties, available forms of support, how to access public and community services, and when to seek professional help. The format could be simple, youth-friendly and adapted for both online and in-person delivery.

Use digital tools without widening exclusion

Athens' strong digital infrastructure could be used to improve access, but not as a substitute for human support. The Lab could support digital service directories, multilingual information materials, AI-supported navigation, telehealth signposting and simple online guidance tools. At the same time, it could provide offline support through helpdesks, printed information, workshops and direct guidance for users with limited digital skills, limited connectivity or language barriers.

Support capacity-building for professionals and community actors

The Lab could train and support professionals and community actors who act as entry points to the mental health ecosystem. This includes NGO staff, municipal social workers, youth workers, educators, accommodation facility staff, cultural mediators and volunteers. Capacity-building could focus on mental health literacy, referral pathways, digital tools, trauma-informed communication, cultural sensitivity and early identification of needs.

Co-design practical solutions with users and frontline organisations

The Lab could organise co-creation workshops with young people, representatives of unaccompanied children where ethically appropriate, NGOs, public services, social economy actors and mental health professionals. These workshops might not remain at consultation level; they could lead to practical outputs, such as improved referral tools, multilingual access guides, outreach formats, service navigation protocols, peer-support models or pilot awareness campaigns.

Connect social economy initiatives with mental health inclusion

The Lab could explore how social economy and community-based organisations could contribute to psychosocial wellbeing, social inclusion and access to care. This might include collaboration with youth initiatives, migrant/refugee organisations, social cooperatives, community centres and grassroots groups that can provide trusted spaces, peer support, empowerment activities and links to formal care pathways.

3.7.11 Useful Resources

Table 49. Key healthcare, social protection, migrant support, digital governance and community resources for the Athens / Attica pilot site

Resource / Initiative	Official Link
Athens Coordination Center for Migrant and Refugee Issues (ACCMR)	https://www.accmr.gr
Attikon University Hospital	https://www.attikonhospital.gr
Child Guarantee National Action Plan	https://childguarantee.gov.gr
	https://diaplous.eu/en/social-cooperatives-koispe/
DYPA – Public Employment Service	https://www.dypa.gov.gr
Eginition Hospital	https://www.eginitionhospital.gr
EPAPSY – Association for Regional Development and Mental Health	https://www.epapsy.gr
EOPYY – National Organisation for Healthcare Services Provision	https://www.eopyy.gov.gr
gov.gr – Greek Government Digital Services	https://www.gov.gr
Greece 2.0 – Recovery and Resilience Plan	https://greece20.gov.gr
KYADA – Athens Homeless Shelter and Social Support Centre	https://kyada-athens.gr
METAdrasi	https://metadrasi.org
Ministry of Migration and Asylum	https://migration.gov.gr
National Action Plan for Mental Health 2021–2030	https://www.moh.gov.gr
National Technical University of Athens (NTUA)	https://www.ntua.gr
PRAKSIS	https://praksis.gr
TOMY – Local Health Units	https://tomy.moh.gov.gr
Athens University of Economics and Business (AUEB)	https://www.aueb.gr
World Health Organisation Greece Office	https://www.who.int/greece

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3.8 Veliko Tarnovo – North-central region (Bulgaria)

3.8.1 Geographical Context & Demographic Overview

The Bulgarian pilot site is located in the Northern Central Region (BG32), specifically in the Veliko Tarnovo district (BG321), and covers the municipalities of Strazhitsa and Pavlikeni. Strazhitsa municipality is characterised by a diversified semi-mountainous landscape that combines parts of the central Danubian hilly plain and the Fore-Balkan region, with altitudes ranging from approximately 40

to 420 metres. Due to its proximity to the Balkan Mountains, also known as Stara Planina, and its natural landscape, the territory is considered suitable for rural tourism and hiking. The municipality covers an area of approximately 512 km².

Pavlikeni municipality is primarily situated within the central Danubian Plain and is characterised by fertile plains, rolling hills and the presence of the Rositsa River. It covers an area of approximately 622.56 km². Together, the municipalities of Strazhitsa and Pavlikeni have an estimated combined population of around 22,000–23,000 residents, according to the 2021 National Census. Both municipalities are experiencing population decline, demographic ageing and continued outmigration of younger residents towards larger urban centres and abroad. A high proportion of the local population is aged over 60 years, which increases pressures on social care, healthcare and community support systems.

The majority of residents identify as ethnic Bulgarian, while both municipalities also host significant Roma communities, particularly in specific villages and neighbourhoods. In Strazhitsa municipality, the Roma population is estimated to represent approximately 10–15% of residents, while in Pavlikeni municipality estimates range between 8–12%, depending on settlement patterns. Socioeconomic inequalities between ethnic Bulgarian and Roma populations remain substantial, especially in relation to employment, educational attainment, housing conditions and continuity of health insurance coverage. These disparities increase vulnerability to poor mental health outcomes and create additional barriers to accessing healthcare, mental health services and psychosocial support.

Demographic pressures and socioeconomic vulnerability

The pilot area is strongly affected by demographic ageing and population decline. The outmigration of younger residents towards larger urban centres and abroad reduces the local labour force and places additional pressure on older adults, families and community support systems. These demographic trends affect the long-term economic sustainability of the municipalities and increase demand for accessible health, social care and psychosocial support services.

Figure 29 below presents the population profile of the Strazhitsa and Pavlikeni municipalities, focusing on ethnic composition and age structure. In terms of ethnic composition, the majority of the population is ethnic Bulgarian, representing 82.0% of residents. Roma communities account for 13.0%, while other minorities represent 5.0% of the population. This indicates that, although ethnic Bulgarians form the dominant population group, Roma communities constitute a significant minority within the pilot area.

The age structure shows a demographically ageing population. Working-age residents aged 18–64 represent the largest group, accounting for 58.0% of the population. Elderly residents aged 65 and above make up 26.0%, while children aged 0–17 represent 16.0%. The relatively high share of older adults highlights the demographic pressures affecting the municipalities, including increased demand for healthcare, social care and community-based support services.

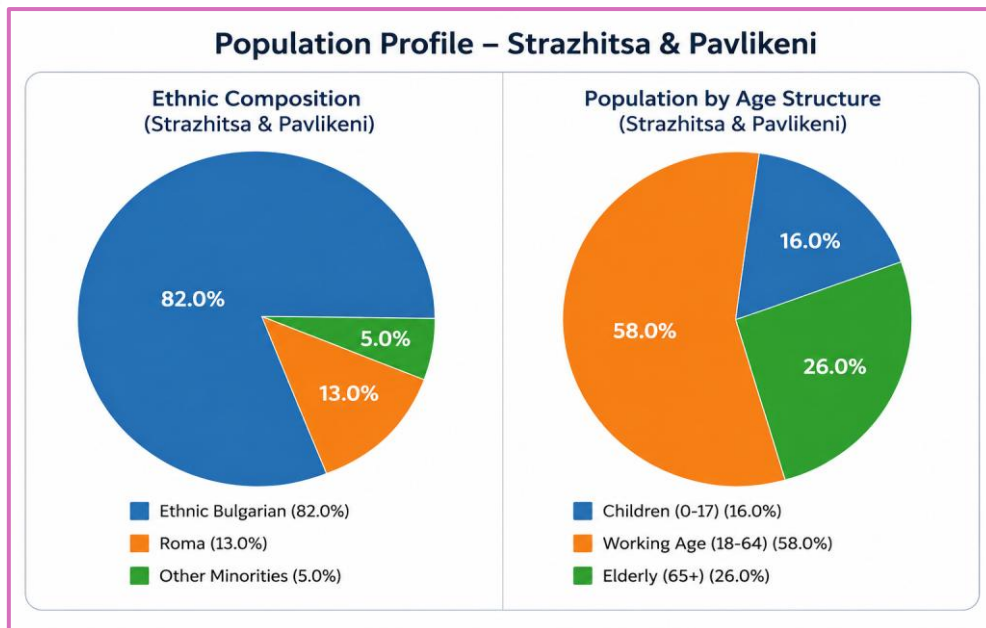


Figure 29. Demographic Profile of the Population in Strazhitsa and Pavlikeni Municipalities

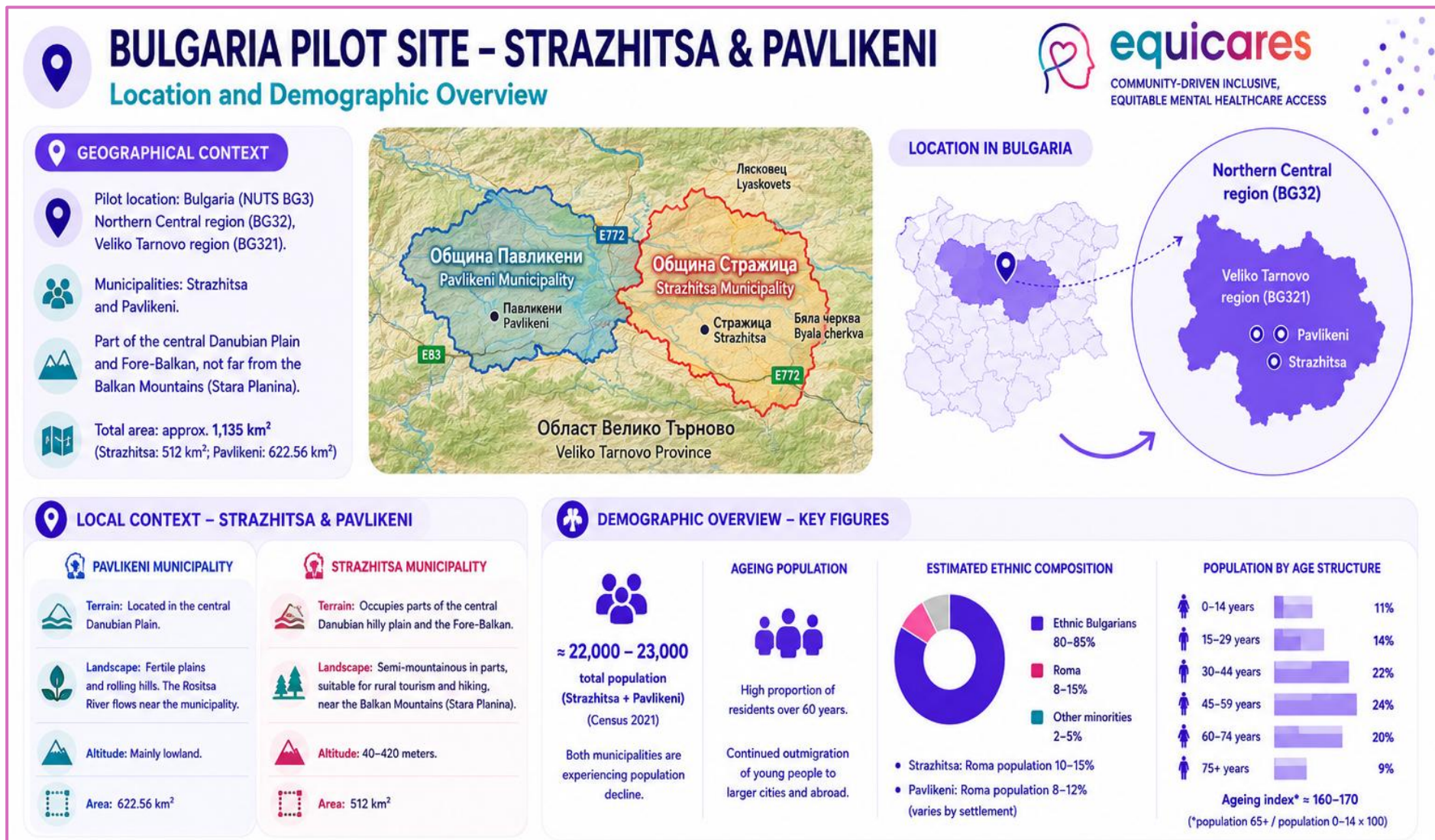


Figure 30. Veliko Tarnovo (Bulgaria) Pilot Site Location and Demographic Overview

3.8.2 Techno-Economic Context

This section examines the socioeconomic and digital conditions shaping access to mental health and psychosocial support in Strazhitsa and Pavlikeni. The pilot area faces a combination of rurality, limited employment opportunities, demographic ageing, uneven digital access and affordability barriers. These factors influence residents' ability to access information, use digital and health services, maintain stable health insurance coverage and receive specialised mental healthcare.

Digital infrastructure and territorial inequalities

Digital infrastructure is available across the pilot territory, but access remains uneven, particularly in smaller villages and socioeconomically marginalised areas. Rural settlements often face more limited access to stable internet connectivity and digital technologies. This creates additional barriers for residents who could otherwise benefit from e-government services, online information, telehealth solutions and digital mental health resources.

Digital literacy and access to online services

Digital literacy levels remain comparatively low among older adults and vulnerable populations, particularly within Roma communities. Limited digital skills reduce the ability of these groups to use online public services, digital health tools and mental health information platforms. As a result, digitalisation alone may not improve access unless it is accompanied by targeted guidance, training and offline support.

Limited development of telehealth and digital mental health tools

Telehealth services and digital mental health support systems remain minimally developed at local level. This is particularly relevant for rural municipalities, where specialised mental health professionals and services may be limited or located at a distance. The limited availability of digital mental health support contributes to territorial inequalities and reinforces dependence on already constrained local and regional healthcare structures.

Digital access and local service uptake

National e-government and some telehealth options are available, but their use remains limited in the pilot area. Digital tools could help reduce territorial barriers, yet they are not sufficiently embedded in local mental health support.

The main constraints are:

- limited digital skills among older adults and vulnerable groups;
- uneven internet connectivity in smaller villages;
- affordability barriers related to devices and internet access;
- limited awareness of available digital services;
- absence of structured local tele-mental health provision.

Digital solutions therefore need to be accompanied by face-to-face support, training and non-digital access points.

Economic structure and employment conditions

Strazhitsa and Pavlikeni municipalities are characterised by a predominantly rural economic structure. Local economies rely mainly on agriculture, small-scale manufacturing, trade and public sector employment. Employment opportunities remain limited, particularly in smaller settlements, where seasonal work, informal labour and unstable income conditions are common. These factors contribute to financial insecurity and socioeconomic vulnerability, both of which are important social determinants of mental health.

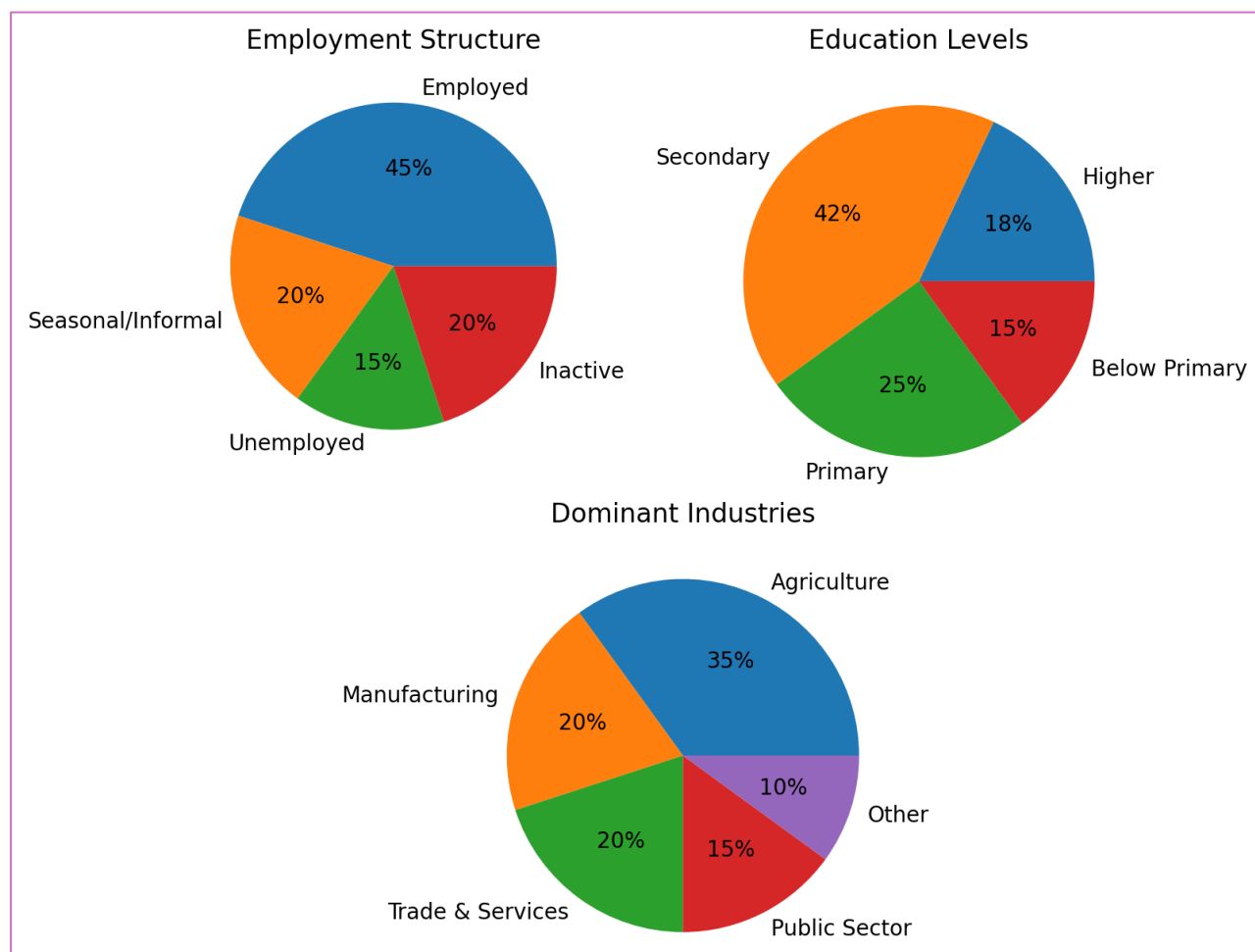


Figure 31. Employment Structure, Education Levels, Dominant Industries

The figure above shows that employment in the pilot area is relatively limited and marked by economic vulnerability. Employed residents represent 45% of the population, while 15% are unemployed. A further 20% are engaged in seasonal or informal work, indicating unstable income patterns and limited employment security. Another 20% of residents are economically inactive. This employment profile reflects the rural and semi-peripheral character of the municipalities and highlights the socioeconomic pressures that may affect mental health and access to care.

The education profile shows that secondary education is the most common level of attainment, accounting for 42% of the population. Primary education represents 25%, while 18% have higher education. At the same time, 15% of residents have below-primary education levels. This indicates that a significant share of the population may face barriers related to low literacy, limited access to information, and reduced ability to navigate healthcare, social support and digital services.

The local economy is mainly based on agriculture, which accounts for 35% of economic activity. Manufacturing and trade and services each represent 20%, while the public sector accounts for 15%. Other sectors represent 10%. This structure confirms the rural economic profile of Strazhitsa and Pavlikeni, with dependence on agriculture, small-scale employment and local services. The limited diversification of the economy may contribute to income insecurity, outmigration and reduced access to specialised health and mental health resources.

Health insurance, affordability and access to specialised care

Access to specialised healthcare remains closely linked to health insurance coverage, which is often dependent on employment status and regular social insurance contributions. Long-term unemployed individuals, informal workers and economically vulnerable households may experience interruptions in coverage, creating barriers to specialised mental healthcare. At the same time, private psychological and psychiatric care is largely unaffordable for low-income populations, increasing reliance on limited public services and further restricting timely access to care.

Figure 32 explains that most residents in the pilot area are continuously insured, representing 65% of the population. However, 20% experience interrupted health insurance coverage, while 15% are uninsured or have irregular coverage. This indicates that a significant share of residents may face administrative, financial or eligibility-related barriers when trying to access specialised healthcare and mental health services. These barriers are particularly relevant for unemployed people, informal workers and economically vulnerable households.

The second chart illustrates the limited and uneven structure of mental health service provision in the area. General practitioners represent the main point of access, accounting for 45% of the service structure, followed by specialised psychiatric services through external referral at 25%. School-based support accounts for 15%, while psychologists remain limited at 10%. Community mental health centres are largely absent, represented at only 5%. Overall, the figure highlights the strong dependence on primary care and external referrals, combined with limited local specialised and community-based mental health capacity.

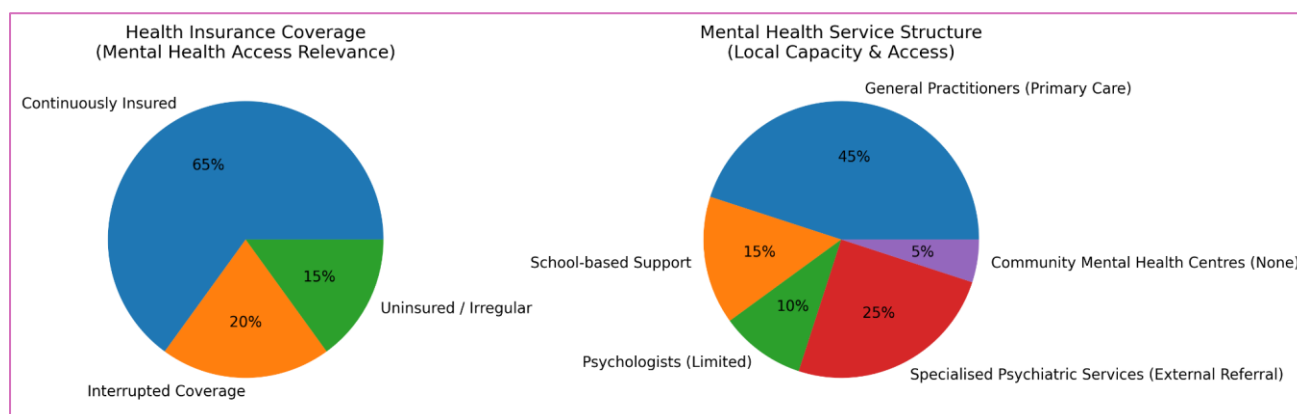


Figure 32. Health Insurance Coverage, Mental Health Service Structure

3.8.3 Ecological and Environmental Factors

The pilot area is predominantly rural, with Strazhitsa and Pavlikeni acting as small municipal centres for surrounding villages and dispersed rural communities. Low population density and settlement dispersion shape everyday access to services, particularly as specialised healthcare and psychiatric care are concentrated mainly in Veliko Tarnovo.

Transport and distance-related barriers

Access to specialised mental healthcare is constrained by limited public transport between villages, municipal centres and Veliko Tarnovo. Services are often difficult to reach outside standard working hours, and residents may need private transport or several bus connections to attend appointments. This creates particular barriers for:

- low-income households without access to a car;
- Roma families living in peripheral settlements;
- older adults with reduced mobility;
- people requiring follow-up consultations or urgent mental health support.

In practice, distance, transport costs and limited mobility reinforce inequalities in access to care.

Environmental and seasonal access constraints

The region benefits from relatively favourable environmental conditions, including low industrial pollution, clean air and agricultural landscapes. However, seasonal conditions may temporarily restrict access to services, especially in more remote settlements.

Access may be affected by:

- winter snow and icy roads;
- occasional flooding;
- poor road conditions in some villages;
- isolation of elderly residents living alone;
- delays in reaching health or social care services during adverse weather.

These conditions are particularly relevant for residents who already face limited mobility, poverty or social exclusion.

Housing and living conditions

Housing conditions vary across Strazhitsa and Pavlikeni. Although the municipalities do not face a major urban housing crisis, economic hardship affects housing quality in some settlements, especially in marginalised Roma neighbourhoods. Overcrowding, inadequate infrastructure, poor heating conditions, energy poverty and limited capacity for household repairs create additional pressures for vulnerable households. These conditions can contribute to chronic stress, insecurity and poorer mental wellbeing, particularly where poverty is combined with limited access to health and social support services.

Older adults living in depopulating villages face additional challenges linked to territorial isolation, weakened family networks and deteriorating housing conditions. Youth outmigration has reduced informal support structures, leaving many elderly residents with fewer opportunities for regular social contact and practical assistance. Limited transport connections and difficulties reaching municipal or regional services further increase isolation, especially during winter or periods of bad weather. For this group, mental health vulnerability is closely connected to living alone in remote settlements, reduced community support and limited access to locally available care. This highlights the importance of community-based outreach and accessible support services within the pilot area.

3.8.4 Regulatory and Policy Landscape

The regulatory and policy framework governing mental health services in Bulgaria is centrally regulated and applies uniformly across all municipalities, including Strazhitsa and Pavlikeni. Local implementation depends on municipal structures, regional health authorities and social service providers.

The main legal and strategic documents relevant to mental health policy are presented in [Table 50](#):

Table 50. National Mental Health Policy and Strategic Frameworks in Bulgaria

Policy / Framework	Description and Relevance to Mental Health
Health Act	The primary legislative framework governing healthcare in Bulgaria. It regulates mental health services, patient rights, involuntary treatment procedures, and the protection of individuals receiving mental healthcare.
National Mental Health Strategy 2021–2030	Establishes the national vision for mental health reform, focusing on the development of community-based services, deinstitutionalisation, improved accessibility, prevention, and social inclusion of people with mental health conditions.
National Health Strategy 2030	Provides the overarching strategic framework for the Bulgarian health system, including objectives related to mental health promotion, disease prevention, health equity, and improved service delivery.
National Programme for Prevention of Suicide and Promotion of Mental Health	Supports awareness-raising, prevention initiatives, early intervention measures, and actions aimed at improving population mental wellbeing and reducing suicide risk.
National Framework Contract with the National Health Insurance Fund (NHIF)	Regulates the financing and reimbursement of healthcare services, including psychiatric care and selected psychological services, defining the conditions under which mental health support is covered by public health insurance.

At the regional level, the Regional Health Inspectorate (RHI) in Veliko Tarnovo oversees implementation of national mental health regulations. However, there are no dedicated municipal mental health strategies specific to Strazhitsa or Pavlikeni.

Inclusion and Minority-Focused Policies

Roma inclusion and minority-focused policies form an important part of the wider social and health context in Bulgaria, particularly in municipalities such as Strazhitsa and Pavlikeni, where Roma communities represent a significant share of the local population. These frameworks recognise that Roma communities and other vulnerable groups continue to face structural inequalities in education, employment, housing, healthcare access and social participation. Although they do not always refer directly to mental health, they are highly relevant for the pilot site because these same inequalities are closely linked to psychosocial vulnerability, reduced access to care and poorer wellbeing outcomes. Regarding Roma and minority inclusion, the following national frameworks are particularly relevant:

Table 51. National Social Inclusion and Roma Integration Policy Frameworks in Bulgaria

Policy / Framework	Description
National Strategy for Equality, Inclusion and Participation of Roma (2021–2030)	Focuses on education, employment, healthcare, and housing. It follows the European Roma Strategic Framework adopted by the European Commission in October 2020 and was approved by the Bulgarian Council of Ministers on 5 May 2022. Following its

adoption, municipalities, including Strazhitsa and Pavlikeni, developed Local Plans for Equality, Inclusion and Participation of Roma. Mental health is not explicitly included in either the national strategy or the local plans.

National Strategy for Reducing Poverty and Promoting Social Inclusion 2030	Addresses poverty reduction and social inclusion measures targeting vulnerable populations, including ethnic minorities.
Child Protection Act and Related Social Service Legislation	Provides the legal framework for child protection and social support measures, including interventions for vulnerable children and families.
Social Services Act (2019)	Regulates the provision, organisation, and delivery of community-based social services in Bulgaria.
Implementation Context	These policies acknowledge inequalities affecting Roma communities; however, implementation at the local level often depends on municipal capacity and project-based funding.

These policy frameworks acknowledge the social inequalities affecting Roma communities and other vulnerable groups, but their implementation remains uneven at local level. Municipalities often depend on limited administrative capacity, external funding and project-based initiatives to deliver inclusion measures. For Strazhitsa and Pavlikeni, this means that policy commitments do not always translate into stable, accessible and continuous support on the ground. From the perspective of the Smart Health Lab, this creates an opportunity to connect Roma inclusion, poverty reduction, child protection and community-based social services more explicitly with mental health promotion, psychosocial support and improved access to care.

Training and Professional Regulation

Mental health professionals (psychiatrists, psychologists) are regulated through:

- Bulgarian Medical Association (for psychiatrists)
- Professional psychological associations (non-uniform regulation for psychologists)

Unlike psychiatrists, psychological counselling and psychotherapy services are not uniformly regulated under a single licensing act, and many private providers operate outside the public health reimbursement framework.

Training on cultural competence and minority inclusion is not systematically embedded in all mental health services, and structured outreach programmes targeting Roma communities are limited.

Identified Gaps and Implementation Challenges

Although Bulgaria has established national strategies and legislation relevant to mental healthcare, social inclusion, child protection and Roma integration, several implementation gaps remain visible in Strazhitsa and Pavlikeni. These gaps are linked less to the absence of formal policy frameworks and more to the limited capacity to translate national priorities into locally accessible, continuous and culturally appropriate support.

A major challenge is the centralisation of specialised mental health services. Psychiatric care and specialist consultations are largely concentrated in regional centres, particularly Veliko Tarnovo. For residents of smaller villages, this creates distance-related barriers, especially when public transport is limited or when households cannot afford private transport. As a result, access to specialist assessment, follow-up care and crisis support may be delayed or avoided altogether.

Another key gap concerns the limited availability of community-based mental health services. Despite national policy commitments towards deinstitutionalisation and community-based care, local multidisciplinary mental health teams are not available in Strazhitsa and Pavlikeni. This leaves general practitioners, social workers, schools, municipal services and NGOs to respond to psychosocial needs without sufficient specialist support. The absence of local community mental health structures is particularly problematic for older adults, Roma communities and low-income families facing multiple vulnerabilities.

The pilot area also faces fragmented coordination between the health and social care sectors. Cooperation between general practitioners, social workers, psychologists, schools, municipal services and psychiatric specialists is not always systematic. Referrals often depend on informal contacts, personal initiative or project-based cooperation rather than stable protocols. This can result in delayed support, duplication of efforts and weak continuity of care, especially for people requiring both social assistance and mental health support.

Insurance-based access barriers remain another important obstacle. Access to specialised healthcare in Bulgaria is closely linked to health insurance coverage, which may be interrupted among long-term unemployed people, informal workers and economically vulnerable households. In Strazhitsa and Pavlikeni, where seasonal and informal employment are common, interruptions in insurance contributions can reduce access to specialist mental healthcare and reinforce reliance on already limited local services.

There is also a clear need for more culturally adapted mental health support. While Roma inclusion is addressed through national and local policy frameworks, Roma-focused mental health outreach is not systematised. Mental health information, prevention activities and referral support are not consistently adapted to the needs, language, trust barriers and lived experiences of Roma communities. This may contribute to lower service use, delayed help-seeking and limited engagement with formal institutions.

Finally, affordability remains a significant barrier due to the limited regulation and accessibility of private psychological services. Many psychological and psychotherapeutic services are available mainly through the private sector and require direct out-of-pocket payment. For low-income families, unemployed residents and marginalised households, these costs are largely unaffordable. This reinforces unequal access to timely psychological support and increases dependence on public structures that may be distant, overburdened or difficult to reach.

3.8.5 Priority PVS and Current Mental Health Needs

The Bulgarian pilot focuses on the municipalities of Pavlikeni and Strazhitsa, where Roma communities and other ethnic and religious minority groups, including Millet and Rudari populations, have been identified as the priority PVS. These groups face a range of social and structural challenges that can negatively affect mental wellbeing and access to support services and are presented in the following table:

Table 52. Priority People in Vulnerable Situations (PVS) and Mental Health-Related Challenges in the Pavlikeni and Strazhitsa Municipalities

Priority PVS	Characteristics and Mental Health-Related Challenges
Roma Communities	Experience discrimination, anti-Roma stereotypes, and social exclusion in everyday life, including bullying and unequal treatment in public spaces. These experiences can contribute to psychological distress, particularly among young people. Strong stigma surrounding mental health often discourages individuals from seeking professional support.
Ethnoreligious Minorities (Millet and Rudari Communities)	Although not all members identify as Roma, they are often perceived as Roma by the wider population and may experience similar forms of discrimination, prejudice, and exclusion. Mental health stigma and limited help-seeking behaviours are also reported within these communities.
Young People from Minority Communities	Young people, especially girls, may be affected by practices such as early marriage and limitations on educational opportunities. These factors can influence wellbeing, personal development, and mental health outcomes.
Residents of Rural and Remote Areas	Limited availability of mental health services in Pavlikeni and Strazhitsa creates additional barriers to care. Individuals seeking specialised mental health support often need to travel to larger urban centres such as Veliko Tarnovo or Gorna Oryahovitsa, reducing accessibility and continuity of care.

Figure 33 provides a visual overview of the Bulgaria pilot site, focusing on Roma communities and ethnoreligious minorities, including Millet and Rudari communities, as priority groups in vulnerable situations. The figure summarises the main contextual factors affecting mental health and wellbeing, including discrimination, social exclusion, bullying, mental health stigma and limited trust in formal support systems.



BULGARIA PILOT SITE

Priority People in Vulnerable Situations (PVS):
Roma Communities & Ethnoreligious Minorities



equicares

COMMUNITY-DRIVEN, INCLUSIVE,
EQUITABLE MENTAL HEALTHCARE ACCESS



1. PRIORITY GROUPS

1 ROMA COMMUNITIES

- Experience discrimination and anti-Roma stereotypes
- Face social exclusion in everyday life

- Young people may be affected by bullying and unequal treatment
- Mental health stigma can discourage professional support-seeking

2 ETHNORELIGIOUS MINORITIES (MILLET & RUDARI)

- Not all members identify as Roma
- Often perceived as Roma by the wider population

- May experience similar prejudice, discrimination and exclusion
- Mental health stigma and limited help-seeking are also reported



Both groups may face cumulative disadvantage linked to discrimination, exclusion and low trust in formal support systems.

2. ABOUT THE PRIORITY CONTEXT



Discrimination and exclusion can generate psychological distress and reduce wellbeing.



Bullying and unequal treatment may particularly affect young people.



Stigma around mental health and low trust in services can reduce help-seeking and continuity of care.

3. KEY BARRIERS & SUPPORT PRIORITIES



Anti-Roma stereotypes and prejudice



Social exclusion and unequal treatment



Bullying affecting young people



Mental health stigma



Limited help-seeking behaviours



Need for culturally sensitive and trusted support



Importance of community outreach and mediation



Inclusive, accessible and equitable mental healthcare access

4. KEY MENTAL HEALTH NEEDS



Psychological distress linked to discrimination and exclusion



Support for young people facing bullying



Safer and more inclusive community environments



Mental health literacy and stigma reduction



Trusted, culturally responsive and accessible care

5. PRIORITY ACTION AREAS



Community-based outreach and engagement



Anti-stigma and awareness-raising activities



Trusted mediators and local organisations



Early support and clearer referral pathways



Youth-sensitive and culturally adapted responses

6. WHY THESE GROUPS ARE PRIORITISED



Discrimination and exclusion may undermine mental wellbeing.



Stigma and low help-seeking can delay access to support.



Inclusion and community action can reduce inequalities and strengthen wellbeing.

Figure 33. Priority PVS and their Current Mental Health Needs in Veliko Tarnovo, Bulgaria

The Veliko Tarnovo Smart Health Lab will prioritise Roma communities and other ethnoreligious minority groups, including Millet and Rudari communities, in the municipalities of Strazhitsa and Pavlikeni. This reflects both the project objectives and the specific social and structural vulnerabilities identified in the local ecosystem. These groups face heightened vulnerability due to the interaction of poverty, discrimination, rural isolation, low mental health literacy, limited access to specialised services, and persistent barriers in navigating healthcare and social support systems.

Roma communities constitute a significant minority population within the pilot area, particularly in specific villages and neighbourhoods of Strazhitsa and Pavlikeni. Although exact figures vary depending on settlement patterns and self-identification, Roma residents are estimated to represent an important share of the local population. These communities often experience multiple and overlapping disadvantages, including socioeconomic exclusion, lower educational attainment, unstable employment, poor housing conditions, interrupted health insurance coverage, and discrimination in everyday life. These factors can negatively affect mental wellbeing and increase barriers to accessing timely and appropriate mental health and psychosocial support.

The mental health needs of Roma communities are closely linked to the broader social determinants of wellbeing. Experiences of poverty, anti-Roma stereotypes, social exclusion, bullying, unemployment, financial insecurity and poor living conditions may contribute to anxiety, stress, emotional distress, low self-esteem and reduced trust in formal institutions. Mental health stigma can also discourage individuals and families from seeking support, while limited awareness of available services may delay help-seeking until needs become more severe. Young people from Roma communities may be particularly affected by school exclusion, limited future opportunities, early marriage practices in some contexts, and experiences of discrimination, all of which can shape mental health outcomes and social participation.

Ethnoreligious minority groups, including Millet and Rudari communities, represent a second important focus of the Veliko Tarnovo Smart Health Lab. Although not all members of these communities identify as Roma, they may be perceived as Roma by the wider population and may experience similar forms of prejudice, social exclusion and unequal treatment. Their access to mental health support may also be affected by stigma, low trust in institutions, limited mental health literacy, poverty, and difficulties navigating health and social care systems.

Access to mental healthcare in Strazhitsa and Pavlikeni is further shaped by the rural and semi-peripheral character of the pilot area. Specialised mental health services are limited locally, and residents often need to travel to larger urban centres such as Veliko Tarnovo or Gorna Oryahovitsa to access psychiatric or psychological support. Limited public transport, transport costs, health insurance interruptions and the unaffordability of private psychological services further reduce practical access to care.

3.8.6 Local Mental Health Ecosystem

Mental health care in Strazhitsa and Pavlikeni is primarily organised through the public healthcare system, with general practitioners (GPs - Personal doctors) acting as the first point of contact. GPs assess patients and refer them to specialised psychiatric services, which are mainly located in the regional centre of Veliko Tarnovo. Private psychological services are available in the wider region but usually require out-of-pocket payment, which limits access for low-income populations. Municipal social services and schools provide some psychosocial support for vulnerable individuals and families, but there are no dedicated community-based mental health centres in the municipalities.

Mental health governance is largely centralised at the national level, with policies implemented by the Ministry of Health and supervised regionally by the Regional Health Inspectorate. At the municipal level, local authorities coordinate social services and cooperate with health institutions and schools. However, formal coordination mechanisms between health, social and educational sectors are limited, and collaboration often occurs on an informal or case-by-case basis.

Role of Primary Care, Specialised Services, NGOs and Informal Actors

Primary care providers (GPs) play a key role in identifying mental health problems and referring patients to specialised services. Specialised mental health care, including psychiatric treatment, is mainly provided outside the municipalities in Veliko Tarnovo. Municipal social workers and school psychologists support vulnerable individuals and children, particularly in cases involving social risk or family difficulties. NGOs working directly on mental health issues are limited locally, although some organisations address social inclusion and minority support. Informal actors, including family members and community networks, particularly within Roma communities, often provide the first line of emotional support.

In practice, the mental health system faces several challenges, including limited local specialist capacity, fragmentation between health and social services, and geographic barriers to accessing specialised care. Coordination between GPs, social workers and mental health specialists is inconsistent, and preventive or community-based mental health services are limited. Financial barriers and lower mental health literacy further restrict access for vulnerable groups, particularly Roma and other minority communities.

3.8.7 Service Exclusion Trends

Roma communities and other ethno-religious minorities in Strazhitsa and Pavlikeni municipalities face a range of structural barriers that limit their access to mental health services. These barriers are largely linked to socioeconomic inequalities, geographic isolation, and social stigma, which together create significant obstacles to timely and effective mental health support. At the same time, poverty, unstable employment, interruptions in health insurance coverage, discrimination, and strong stigma surrounding mental health further affect help-seeking behaviours among vulnerable groups. [Table 53](#) below presents the main forms of service exclusion and the specific barriers influencing access to mental healthcare in the Pavlikeni and Strazhitsa pilot area.

Table 53. Main service exclusion trends Roma community and ethnoreligious minorities in Veliko Tarnovo, Bulgaria, including barriers influencing access to mental healthcare and psychosocial support services.

Type of Service Exclusion	Description of Barriers and Accessibility Challenges
Financial	Many Roma and minority households experience higher levels of poverty, unstable employment, and informal labour conditions. These socioeconomic vulnerabilities often result in interruptions in health insurance contributions, restricting access to publicly funded specialised mental healthcare services. In addition, most psychological counselling and psychotherapy services are privately provided and require out-of-pocket payment, making them largely unaffordable for low-income households and economically vulnerable families.
Geographical and Territorial	Specialised mental health services, including psychiatrists and clinical psychologists, are mainly concentrated in the regional centre of Veliko Tarnovo. Residents of smaller villages and segregated neighbourhoods within Strazhitsa

	and Pavlikeni face significant territorial and transport barriers due to limited public transport connections, travel costs, and geographic isolation. These barriers frequently delay or prevent access to specialist consultations, follow-up care, and preventive mental health services.
Social and Cultural	Social stigma surrounding mental health remains particularly strong within small rural communities, including among Roma populations. Limited mental health literacy, cultural perceptions of mental illness, distrust toward institutions, and experiences of discrimination or social exclusion may discourage individuals from seeking professional support. These factors contribute to delayed help-seeking and reduced engagement with formal healthcare services.
Legal and Policy-Related	Access to many publicly funded healthcare services in Bulgaria depends on continuous health insurance coverage. Individuals with interrupted insurance status may experience restricted access to specialised mental healthcare or may be required to pay privately for services. Although national policies promote social inclusion and equal access to healthcare, targeted local programmes addressing mental health inequalities affecting Roma and minority populations remain limited.

3.8.8 Priority Areas for Investment within the Mental Health Care System in Veliko Tarnovo, Bulgaria

Table 54 highlights the key areas where targeted investments and innovative approaches could contribute to improving mental health outcomes in the Pavlikeni and Strazhitsa municipalities. Building on the ecosystem analysis, it identifies existing service gaps, structural challenges, and opportunities for intervention, while outlining actions that could strengthen accessibility, inclusiveness, and coordination within the local mental health ecosystem.

Table 54. Priority system gaps, investment needs, and Smart Health Labs alignment for the Roma community and ethnoreligious minorities in Veliko Tarnovo, Bulgaria

Priority Area for Investment and Innovation	Main Challenges Identified	Proposed Investment / Innovation Actions	Expected Impact
Development of Community-Based Mental Health Services	The municipalities lack structured community-based mental health teams and locally accessible psychosocial support services, particularly in smaller settlements and rural villages.	Development of mobile and community-based multidisciplinary mental health teams including psychologists, social workers, and health mediators providing counselling, early intervention, outreach, and follow-up support directly within communities.	Improved territorial accessibility; earlier intervention; strengthened prevention and continuity of care for vulnerable and isolated populations.
Improving Access for Roma and Minority Communities	- Roma and minority populations experience higher levels of poverty, social exclusion, low educational attainment, and barriers to healthcare access. - Distrust towards institutions and stigma further reduce engagement with mental health services.	Investment in culturally sensitive mental health programmes, community mediators, outreach activities, awareness campaigns, and stronger cooperation between healthcare providers, social services, schools, and community organisations.	Increased accessibility, trust, and participation among Roma and minority communities; reduction of inequalities in mental healthcare access.
Strengthening Mental Health Capacity in Primary Healthcare	General practitioners (GPs) often represent the first point of contact for mental health concerns but frequently lack sufficient training, time, and specialist support to address mental health needs effectively.	Training programmes for primary healthcare professionals; integration of psychologists and mental health specialists within primary care settings; development of referral and support pathways.	Earlier identification of mental health conditions; improved referral processes; strengthened local care capacity and prevention.
Expanding School-Based Mental Health Support	Children and adolescents in socioeconomically disadvantaged communities face increased psychosocial vulnerabilities, while school-based mental health support remains limited.	Expansion of school psychology services, mental health promotion programmes, psychosocial education, and early detection initiatives within schools.	Improved prevention, early intervention, and emotional support for children and young people; strengthened resilience and wellbeing.

Addressing Rural Accessibility and Transport Barriers	Geographic isolation, limited public transport, and centralisation of specialised services in Veliko Tarnovo significantly restrict access to mental healthcare for rural populations.	Investment in mobile mental health services, tele-mental health solutions, outreach programmes, and locally accessible support points within smaller settlements.	Reduced geographic inequalities; improved access to specialised support for rural and isolated communities.
Increasing Mental Health Literacy and Reducing Stigma	Mental health stigma remains particularly strong within small rural communities, discouraging help-seeking behaviour and delaying intervention.	Public awareness campaigns, community education initiatives, local peer-support groups, and mental health literacy programmes targeting both the general population and vulnerable groups.	Increased understanding of mental health issues; reduced stigma; earlier and more frequent help-seeking behaviour.
Strengthening Workforce Capacity and System Coordination	Limited availability of mental health professionals and fragmented coordination between healthcare and social services reduce the efficiency and continuity of support pathways.	Investment in workforce development, specialist training, institutional cooperation mechanisms, and integrated coordination between health, education, and social care sectors.	Stronger service coordination; improved continuity of care; increased effectiveness and sustainability of the local mental health ecosystem.

3.8.9 Social Economy Initiatives to Be Prioritised by the Smart Health Labs

In addition to formal health care providers, Strazhitsa and Pavlikeni municipalities include several social economy actors, as presented below, that interact with residents in everyday community settings. These organisations are not part of the medical care system but provide social support, community engagement and informal counselling that can indirectly support mental wellbeing. For Roma communities and other ethno-religious minorities, such actors often represent accessible and trust-based entry points embedded in everyday life.

Table 55. Social economy and community-based initiatives supporting mental health inclusion and psychosocial wellbeing in Strazhitsa and Pavlikeni municipalities (Veliko Tarnovo Region, Bulgaria).

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>Center Amalipe</u>	Roma inclusion, educational support, youth engagement, family mediation, community empowerment	Provides trusted community-based outreach to Roma communities and supports mediation between vulnerable families and institutions. Can support culturally sensitive mental health awareness and referral activities.
<u>Local Initiative Group Lyaskovec–Strazhitsa</u>	Rural development, local community initiatives, social inclusion, local partnerships	Supports local development and community engagement initiatives that can facilitate outreach, awareness campaigns, and cooperation between community stakeholders and social services.
<u>Community Cultural Centres (Chitalishta)</u>	Cultural activities, youth workshops, informal education, community participation	Offer accessible local spaces for community interaction, youth engagement, and wellbeing-related activities that may help reduce social isolation and stigma.
<u>Municipal Employment and Social Inclusion Programmes in Pavlikeni and Strazhitsa</u>	Vocational training, public employment schemes, skills development, labour inclusion	Improve financial stability, social participation, and self-confidence among vulnerable populations, contributing indirectly to improved mental wellbeing and social inclusion.
<u>Community Mediators and NGO Counselling Structures</u>	Administrative support, social orientation, informal counselling, service navigation	Act as low-threshold contact points helping vulnerable individuals navigate healthcare and social systems, identify psychosocial needs, and connect with support services.

3.8.10 SWOT Analysis of the Bulgarian Pilot Site and strategic directions for the design of the Smart Health Lab

The mental health ecosystem of the Pavlikeni and Strazhitsa municipalities is shaped by a combination of local assets, structural limitations, emerging opportunities, and external challenges. As predominantly rural areas with significant Roma and minority populations, the municipalities benefit from strong community networks, active social economy organisations, and established

primary healthcare and social support structures. At the same time, limited availability of specialised mental health services, geographic isolation, socioeconomic inequalities, and persistent mental health stigma continue to affect access to care and wellbeing outcomes.

The SWOT analysis presented below summarises the key internal and external factors influencing the development of a more accessible, inclusive, and resilient mental health ecosystem in the pilot area and highlights opportunities that could be leveraged through future investment and innovation initiatives.

Table 56. SWOT Analysis of the Bulgarian Pilot Site

Strengths	Weaknesses
General practitioners (GPs) are present across the municipalities and serve as the primary entry point to healthcare services.	Dedicated community-based mental health centres and multidisciplinary mental health teams are absent from the municipalities.
Municipal social services, schools, and community mediators provide support to vulnerable individuals and families.	Specialised mental health services are concentrated in Veliko Tarnovo and other urban centres, requiring travel for access.
Social economy organisations, including Center Amalipe and local community structures, have strong relationships with Roma and minority communities.	The availability of psychiatrists, psychologists, and specialised mental health professionals at local level is limited.
Strong family and community support networks exist, particularly within Roma communities.	Coordination between healthcare providers, social services, schools, and mental health specialists remains fragmented.
Community cultural centres (Chitalishta) and local organisations provide trusted spaces for community engagement and awareness activities.	Mental health stigma remains strong, discouraging help-seeking behaviour and delaying access to support.
National mental health, social inclusion, and Roma integration policies provide a supportive regulatory framework.	Mental health literacy is limited among parts of the population, particularly within vulnerable groups.
Health insurance coverage is available for the majority of residents.	Poverty, informal employment, and interruptions in health insurance coverage create barriers to accessing specialised care.
Opportunities	Threats
The EQUICARES Smart Health Lab can strengthen service accessibility, coordination, and mental health literacy.	Population decline and demographic ageing continue to increase demand for health and social care services.
Community-based, mobile, and outreach mental health services can be expanded across rural settlements.	Poverty, unemployment, informal labour, and economic insecurity continue to affect vulnerable households.
Tele-mental health and digital support solutions can help overcome geographical barriers to care.	Discrimination, anti-Roma prejudice, and social exclusion continue to negatively affect mental wellbeing and access to services.

Community mediators and trusted local organisations can support culturally sensitive outreach and referral pathways.

Geographic isolation, dispersed settlements, and limited public transport connections restrict access to specialised mental healthcare.

School-based mental health promotion and early intervention initiatives can be further developed.

Shortages of specialised mental health professionals may further reduce service availability in rural areas.

Stronger collaboration between healthcare providers, social services, schools, municipalities, and community organisations can improve service coordination.

Dependence on continuous health insurance coverage may exclude vulnerable individuals from specialised mental healthcare.

Strategic directions for the design of the Smart Health Lab in Veliko Tarnovo



Figure 34. Strategic directions for the design of the Bulgarian Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Bulgarian Smart Health Lab could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The Veliko Tarnovo Smart Health Lab could focus on improving access to mental health and psychosocial support for Roma communities, ethnoreligious minorities, young people from minority communities, older adults and residents of rural and remote settlements in Pavlikeni and Strazhitsa. The Lab would not replace specialised mental health services, which remain concentrated in regional urban centres, but could operate as a local access, coordination and community engagement mechanism that strengthens existing municipal, social, educational and community structures.

Creating trusted local entry points in Pavlikeni and Strazhitsa

Given the absence of dedicated community-based mental health centres in the municipalities, the Lab could establish trusted local access points where residents can receive information, basic guidance and referral support. These access points could be connected to municipal social services, schools, Chitalishta, community centres and the networks of Center Amalipe. Their purpose could be to help residents understand available support options, reduce uncertainty around where to seek help and facilitate earlier access to care.

Linking GPs, municipal services, schools and community mediators

General practitioners, municipal social services, schools and community mediators already act as important first points of contact for vulnerable residents, but their cooperation remains fragmented. The Lab could therefore create a more structured local coordination mechanism between these actors. This might include agreed referral pathways, regular coordination meetings, shared contact points and practical procedures for identifying and supporting people with psychosocial or mental health needs.

Strengthening Roma and minority outreach through trusted community actors

Community mediators and Roma-focused organisations could play a central role in the Lab's activities. Their involvement might be essential for reaching Roma, Millet and Rudari communities, where discrimination, stigma and mistrust of institutions may discourage help-seeking. Outreach could use familiar language, trusted intermediaries and non-stigmatising communication to explain mental health needs, available support and referral options.

Using Chitalishta and schools as community anchors

Chitalishta, schools and local community spaces could be used as key entry points for awareness-raising and engagement. These settings are already familiar to residents and might support activities on mental health literacy, stigma reduction, bullying, discrimination, stress, anxiety, early marriage pressures and help-seeking. For young people from minority communities, schools could also support early identification and prevention, particularly where educational exclusion or family pressures affect wellbeing.

Reaching dispersed villages through mobile and outreach-based formats

Because many settlements are geographically dispersed and public transport is limited, the Lab could not rely only on residents travelling to municipal centres or Veliko Tarnovo. Outreach activities could be organised in villages, schools, community spaces and Roma neighbourhoods. Mobile visits, local information days, mediator-led sessions and community meetings could help reach people who are isolated, uninsured, elderly, low-income or unable to travel for support.

Facilitating referrals to Veliko Tarnovo and nearby specialist services

Specialised psychiatric and psychological services are largely located outside Pavlikeni and Strazhitsa, particularly in Veliko Tarnovo and other urban centres. The Lab could therefore support residents and frontline actors in navigating external referrals. This may include help with appointment information, documentation, transport options, health insurance questions and follow-up communication after referral.

Reducing insurance, poverty and affordability barriers

Economic insecurity, informal employment and interrupted health insurance coverage could limit access to specialised mental healthcare. The Lab could include practical guidance on health insurance continuity, access rights and available public or social support channels. This might be particularly important for unemployed residents, informal workers, low-income families and marginalised households for whom private psychological services are unaffordable.

Introducing assisted digital and tele-mental health access

Digital and tele-mental health tools could help reduce distance-related barriers, but they need to be introduced with local support. The Lab could provide assisted access to digital information, teleconsultation options where available and future EQUICARES tools, including the AI-based Assistant. Guided use will be important for older adults, Roma communities and residents with limited digital literacy or poor internet access.

Anchoring the Lab in Bulgaria's social economy and community infrastructure

The Lab could build on existing social economy and community-based structures, including Center Amalipe, Chitalishta, schools, local associations and community mediators. These actors might offer trusted spaces, local knowledge and established relationships with vulnerable groups. Co-designed actions could therefore be rooted in these structures to ensure that solutions are realistic, accepted by communities and sustainable beyond the project.

Producing rural and minority-focused evidence for policy uptake

The Lab could document local barriers, referral needs, outreach results, participation patterns and feedback from Roma and minority communities. This evidence can support future policy recommendations, strengthen the case for community-based and mobile mental health services in rural Bulgaria, and inform the EQUICARES Policy Dashboard. For the Veliko Tarnovo pilot, the Lab could demonstrate how rural, minority-focused and community-based approaches can improve equitable access to mental health and care services.

3.8.11 Useful Resources

Table 57. Key healthcare, social protection, Roma inclusion, education, employment, digital governance and community resources for the Veliko Tarnovo / Strazhitsa / Pavlikeni pilot site

Resource / Initiative	Official Link
Ministry of Health of the Republic of Bulgaria	https://www.mh.government.bg
National Mental Health Strategy 2021–2030	https://www.strategy.bg
National Health Strategy 2030	https://www.mh.government.bg
National Health Insurance Fund (NHIF)	https://www.nhif.bg
Regional Health Inspectorate – Veliko Tarnovo	https://rzi-vt.egov.bg
Mental Health Centre – Veliko Tarnovo	https://tcentarpzvt.com
State Psychiatric Hospital – Tserova Koria	https://dpb-zcoria.com
MOBAL “Dr. Stefan Cherkeзов” – Veliko Tarnovo	https://mobaltarnovo.com
National Centre of Public Health and Analyses	https://ncpha.government.bg
National Statistical Institute of Bulgaria (NSI)	https://www.nsi.bg
Municipality of Pavlikeni	https://www.pavlikeni.bg
Municipality of Strazhitsa	https://strazhitsa.com
Ministry of Labour and Social Policy	https://www.mlsp.government.bg
Agency for Social Assistance	https://asp.government.bg
Employment Agency	https://www.az.government.bg
Ministry of Education and Science	https://www.mon.bg
State Agency for Child Protection	https://sacp.government.bg
National Strategy for Equality, Inclusion and Participation of Roma 2021–2030	https://www.strategy.bg
National Council for Cooperation on Ethnic and Integration Issues	https://www.strategy.bg
Center Amalipe	https://amalipe.bg

Local Action Group Lyaskovets–Strazhitsa	https://www.nsm.bg
Public Register of Community Cultural Centres (Chitalishta)	https://chitalishta.com
Bulgarian e-Government Portal	https://egov.bg
WHO Country Office in Bulgaria	https://www.who.int/bulgaria
European Union Agency for Fundamental Rights – Roma	https://fra.europa.eu/en/themes/roma

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3.9 Antakya, Hatay Province (Türkiye)

3.9.1 Geographical Context & Demographic Overview

The Turkish pilot site is located in the Antakya district of Hatay Province, in southern Türkiye near the Syrian border. Hatay forms part of the TR63 region, together with Kahramanmaraş and Osmaniye. Hatay Province covers approximately 5,524 km² and is characterised by a diverse physical geography that includes mountains, plains, river valleys and plateaus. The Amanos, or Nur, Mountains form a major physical barrier between the Mediterranean coast and inland areas, while the Amuq, or Amik, Plain represents one of the province's most important agricultural zones. Antakya is situated approximately 25 km inland from the Mediterranean coast and surrounded by mountainous terrain.

According to the Turkish Statistical Institute, Hatay has a population of approximately 1,577,531 inhabitants, with a relatively balanced gender distribution of 50.5% male and 49.5% female residents. The province has a young population structure, with approximately 39.5% of residents aged 18 years or younger, while around 9.5% are aged 65 years and above.

The demographic and social profile of Hatay has been profoundly affected by the earthquakes of 6 February 2023, which caused severe destruction across the province. They resulted in significant loss of life, widespread housing destruction, infrastructure damage and large-scale population displacement. Hatay's population declined from 1.69 million inhabitants in 2022 to around 1.54 million in 2023, reflecting both earthquake-related mortality and substantial outward migration. In 2023, approximately 164,247 residents left the province, corresponding to around 10.6% of the provincial population. Although outmigration slowed considerably in 2024, it remained significant.

Hatay continues to host an important refugee population with 143,000 Syrian refugees currently residing in the province, contributing to the region's demographic diversity and increasing demand for social, healthcare and psychosocial support services. Antakya and the wider Hatay region face overlapping challenges linked to post-disaster recovery, displacement, infrastructure damage, demographic change and the need for accessible, culturally sensitive and trauma-informed mental health support. Overall, Hatay's geography and demographic profile are closely connected to mental health vulnerability. The combination of mountainous terrain, dispersed settlements, damaged infrastructure, population displacement, a large refugee population and the continuing effects of the 2023 earthquakes creates practical and psychosocial barriers to accessing care. For many residents, especially those living in temporary settlements, rural or peripheral areas, these conditions increase exposure to stress, uncertainty and social disruption, while making it harder to reach timely and continuous mental health and psychosocial support.

TÜRKİYE PILOT SITE – HATAY (ANTAKYA DISTRICT)

Location and Demographic Overview

6.2.1 GEOGRAPHICAL CONTEXT

- Pilot location:** Hatay Province, Antakya district, located in southern Türkiye near the Syrian border.
NUTS classification: TR63 region (Hatay, Kahramanmaraş, Osmaniye) within the Mediterranean region of Türkiye.
- Hatay Province covers approximately 5,524 km².
Topography: Mountains 46.1%, Plains 33.5%, Plateaus 20.4%.
- Amanos (Nur) Mountains form a key barrier. To the east lies the Amuq (Amik) Plain, a major agricultural zone, along with other plains (İskenderun, Dörtöl, Payas, Erzin) and the Orontes (Asi) River delta.
- Antakya is located in the Amuq Plain along the Orontes River, ~20–25 km inland from the Mediterranean coast, surrounded by mountains (Amanos Mountains to the west and northwest).
- Mediterranean climate: hot, dry summers and mild, rainy winters. Average annual temperature: 15.1–20°C; annual precipitation: 562–1,216 mm, concentrated in winter.
- Fertile plains, river valleys and mountains have historically supported agriculture, trade and settlement patterns in the region.



LOCATION IN TÜRKİYE



Antakya – Orontes (Asi) River



6.2.2 DEMOGRAPHIC OVERVIEW

POPULATION SIZE AND AGE DISTRIBUTION (2025)



POPULATION CHANGE AFTER 2023 EARTHQUAKES



OUTWARD MIGRATION TRENDS (RESIDENTS MOVING OUT OF HATAY)



SYRIAN POPULATION IN TÜRKİYE AND HATAY



KEY TAKEAWAYS



Antakya is in the fertile Amuq (Amik) Plain, along the Orontes River, surrounded by mountains.



Hatay has a Mediterranean climate and a landscape that supports agriculture, trade and settlement.



A young population, but with a significant share of older adults (9.5% aged 65+).



Severe population decline after the 2023 earthquakes due to mortality and large-scale out-migration.



Outward migration has decreased in 2024, showing a stabilization trend after the initial shock.



A diverse population with a sizeable Syrian community, requiring inclusive and equitable service delivery.

Figure 35. Hatay (Türkiye) Pilot Site Location and Demographic Overview

3.9.2 Techno-Economic Context

The socioeconomic context of Hatay has been deeply affected by the 6 February 2023 earthquakes, which intensified pre-existing vulnerabilities and created new pressures on households, services and local institutions. Education inequalities, labour market disruption, income insecurity, damaged infrastructure and reduced service capacity all influence mental health outcomes and access to psychosocial support. These factors are particularly relevant for earthquake-affected residents, women, children and young people, low-income households, displaced populations and Syrian refugees.

Education, literacy and mental health awareness

Education levels in Hatay show persistent inequalities that may affect mental health literacy, awareness of available services and help-seeking behaviour. According to 2024 education statistics, around 1.7% of the population aged six years and above is illiterate. Gender disparities remain important, with illiteracy among women reaching 2.7%, compared to 0.7% among men. A larger proportion of women can read and write but have not completed formal schooling, while men are more likely to complete high school and higher education.

Lower educational attainment may reduce awareness of mental health symptoms, preventive healthcare practices and available support pathways. This is especially relevant for women, rural communities and socially disadvantaged groups, where limited education may combine with stigma, financial hardship and reduced access to information.

Economic structure and post-earthquake labour market disruption

The economy of the TR63 region, which includes Hatay, is mainly based on services, industry and agriculture. Services account for approximately 56% of employment, followed by industry at 28% and agriculture at 16%. Agriculture remains particularly important in Hatay due to the fertile Amuq Plain and long-standing agricultural production systems. Following the earthquakes, construction activity increased significantly as reconstruction and housing programmes became central to economic recovery.

Despite these reconstruction investments, many sectors experienced serious disruption. Trade, manufacturing, local businesses and informal livelihoods were affected by destruction, displacement and reduced economic activity. This has weakened employment stability and placed additional financial pressure on households already affected by housing loss, displacement and trauma.

Unemployment, income insecurity and psychosocial stress

Hatay already had relatively high unemployment before the earthquakes, ranking 12th nationally in 2022 with an unemployment rate of 14.4%. Following the disaster, unemployment increased to 15.6% in 2023, placing Hatay among the provinces with the highest unemployment rates in Türkiye. Although unemployment declined to 12.0% in 2024, the province continues to experience the effects of economic contraction, business closures, workforce displacement and livelihood loss.

These pressures increase psychosocial stress and financial insecurity. For many households, the loss of income, unstable employment and uncertainty about recovery may contribute to anxiety, depression, chronic stress and reduced resilience.

Poverty, affordability and access to care

Income data for the TR63 region indicate that average disposable household income remains substantially below the national average, even though income inequality indicators such as the Gini coefficient and S80/S20 ratio appear relatively moderate. This suggests that the region is marked less by extreme income polarisation and more by generally low income levels.

Lower household income, combined with post-earthquake hardship, creates barriers to healthcare, psychosocial support, transportation and private mental health services. Although Türkiye's General Health Insurance system covers most public mental healthcare services, psychotherapy is still largely provided through the private sector and often requires out-of-pocket payment. This limits access for low-income residents and increases dependence on overstretched public and NGO-based services.

Digital access and innovation capacity

Internet use and e-government service utilisation are high at national level in Türkiye, but digital inequalities remain, particularly among older adults, women and disadvantaged households. In Hatay, earthquake-related infrastructure damage temporarily disrupted internet connectivity and access to digital services. This is relevant for mental health support because digital tools, telehealth services and online information could help expand access, but only if users have reliable connectivity, devices and sufficient digital skills.

Hatay also has regional innovation assets, including Mustafa Kemal University, MKU Technopark and the Eastern Mediterranean Development Agency. However, the earthquakes disrupted local research, entrepreneurship and innovation infrastructure. Rebuilding this ecosystem could support future digital health, psychosocial support and community-based innovation activities, but recovery remains uneven.

Mental health workforce and service capacity

Hatay has a limited psychiatric workforce capacity in relation to population needs. The earthquakes severely damaged hospitals, primary healthcare facilities and local service infrastructure, contributing to workforce shortages, fragmented service delivery and reduced continuity of care. Mental health and psychosocial support are currently provided through public institutions, municipalities, NGOs and mobile teams, but demand remains higher than available capacity.

Access is further restricted by transport difficulties, displacement, financial hardship, workforce turnover and fragmented coordination between service providers. These factors make it difficult to ensure continuous care, especially for people requiring follow-up support, trauma-informed services or specialised mental health interventions.

3.9.3 Ecological and Environmental Factors

The post-earthquake context has further complicated access to mental health and social support services in Hatay. Damage to infrastructure, limited public transportation options, and long travel distances between temporary settlements and service providers create significant practical barriers to care. These challenges are particularly pronounced for people in vulnerable situations, including older adults, individuals with disabilities, low-income households, and residents of rural or peripheral areas. Physical accessibility therefore, remains a key determinant of service utilisation and continuity of care.

Territorial Accessibility and Urban–Rural Disparities

Geographical inequalities continue to affect access to mental health and psychosocial support services across Hatay. While a significant proportion of healthcare, social services, and psychosocial support facilities are concentrated in central districts such as Antakya and İskenderun, residents of rural and peripheral areas often face greater difficulties in accessing care. Longer travel distances, disrupted transportation infrastructure, and the limited availability of specialised services contribute to unequal access, particularly for vulnerable populations with reduced mobility or limited financial resources.

Environmental Conditions and Post-Disaster Living Environment

The physical environment of Hatay continues to reflect the long-term impacts of the earthquakes and remains an important source of psychosocial stress. Large-scale reconstruction activities, building demolitions, debris removal, construction noise, and dust continue to shape daily life for many residents. These conditions contribute to a persistent sense of disruption and instability, while uncertainty regarding reconstruction plans and timelines further exacerbates anxiety about the future. The limited availability of accessible public spaces, recreational facilities, and community gathering areas also reduces opportunities for social interaction, relaxation, and psychological recovery.

These disparities may delay help-seeking and continuity of care, particularly for people in vulnerable situations including individuals living in temporary settlements, women, older adults, and people with disabilities.

3.9.4 Regulatory and Policy Landscape

Affordability and Financial Accessibility

Mental health services in Türkiye are primarily delivered through the public health system under the Ministry of Health, and psychiatric consultations are formally covered by the national health insurance scheme. Individuals can access psychiatric care through public hospitals; however, certain out-of-pocket expenses remain, including consultation co-payments and contributions towards medication costs. Additional financial barriers may arise for individuals who seek regular consultations with specific physicians through paid specialist outpatient services, such as faculty member consultations offered by university hospitals. While public mental healthcare is generally more affordable than private alternatives, these costs may still represent a significant burden for individuals experiencing economic hardship following the earthquakes.

Availability and Quality of Mental Health Services

Despite formal coverage, access to psychiatric care is affected by capacity constraints within the healthcare system. Appointments through the national hospital appointment system frequently involve long waiting times, while consultation durations are often limited due to high patient volumes. Although official consultation times are approximately ten minutes, in practice appointments may be considerably shorter. Continuity of care is also difficult to maintain, as patients may not consistently be seen by the same psychiatrist across successive visits. These challenges may negatively affect the quality and effectiveness of care, particularly for individuals requiring long-term mental health support and follow-up.

Accessibility of Psychosocial Support Services

Psychotherapy services are generally not covered by the national health insurance system, creating an important gap in mental health service provision. To address this need, psychosocial support services are offered by District Health Directorates, municipalities, and non-governmental organisations. However, these services often operate under considerable resource constraints. Psychologists and social workers frequently combine psychosocial support activities with broader public health and social service responsibilities, limiting the availability, intensity, and continuity of support that can be provided to service users.

Social Inclusion and Community Participation

A range of national and local initiatives seek to support social inclusion, economic recovery, and community participation following the earthquakes. These include vocational training programmes, employment support schemes, livelihood initiatives, and community-based activities implemented by public authorities and civil society organisations. NGOs have also played an important role in organising educational, social, and recreational activities within temporary settlements. Nevertheless, the availability and quality of these opportunities vary considerably across different locations. Some settlements benefit from well-developed support networks and active programming, while others have more limited access to social inclusion initiatives, contributing to unequal recovery experiences.

Remaining Systemic Challenges

Although policy frameworks and support mechanisms exist to facilitate access to mental healthcare and social support, important implementation challenges remain. Limited consultation times, long waiting periods, transportation difficulties, uneven distribution of support programmes, and high workloads among healthcare and psychosocial support professionals continue to constrain effective service delivery. These barriers particularly affect earthquake-affected and displaced populations, highlighting the need for more coordinated, accessible, and community-based approaches to mental health and psychosocial support in Hatay.

3.9.5 Priority PVS and Current Mental Health Needs

The 2023 Kahramanmaraş earthquakes had profound psychological consequences for the population of Hatay, one of the provinces most severely affected by the disaster. Recent studies indicate that earthquake survivors in the region experience high levels of psychological distress, including post-traumatic stress disorder (PTSD), depression, anxiety, and prolonged stress related to trauma exposure and loss of social stability.

Research conducted among adults living in temporary shelter areas in Hatay reported that 29% of participants met the criteria for PTSD and 38.8% for depression, highlighting the substantial mental health burden in the post-disaster context (Yılmaz and Erdem, 2025). Risk factors associated with PTSD in these populations include unemployment following the disaster, loss of family members or close friends, high levels of fear experienced during the earthquake, and pre-existing psychiatric conditions (Yılmaz and Erdem, 2025). Moreover, the extreme scale of the disaster and widespread exposure to traumatic events across the region have contributed to persistent trauma-related symptoms among survivors (Kiymis and Fakioglu, 2024).

While psychological resilience may mitigate some of these effects, evidence suggests that in large-scale disasters such as the Kahramanmaraş earthquakes, resilience alone may not sufficiently protect individuals from developing PTSD or other mental health disorders (Kiymis and Fakioglu, 2024). Evidence also suggests that psychological effects can persist long after earthquakes, with PTSD

symptoms potentially continuing for years following traumatic events. At the same time, some individuals may experience post-traumatic growth alongside distress, highlighting the complex psychological trajectories that can emerge following large-scale disasters (Kartol et al., 2025).

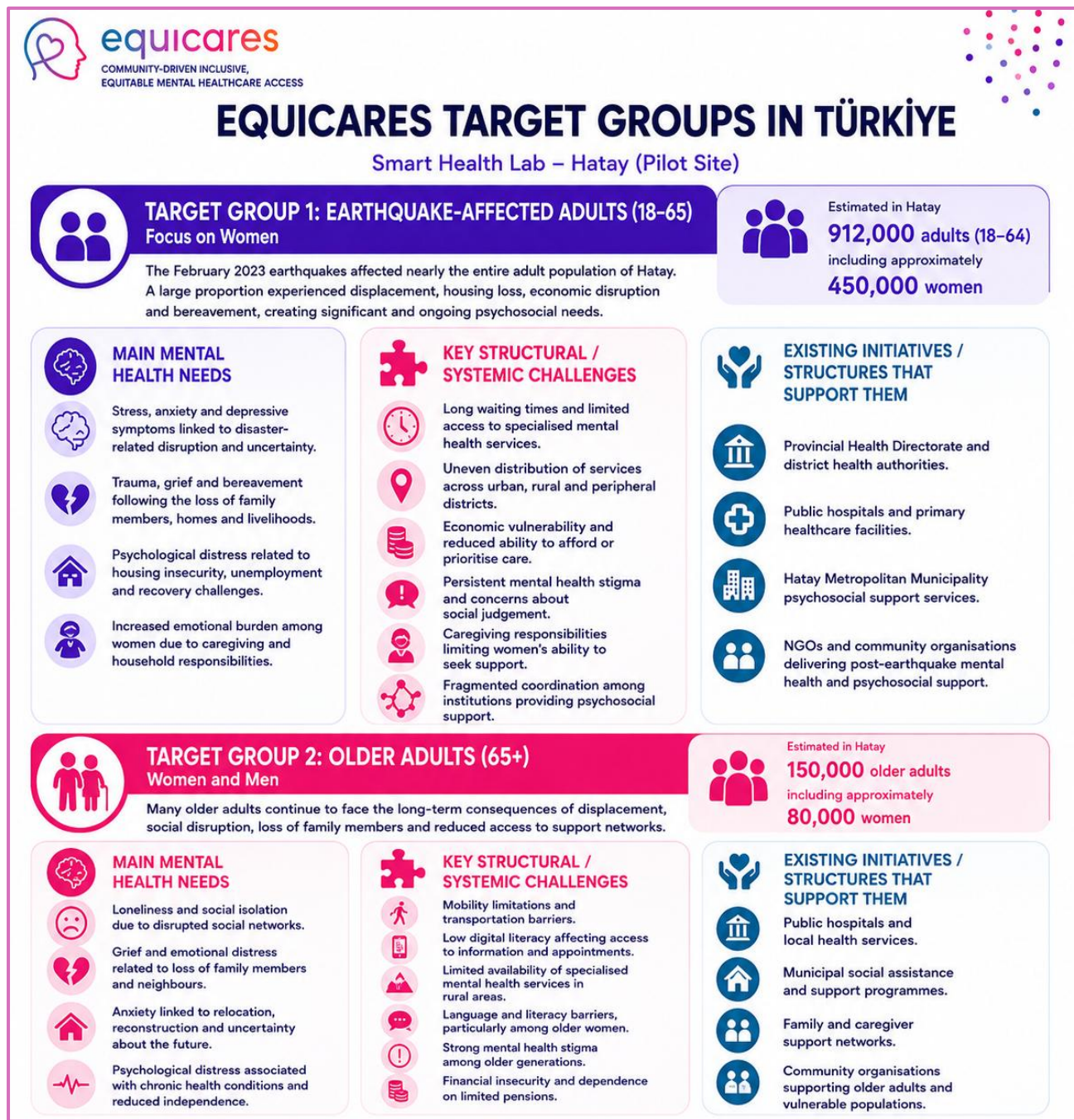


Figure 36. Priority PVS and their Current Mental Health Needs in Hatay, Türkiye

The Smart Health Lab in Hatay will focus on two main target groups: earthquake-affected adults aged 18–65, with particular attention to women, and older adults aged 65 and above. Both groups continue to experience significant mental health and psychosocial challenges following the February 2023 earthquakes, including stress, anxiety, grief, trauma, social isolation, and ongoing uncertainty related to housing, livelihoods, and community recovery.

For earthquake-affected adults, women are considered especially vulnerable due to increased caregiving responsibilities, economic insecurity, limited financial autonomy, and persistent mental

health stigma. Access to support is further constrained by disrupted health infrastructure, uneven service distribution, long waiting times, and fragmented coordination among service providers. The Smart Health Lab will engage adults in identifying barriers to care, co-creating solutions, strengthening social networks, and exploring links between psychosocial well-being and local economic empowerment initiatives, particularly through collaborations with women's cooperatives and community organisations.

Older adults face additional challenges related to mobility limitations, transportation difficulties, lower digital literacy, economic vulnerability, social isolation, and, in some cases, language and literacy barriers. Many have experienced the loss of family members and long-standing social networks, while access to specialised mental health services remains limited.

Through the Smart Health Lab, older adults and earthquake affected individuals would contribute to the design of more accessible mental health services and participate in activities that promote intergenerational learning, community engagement, and social cohesion.

3.9.6 Local Mental Health Ecosystem

Mental Health Service Provision and Infrastructure

Mental health services in Hatay are delivered through a combination of public health institutions, social service agencies, private providers, and non-governmental organisations. In the public sector, services are mainly provided through hospitals, Community Mental Health Centers (Toplum Ruh Sağlığı Merkezleri – TRSM), primary care facilities, and psychosocial support units operating under different ministries. Following the 2023 earthquakes, additional psychosocial support activities were introduced through temporary service units, mobile teams, and services operating in container settlements.

Mental Health Service Provision and Infrastructure

Mental health services in Hatay are delivered through a combination of public health institutions, social service agencies, municipalities, private providers, and non-governmental organisations. Public sector services are primarily provided through hospitals, Community Mental Health Centres (Toplum Ruh Sağlığı Merkezleri – TRSMs), primary healthcare facilities, Healthy Life Centres (SHMs), and psychosocial support units operating under different ministries. In response to the 2023 earthquakes, additional psychosocial support services were introduced through temporary service units, mobile teams, and facilities operating within container settlements. While these interventions helped address urgent post-disaster needs, many temporary services have gradually been scaled down as the recovery process has progressed.

Access Pathways and Levels of Care

Primary healthcare serves as the main entry point to the mental health system, with family physicians often being the first professionals consulted by individuals experiencing mental health concerns. However, specialised mental healthcare is generally delivered through secondary and tertiary care services, particularly psychiatry outpatient clinics within public hospitals. Healthy Life Centres and District Health Directorates also provide counselling and psychosocial support through psychologists and child development specialists. Community Mental Health Centres play a particularly important role in providing rehabilitation, long-term follow-up, and community-based support for individuals living with severe mental health conditions such as schizophrenia and bipolar disorder.

Community-Based and Post-Earthquake Psychosocial Support

The earthquake significantly increased the involvement of non-governmental organisations in the provision of psychosocial support. During the immediate response and early recovery phases, numerous NGOs established psychosocial support centres within temporary settlements and container sites. Public authorities also deployed mobile psychosocial support teams to reach affected populations. Although many of these emergency interventions have since been reduced or discontinued, municipal psychosocial support services and district-level outreach teams continue to operate. Nevertheless, their effectiveness is often constrained by limited human and logistical resources, particularly in remote and rural areas.

Private Sector Mental Health Services

In addition to public services, mental healthcare can be accessed through private hospitals, psychiatrists, and psychologists operating in private practice. These services often provide an alternative for individuals seeking specialised care; however, they require out-of-pocket payment and may therefore be inaccessible for economically vulnerable groups. Although public mental health services are generally free at the point of use, financial barriers may still arise through transportation costs, waiting times, or the need to seek private alternatives when public services are unavailable.

Care Coordination, Referral Mechanisms and Continuity of Care

A key challenge within the Hatay mental health ecosystem concerns the limited coordination and continuity of care between different service levels. Türkiye does not operate a fully established gatekeeping or mandatory referral system, and referrals often rely on informal guidance rather than structured pathways. While recent reforms have enabled primary care providers to facilitate appointments to specialised services, referral capacities remain limited, and there is no systematic mechanism to monitor whether patients attend referred services or receive appropriate follow-up care. As a result, continuity of care across the mental health system remains fragmented, creating risks for vulnerable individuals requiring ongoing support.

Intersectoral Collaboration and School-Based Support

Collaboration between the mental health sector and other sectors remains relatively limited. The most established form of intersectoral cooperation is found within educational settings, where school counsellors may identify children experiencing psychosocial difficulties and provide basic support through observation and individual consultations. However, this capacity is not available in all schools, particularly in smaller or rural areas. Although schools may communicate with relevant public institutions when concerns arise, formal referral pathways between educational and health services remain underdeveloped. Consequently, opportunities for integrated and coordinated support across sectors are still limited within the broader mental health ecosystem.

3.9.7 Service Exclusion Trends

The analysis of service accessibility in Hatay reveals that, despite the existence of a broad network of public, municipal, and civil society actors providing mental health and psychosocial support, significant barriers continue to affect equitable access to care. The post-earthquake context has further intensified many pre-existing challenges by disrupting infrastructure, reducing service capacity, increasing psychosocial needs, and placing additional pressure on vulnerable populations. Barriers to access are multidimensional and extend beyond the availability of services, encompassing

financial constraints, geographical inequalities, workforce shortages, system fragmentation, stigma, and the long-term psychological impacts of disaster-related displacement and uncertainty.

The following table summarises the main forms of service exclusion identified within the Hatay mental health ecosystem and highlights the factors that continue to influence access to mental health and psychosocial support services.

Table 58. Main accessibility barriers affecting mental health service access and continuity of care in Hatay Province following the 2023 earthquakes.

Service Exclusion Type	Description of Barriers and Accessibility Challenges
Financial	Although most of the population in Türkiye is covered by the General Health Insurance scheme (GSS), out-of-pocket payments remain necessary for consultation co-payments and medications. In Hatay, the economic consequences of the earthquake significantly reduced household income and financial stability, particularly due to the destruction of small businesses and employment losses. Transportation costs also create additional burdens, as many residents rely on private vehicles because of limited public transport and severe traffic congestion. These factors particularly affect older adults and earthquake-affected populations. Sources: Field observations; regional contextual analysis.
Geographical and Infrastructure	Access to health services remains affected by damaged infrastructure, ongoing reconstruction activities, traffic congestion, and long travel distances. Many residents currently live in temporary settlements or container sites located outside the city centre, increasing the distance to healthcare facilities. Public awareness regarding the location of newly established or relocated health institutions also appears limited. Inadequate public transportation further exacerbates geographic inequalities in access to care. Sources: Field observations; regional contextual analysis.
Social and Cultural	Mental health stigma remains prevalent, particularly among older adults and individuals with lower socioeconomic and educational backgrounds. Negative perceptions toward psychiatric care are common, including beliefs that consultations are too brief and mainly focused on medication prescription. Hatay's close-knit social environment may also increase concerns about confidentiality and social judgement, discouraging help-seeking behaviour. Sources: Field observations; stakeholder interviews.
Legal and Policy-Related	No major legal restrictions directly limit access to public mental health services for insured populations. However, broader structural challenges related to system capacity, institutional coordination, and service organisation may indirectly affect effective access to care in practice. Sources: Regional contextual analysis.
Mental Health Workforce Shortages	Hatay experienced substantial loss of healthcare personnel following the earthquake due to death, displacement, reassignment, and voluntary relocation of staff. Workforce shortages affect both primary and specialised mental health services, reducing service capacity and continuity of care. High staff turnover and limited experience among newly assigned personnel may

also affect the quality of trauma-sensitive care. Sources: Stakeholder interviews; regional contextual analysis.

Waiting Times and Appointment Availability	Access to psychiatry outpatient services generally requires appointments through the national MHRS appointment system. Due to limited specialist capacity and high service demand, appointments may be difficult to obtain and waiting times can be prolonged, discouraging or delaying help-seeking. Sources: Stakeholder interviews; field observations.
System Navigation and Coordination	Following the earthquake, many services were relocated, reorganised, or newly established, making the system difficult to navigate for residents. Mental health and psychosocial support services are fragmented across hospitals, NGOs, public institutions, and social services, while referral pathways between sectors remain unclear and insufficiently coordinated. Sources: Regional contextual analysis; stakeholder interviews.
Psychological Barriers in the Post-Disaster Context	Emotional distress has become normalised within many disaster-affected communities, leading some individuals to perceive psychological symptoms as expected reactions rather than reasons to seek professional support. Ongoing displacement, unemployment, bereavement, temporary housing conditions, and environmental disruption continue to intensify psychosocial stress while reducing the priority given to mental healthcare.

In Hatay, exclusion from mental health and psychosocial support is closely linked to the continuing consequences of the 2023 earthquakes. The destruction of homes, health facilities, transport routes and local livelihoods has changed how people access care and how services are organised. Many residents are still coping with displacement, loss, unstable housing and financial uncertainty, while the institutions providing support are operating under increased pressure and reduced capacity.

The main barriers are interconnected. Economic hardship limits people's ability to cover transport, medication or private psychological support. Damaged infrastructure, traffic congestion and the relocation of services make appointments harder to reach. At the same time, shortages of mental health professionals and high demand contribute to longer waiting times and weaker continuity of care. For many residents, especially those living in temporary settlements or outside central areas, the pathway to support remains unclear and difficult to follow.

Social and psychological factors further shape access. Stigma, concerns about being judged in close-knit communities, and limited confidence in psychiatric services can prevent people from seeking help. In the post-disaster context, emotional distress is often treated as a normal part of daily life, which may delay recognition of more serious mental health needs.

3.9.1 Priority Areas for Investment within the Mental Health Care System

The proposed investment and innovation areas are expected to support the gradual reconstruction of a more accessible, coordinated and community-oriented mental health ecosystem in Hatay. In the post-earthquake context, the main outcome should be a clearer and more connected pathway between residents, public institutions, municipalities, NGOs, mobile teams and specialised services. By strengthening coordination and referral mechanisms, the Smart Health Lab can help reduce fragmentation, improve follow-up and make it easier for people to move between different levels of support without losing continuity of care.

A second expected outcome concerns the improvement of local access to mental health and psychosocial support. Community-based access points, outreach activities and better information tools can help reach residents who face transport barriers, live in temporary settlements, or are not fully aware of relocated or newly established services. This is particularly important for displaced households, older adults, refugees, low-income families and earthquake-affected residents who may struggle to access centralised services.

The proposed actions are also expected to strengthen prevention, resilience and social connectedness. By investing in psychosocial wellbeing activities, peer support, safe community spaces and trauma-informed outreach, the Smart Health Lab can contribute to reducing isolation and rebuilding trust within affected communities. These actions are especially relevant in Hatay, where displacement, bereavement, housing insecurity and the disruption of familiar neighbourhoods continue to shape everyday life and mental wellbeing.

Digital and information-based solutions are expected to improve service visibility and mental health literacy, provided that they are accessible and adapted to local needs. Service mapping, online guidance and awareness resources can help residents better understand where to seek support and how to access available services. However, these tools should be combined with face-to-face guidance and community outreach to avoid excluding people with limited digital access or lower literacy levels.

Finally, the focus on housing transition and long-term recovery is expected to support residents as they move from temporary accommodation to more permanent living arrangements. Psychosocial accompaniment during relocation can help reduce anxiety, uncertainty and disaster-related fears, while supporting community reintegration. Overall, the expected impact of these actions which are presented in [Table 59](#) is a more responsive mental health ecosystem that not only addresses immediate psychological distress, but also supports long-term recovery, resilience and social cohesion in Hatay.

Table 59. Priority areas for investment and innovation to strengthen mental health service accessibility, coordination, and psychosocial recovery in Hatay Province following the 2023 earthquakes.

Priority Area for Investment and Innovation	Main Challenges Identified	Proposed Investment / Innovation Actions	Expected Impact
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Strengthening Coordination Across Institutions	Mental health and psychosocial support services are fragmented across health services, municipalities, NGOs, and social services, with weak referral and follow-up mechanisms.	Development of stronger coordination mechanisms, integrated referral pathways, and collaboration platforms between public institutions, municipalities, NGOs, and community actors.	Improved continuity of care, reduced fragmentation, and more efficient navigation across service levels.
Improving Community-Based Access to Mental Health Support	Transportation difficulties, relocated services, and limited public awareness of facilities reduce accessibility particularly for vulnerable and displaced populations.	Expansion of community-based mental health services, outreach programmes, digital information tools, and locally accessible support points.	Increased accessibility, earlier help-seeking, and improved connection between residents and available services.
Expanding Preventive and Well-Being-Oriented Approaches	Mental health services remain primarily treatment-oriented, while preventive, psychosocial, and resilience-focused approaches remain underdeveloped.	Development of prevention-oriented programmes, psychosocial well-being activities, resilience-building initiatives, and community support interventions.	Strengthened psychosocial resilience, improved well-being, and reduced long-term mental health burden.
Improving Access to Information and Digital Navigation Tools	Residents often face difficulties identifying available services, navigating the system, and understanding referral pathways following post-earthquake reorganisation.	Creation of digital mental health tools, online information platforms, accessible service mapping systems, and digital awareness resources.	Improved mental health literacy, reduced navigation barriers, and increased awareness of available support services.
Strengthening Community Engagement and Social Connectedness	Ongoing displacement, environmental disruption, and loss of social spaces have weakened community ties and increased social isolation.	Investment in community-based activities, peer-support initiatives, safe social spaces, and inclusive engagement programmes that rebuild trust and collective participation.	Reduced social isolation, strengthened community cohesion, and improved psychosocial recovery.
Expanding Trauma-Informed and	Persistent stressors such as displacement, bereavement, financial insecurity, and	Development of trauma-informed support models, psychosocial outreach services, resilience	Improved support for disaster-affected populations and reduced long-term

Community-Based Support	environmental disruption continue to affect mental well-being in Hatay.	programmes, and long-term community mental health initiatives.	psychosocial consequences of the earthquake.
Supporting Psychosocial Adaptation During Housing Transition	The transition from temporary settlements to permanent housing may generate renewed anxiety, uncertainty, and disaster-related fears.	Development of transition support programmes, psychosocial accompaniment services, and community adaptation activities during relocation processes.	Smoother long-term recovery, reduced psychosocial stress during relocation, and strengthened community reintegration.

3.9.2 Social Economy Initiatives to Be Prioritised by the Smart Health Lab in Hatay

The social economy and community sector have played a significant role in supporting recovery, resilience, and social cohesion in Hatay following the 2023 earthquakes. Alongside formal health and social care services, a range of community-based organisations, cooperatives, cultural initiatives, and humanitarian actors have contributed to addressing the social, economic, and psychosocial impacts of the disaster.

Through activities promoting community participation, livelihood recovery, social connectedness, cultural engagement, and collective empowerment, these initiatives help strengthen protective factors for mental wellbeing and foster more inclusive recovery processes. As such, they represent valuable stakeholders for the Smart Health Labs, offering opportunities to support community outreach, co-creation activities, social inclusion, and the development of locally embedded solutions that address both mental health needs and broader social determinants of wellbeing.

Table 60. Social economy and community-based initiatives contributing to psychosocial wellbeing, social inclusion, and community recovery in Hatay Province following the 2023 earthquakes.

Organisation / Initiative	Main Focus Areas	Relevance for Smart Health Labs
<u>Rimmen Women's Cooperative</u>	Women's economic empowerment, handicrafts, local production, peer support	Supports women's participation, social interaction, and collective empowerment through community-based economic activities that may strengthen psychosocial wellbeing and resilience.
S.S. Vakıfköy Women's Initiative Production and Business Cooperative	Women's employment, local entrepreneurship, community production activities	Creates safe and inclusive community spaces that foster empowerment, social connectedness, and economic participation among women affected by the earthquake.
Deprem Dayanışma Association (Earthquake Solidarity Association)	Community solidarity, post-earthquake recovery, social support activities	Organises solidarity initiatives and community engagement activities that strengthen social cohesion and community resilience in disaster-affected areas.
Buradayız Hatay Association	Community recovery, social participation, local support initiatives	Promotes social inclusion, local participation, and collective recovery processes through community-based activities and support networks.
Hatay Symphony Orchestra Culture and Arts Association	Cultural activities, arts-based community engagement, social cohesion	Uses cultural and artistic initiatives to rebuild social ties, create shared community spaces, and support emotional recovery after the earthquake.
<u>Support to Life (Hayata Destek)</u>	Livelihood support, humanitarian assistance, resilience strengthening	Supports vulnerable populations through community-based recovery and livelihood programmes that indirectly contribute to mental wellbeing and social stability.

<u>WHH (Welthungerhilfe)</u>	Livelihood support, economic recovery, community development	Contributes to post-earthquake recovery through programmes addressing economic insecurity, local livelihoods, and resilience building.
<u>Development Foundation of Türkiye (Türkiye Kalkınma Vakfı)</u>	Community development, economic resilience, livelihood support	Supports local economic recovery and social inclusion initiatives that help reduce psychosocial stress linked to financial insecurity and displacement.

3.9.3 SWOT Analysis of the Turkish Pilot Site and strategic directions for the design of the Smart Health Lab

The SWOT analysis in [Table 61](#) presents the main internal capacities and external conditions shaping the mental health and psychosocial support ecosystem in Hatay Province in the aftermath of the 2023 earthquakes. In line with the EQUICARES rationale, the analysis focuses not only on the availability of services, but also on whether people in vulnerable situations can effectively identify, reach, use, and benefit from appropriate care. It highlights a context where public health coverage, active civil society, community solidarity, universities, municipalities, NGOs, and social economy actors provide important foundations for innovation and recovery.

Table 61. SWOT Analysis of the Turkish Pilot Site

Strengths	Weaknesses
Broad public mental health coverage through Türkiye's General Health Insurance system.	Mental health and psychosocial support services remain fragmented, with weak referral and coordination mechanisms.
Presence of a diverse mental health ecosystem including hospitals, Community Mental Health Centres (TRSMs), primary care facilities, municipalities, and NGOs.	Shortages of mental health professionals and reduced service capacity following the earthquakes.
Strong community solidarity and active civil society, humanitarian, and social economy organisations supporting recovery.	Long waiting times, short consultation durations, and limited continuity of care.
Existing experience in delivering community-based and psychosocial support interventions following the disaster.	Psychotherapy services are largely dependent on private provision and out-of-pocket payment.
Presence of regional universities, innovation actors, and community organisations that can support innovation and collaboration.	Transportation difficulties, urban-rural disparities, and infrastructure damage limit access to services.
Active women's cooperatives, cultural initiatives, and community associations that promote social inclusion and resilience.	Persistent mental health stigma, low mental health literacy, and difficulties navigating available services.
Opportunities	Threats
Development of community-based, trauma-informed, and prevention-oriented mental health services.	High prevalence of PTSD, anxiety, depression, grief, and psychosocial distress among earthquake-affected populations.
Strengthening collaboration between healthcare providers, municipalities, NGOs,	Mental health needs continue to exceed current service capacity.

community organisations, and social economy actors.

Creation of digital tools for service navigation, information provision, and mental health literacy.

Utilisation of women's cooperatives, cultural organisations, and community initiatives to support psychosocial recovery and social inclusion.

Expansion of peer-support, resilience-building, and community engagement activities.

Integration of mental health promotion with livelihood support and local recovery initiatives.

Reconstruction provides opportunities to develop more resilient, accessible, and community-centred mental health services.

Continued workforce shortages and high staff turnover may affect service quality and continuity.

Economic insecurity, unemployment, and financial hardship continue to increase vulnerability and reduce access to care.

Long-term displacement, housing insecurity, and social fragmentation may prolong psychosocial vulnerability.

Unequal access between urban and rural areas may widen existing health inequalities.

Ongoing environmental disruption, uncertainty regarding reconstruction, and loss of community spaces continue to negatively affect mental wellbeing.

Strategic directions for the design of the Smart Health Lab in Hatay

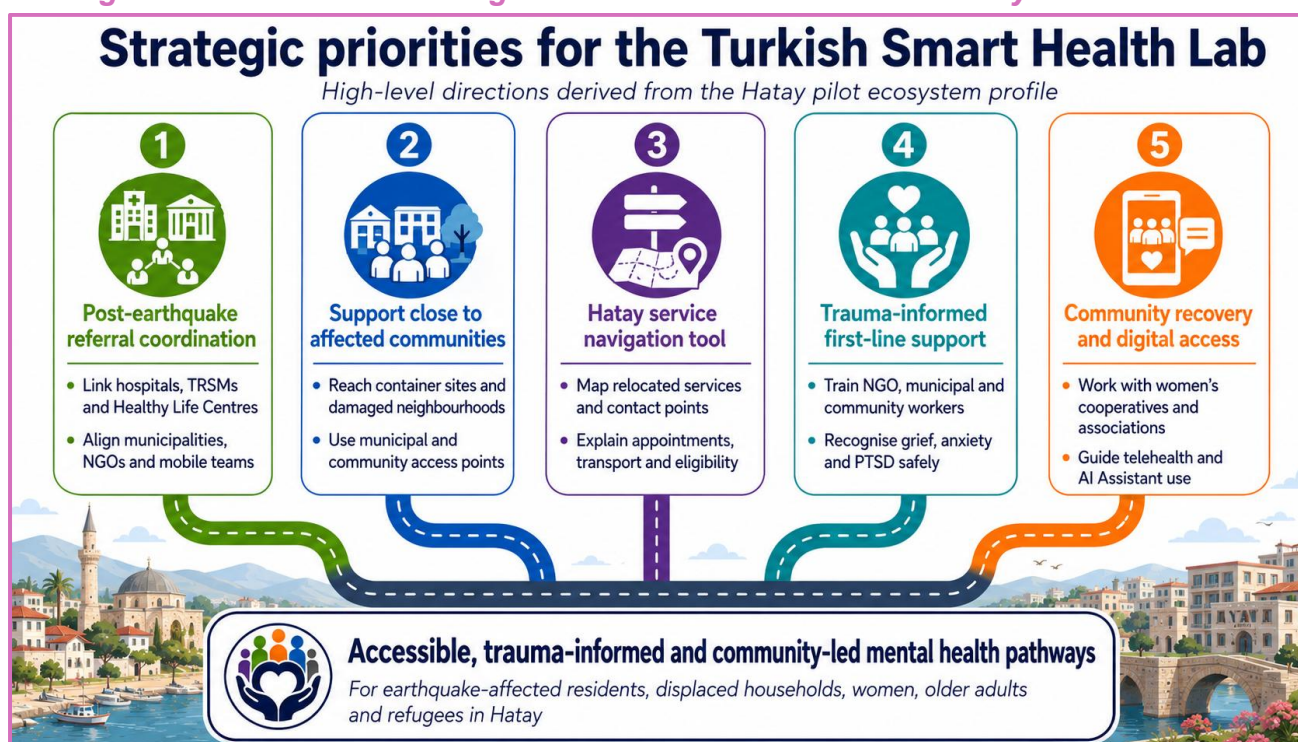


Figure 37. Strategic directions for the design of the Turkish Smart Health Lab

The following highlights and suggested directions are indicative and non-binding. They are intended to support reflection on how the Smart Health Lab in Hatay could be shaped in response to the main findings of the ecosystem profiling and SWOT analysis, while leaving space for further discussion, co-creation and adaptation with local stakeholders.

The SWOT analysis indicates that the Hatay Smart Health Lab could be designed as a post-earthquake access, coordination and community recovery mechanism. Its role would not be limited to awareness-raising, but could support the practical rebuilding of mental health access in a context

where services exist but remain difficult to reach, fragmented, overstretched and unevenly visible to residents. The Lab could therefore focus on connecting public health services, municipalities, NGOs, social economy actors, universities, community initiatives and residents affected by the earthquakes into a more coherent local support ecosystem.

Establish a post-earthquake mental health coordination mechanism

A core direction for the Lab could be to improve coordination between hospitals, Community Mental Health Centres, Healthy Life Centres, District Health Directorates, municipalities, NGOs, mobile psychosocial teams and community organisations. In Hatay, fragmentation is one of the main barriers to continuity of care, particularly since many services were relocated, reorganised or scaled down after the earthquakes. The Lab could support the creation of clear referral pathways, shared contact points, coordination meetings and simple follow-up procedures between institutional and community actors. This would help reduce duplication, improve continuity and ensure that residents do not lose access when moving between different forms of support.

Create locally accessible support points in affected neighbourhoods and temporary settlements

Given the transport difficulties, damaged infrastructure, traffic congestion and distance from services, the Lab could bring mental health and psychosocial support closer to where people currently live. Outreach activities could be organised in temporary settlements, container sites, affected neighbourhoods, community centres, municipal spaces and locations used by women's cooperatives and local associations. These access points could provide service information, basic psychosocial guidance, referral support and links to available public, NGO and municipal services. This approach is particularly relevant for older adults, women, displaced households, refugees and residents with limited financial or mobility capacity.

Develop a Hatay service navigation and referral tool

The Lab could prioritise the development of a practical service navigation tool for Hatay. This might include an updated map of available mental health and psychosocial support services, information on relocated or newly established facilities, eligibility criteria, contact details, appointment procedures, available languages, transport options and referral routes. The tool could be available both digitally and in printed or facilitated formats, as digital access and literacy are not equal across the population. Its main purpose would be to help residents and frontline workers understand where support is available and how to reach it.

Strengthen trauma-informed outreach and psychosocial first-line support

The earthquakes have generated long-term mental health needs related to trauma, grief, displacement, housing insecurity, unemployment and uncertainty. The Lab could therefore promote trauma-informed approaches across community outreach, awareness activities and referral support. This might include training frontline actors, community volunteers, NGO staff, municipal workers and social economy organisations to recognise signs of distress, communicate safely, avoid re-traumatisation and refer people to appropriate services when needed. Particular attention could be given to older adults, women, people living in temporary accommodation, bereaved families and earthquake survivors with prolonged stress or anxiety.

Expand prevention, resilience and wellbeing activities beyond clinical care

The mental health response in Hatay should not rely only on psychiatric consultations or specialised services. The Lab could support preventive and wellbeing-oriented activities that strengthen everyday resilience and reduce isolation. These could include peer-support groups, women's wellbeing sessions, arts and cultural activities, community gatherings, intergenerational activities, stress

management workshops and group-based psychosocial support. Such actions are particularly important in a setting where emotional distress is often normalised, and residents may not seek formal mental health support until their needs become more severe.

Use women's cooperatives and community initiatives as recovery anchors

Hatay has active women's cooperatives, cultural initiatives, solidarity associations and livelihood-focused organisations that could contribute directly to psychosocial recovery. The Lab should work with these actors not only as outreach partners but also as co-design spaces for community-based mental health solutions. Women's cooperatives could support empowerment, social contact, peer support and economic participation, while cultural and arts organisations can help rebuild shared spaces and collective identity. Linking psychosocial support with livelihood recovery is especially relevant for women and households affected by income loss after the earthquakes.

Support psychosocial adaptation during housing transition

As residents move from temporary settlements to permanent housing, new forms of anxiety, uncertainty and social disruption may emerge. The Lab would include a specific focus on housing transition, helping communities prepare for relocation, adapt to new living environments and rebuild social ties. Activities could include group discussions before and after relocation, psychosocial accompaniment, community orientation sessions, peer support between relocated households and activities that help residents regain a sense of stability. This direction is important because recovery does not end with physical reconstruction; social reintegration and emotional security are also needed.

Introduce assisted digital and AI-supported access

Digital tools could support service navigation, mental health literacy and access to information, but they should be introduced carefully in Hatay. The Lab should provide assisted access to digital resources, including service mapping tools, online information materials and the future EQUICARES AI-based Assistant. Guided use through help desks, community sessions or trained facilitators would prevent the exclusion of older adults, people with low literacy, women with limited digital access and residents affected by infrastructure disruption. Digital tools could therefore complement, rather than replace, face-to-face support.

Build capacity among frontline and community actors

The Lab could strengthen the capacity of actors who are already in contact with vulnerable groups. This includes municipal staff, NGO workers, social workers, family physicians, community volunteers, cooperative members, educators and local leaders. Capacity-building could focus on mental health literacy, trauma-informed communication, stigma reduction, referral procedures, confidentiality, digital navigation and culturally sensitive support. This direction might respond directly to workforce shortages by extending basic mental health awareness and referral capacity across the wider community ecosystem.

3.9.4 Useful Resources

Table 62. Key healthcare, social protection, migration, disaster response, digital governance, social economy and community resources for the Antakya / Hatay pilot site

Resource / Initiative	Official Link
Ministry of Health of the Republic of Türkiye	https://www.saglik.gov.tr
Hatay Provincial Health Directorate	https://hatayism.saglik.gov.tr
Hatay Training and Research Hospital	https://hatayeah.saglik.gov.tr
Defne State Hospital	https://defnedh.saglik.gov.tr
MHRS – Central Physician Appointment System	https://www.mhrs.gov.tr

Social Security Institution (SGK)	https://www.sgk.gov.tr
e-Devlet – Türkiye Government Digital Services	https://www.turkiye.gov.tr
Hatay Governorship	https://www.hatay.gov.tr
Hatay Metropolitan Municipality	https://hatay.bel.tr
Antakya Municipality	https://www.antakya.bel.tr
Ministry of Family and Social Services	https://www.aile.gov.tr
Hatay Provincial Directorate of Family and Social Services	https://www.aile.gov.tr/hatay
Presidency of Migration Management	https://en.goc.gov.tr
Hatay Provincial Directorate of Migration Management	https://hatay.goc.gov.tr
AFAD – Disaster and Emergency Management Presidency	https://www.afad.gov.tr
AFAD Earthquake Information System	https://deprem.afad.gov.tr
Turkish Statistical Institute (TÜİK)	https://www.tuik.gov.tr
Turkish Employment Agency (İŞKUR)	https://www.iskur.gov.tr
UNHCR Türkiye Help Platform	https://help.unhcr.org/turkiye
WHO Country Office in Türkiye	https://www.who.int/turkiye
Hatay Mustafa Kemal University	https://www.mku.edu.tr
Hatay Teknopark	https://teknoparkhatay.com.tr
Eastern Mediterranean Development Agency (DOĞAKA)	https://www.dogaka.gov.tr
Rimmen Women's Cooperative	https://www.instagram.com/rimmenkooperatifi
S.S. Vakıfköy Women's Initiative Production and Business Cooperative	https://www.vakifkoykadinkooperatifi.com.tr
Deprem Dayanışması Derneği	https://depremdayanisma.org
Buradayız Hatay Association	https://buradayizhatay.org
Hatay Symphony Orchestra Culture and Arts Association	https://hataysenfoniorkestresi.com
Support to Life (Hayata Destek)	https://www.supporttolife.org
WHH – Welthungerhilfe Türkiye, Syria and Lebanon	https://welthungerhilfe.org.tr
Development Foundation of Türkiye	https://tkv-dft.org.tr

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4. Local Engagement Strategies and Action Plans for Smart Health Labs

The local engagement strategies for the EQUICARES Smart Health Labs are designed to ensure that PVS are reached through trusted, accessible and context-sensitive channels.

To support this objective, the engagement strategies are guided by a common set of principles that apply across all pilot sites while allowing adaptation to local contexts, vulnerable groups and ecosystem conditions.

Table 63. Engagement principles for the Smart Health Labs

Engagement principle	Application in the Smart Health Labs
Trust-based engagement	Engagement should be mainly organised through actors, organisations and spaces that are already known and trusted by the relevant PVS groups. This helps reduce barriers linked to stigma, mistrust, previous negative experiences or fear of disclosure.
Accessibility and inclusion	Engagement formats should take into account barriers related to language, disability, digital access, literacy, mobility, geography, socio-economic circumstances and confidence in using formal services.
Context sensitivity	Each pilot should adapt engagement channels, messages and formats to the local mental health ecosystem, including the specific service gaps, inequalities, policy context and community structures identified during profiling.
Safe and voluntary participation	Participation should be clearly voluntary and organised in ways that minimise risks for vulnerable groups, particularly where participants may face stigma, discrimination, legal insecurity, social exclusion or mental health distress.
Representation of diverse experiences	Engagement should seek to include a range of voices within each PVS group, including people who may be less visible, harder to reach or less connected to existing services and organisations.
Co-creation and feedback	Engagement should not be limited to information-sharing or recruitment. It should create opportunities for participants and stakeholders to contribute to the design, adaptation and validation of Smart Health Lab activities.
Flexibility and learning	Engagement strategies should remain adaptable during implementation, allowing pilot partners to respond to participant feedback, emerging barriers, attendance patterns and locally identified opportunities.
Safeguarding and ethical awareness	Engagement activities should be implemented with attention to confidentiality, informed participation, emotional safety, referral needs and the potential sensitivity of discussing mental health, exclusion or discrimination.

Across all pilot sites, engagement will combine stakeholder mapping, cooperation with local organisations, warm-up events, co-creation workshops, citizen science activities, capacity-building, awareness-raising and consultation processes.

The strategies are tailored to the specific needs of each pilot site, form the starting base for further engagement processes and will remain flexible, allowing partners to adjust activities according to participants' feedback, emerging barriers and opportunities identified during implementation.

4.1 Engagement Strategy for South Dublin, Ireland

4.1.1 Target groups, channels and rationale

The South Dublin Smart Health Lab will engage LGBTQI+ people and LGBTQI+ refugees through a combination of community-based outreach, advisory-group support, and collaboration with established LGBTQI+ organisations. Key stakeholders include Aware, UCD, Age Action, Outhouse Dublin, LGBT Ireland, TENI, IACP, Wicklow Pride and the Irish EQUICARES Advisory Group. These actors will support recruitment, provide contextual knowledge on available services, advise on inclusion and accessibility, and help ensure that the Lab reflects the lived experiences of LGBTQI+ people and LGBTQI+ refugees.

Engagement will rely on trusted community networks, targeted social media, mailing lists, Pride-season activities, and links with refugee-support structures. Particular attention will be given to the vulnerability of LGBTQI+ refugees, ensuring that participation is safe, voluntary and sensitive to participants' legal, social and personal circumstances.

The engagement approach outlined above is grounded in the Irish pilot ecosystem profiling and in the strategic directions derived (see Chapter 3). The profile identified LGBTQI+ people, including LGBTQI+ refugees, as the priority vulnerable group for the South Dublin Smart Health Lab and highlighted a combination of service, territorial, social and data-related barriers affecting access to appropriate mental health support. The SWOT analysis showed that one of the main assets of the Irish pilot site is the presence of trusted LGBTQI+ community organisations and peer-support structures. For this reason, engagement will be anchored in community-based entry points rather than relying only on formal health-service routes. This is particularly important given the profile findings on stigma, mistrust, inconsistent LGBTQI+-inclusive care in mainstream services, and the specific vulnerability of groups who may be less visible in-service data or reluctant to disclose personal circumstances.

The profiling also identified long waiting lists, workforce shortages, fragmented public and private provision, limited access to gender-affirming healthcare, and unclear or uneven referral pathways as key challenges in the local mental health ecosystem. These findings also verify the focus of the engagement strategy by highlighting the need to involve both community-based LGBTQI+ organisations and relevant mental health, support and advisory stakeholders.

Engagement activities will therefore be used not only to recruit participants, but also to explore practical barriers to service navigation, validate unmet needs, and identify where stronger links may be required between community organisations, public services, GPs, inclusive private providers and refugee-support structures.

Finally, the profile highlighted territorial and accessibility differences across the pilot area, including rural mobility barriers in parts of Wicklow and possible digital-access or literacy barriers among some participants. This has informed the use of hybrid engagement methods, combining digital outreach with community-based contact, direct follow-up and accessible formats.

Overall, the engagement strategy translates the profiling findings into practical choices for outreach, participation, safeguarding and co-creation, ensuring that Smart Health Lab activities are shaped by the specific inequalities, assets and risks identified in the Irish pilot ecosystem.

4.1.2 Specific engagement actions planned

Type of activities	Engagement actions
T3.2 – 1st Warm-up Event	Use Pride season, LGBTQI+ mailing lists, social media and LGBTQI+ organisations to reach LGBTQI+ people. For LGBTQI+ refugees, engage current and former participants of the Rainbow Refugee Support Group and Network.
T3.2 – 2nd Warm-up Event	Continue outreach through the same channels, with targeted follow-up to those already engaged.
T3.2 – Co-creation Workshop	Use warm-up event outcomes to identify participant gaps. Engage LGBTQI+ people, LGBTQI+ mental health/support professionals and, where appropriate, contacts from the Irish Refugee Council.
T3.4 – Small-scale Citizen Science Projects	Recruit participants through existing networks and SHL participants' feedback.
T3.5 – Capacity-building Workshops	Mobilise relevant stakeholders through the Irish EQUICARES Advisory Group.
T3.5 – MOOCs	Disseminate through community and advisory networks, with additional support for participants facing digital-access barriers.
T3.2 – Awareness-raising Campaigns	Raise awareness at relevant LGBTQI+ and health events, including the LGBT Ireland Healthcare Conference.
T4.1 – Consultation Workshop	Involve SHL representatives, advisory-group members, healthcare professionals, academics and local supports such as Wicklow Pride, Outhouse and Dublin Pride.
T4.3 – Piloting of Solutions	Engage SHL participants and relevant LGBTQI+ organisations in testing community-based solutions.
T8.1 – Final Conference	Invite selected participants, advisory-group members and community organisations to share lessons learned.
Monitoring indicators: Types and No. of outreach channels used / No. of stakeholder organisations contacted or invited / No. of engagement activities implemented / No. of participants attending where attendance data are collected	

4.2 Engagement Strategy for Évreux, France

4.2.1 Target groups, channels and rationale

The Évreux Smart Health Lab will engage people with disabilities and people supported by LADAPT and related community structures. The strategy is built around co-creation, self-determination and accessibility. Key stakeholders include ARS Normandie, the Seine-Maritime Department Council, CHU de Rouen, the University of Rouen Normandy, LADAPT, ESAT clients and partners, GEMs, UNAFAM, Santé Mentale France, Advocacy France, CRESS Normandie, Mission Locale, local mayors and health coordinators, and social landlords.

For people with physical disabilities, engagement will focus on their expertise in identifying environmental, systemic and territorial barriers to mental health access. In the physical SHL dimension, participants may act as co-investigators by documenting barriers such as inaccessible

services, transport difficulties and rural access challenges. In the digital SHL dimension, participants may test existing digital health platforms and identify accessibility gaps.

For people with cognitive or psychosocial disabilities, engagement will use accessible, creative and visual methods, including simplified modelling and tools such as Dixit. The digital dimension will focus on easy-to-read and understand communication standards, helping ensure that future digital tools reduce cognitive load and support autonomy.

The engagement approach for the Évreux Smart Health Lab is directly informed by the French pilot profile and the strategic directions identified in Chapter 3. The profiling highlighted people with intellectual, psychosocial and physical disabilities as the priority PVS group and showed that access to mental health and psychosocial support is affected by fragmented pathways between health, social care, disability support, housing, employment and community-based services. It also identified territorial inequalities, long waiting times, limited psychosocial rehabilitation capacity in the Évreux area, digital exclusion and the need for more accessible and self-determined support models.

These findings justify the strong involvement of LADAPT, ESAT structures, GEMs, UNAFAM, peer-support actors, social landlords and local disability-support stakeholders in the engagement strategy. These actors are already connected to people with disabilities and can support participation in ways that are accessible, trusted and adapted to different functional, cognitive and psychosocial needs. Engagement will therefore not rely only on formal institutional invitations, but will use existing support relationships, familiar settings and adapted facilitation methods.

The distinction between physical and digital SHL dimensions also reflects the profiling findings. For people with physical disabilities, engagement will focus on identifying practical, environmental and territorial barriers to accessing services. For people with cognitive or psychosocial disabilities, engagement will prioritise accessible communication, visual methods, simplified materials and formats that reduce cognitive load. The action plan should therefore emphasise accessibility adjustments, supported participation, co-investigation of barriers and the testing of digital tools from the perspective of users with different disability profiles.

4.2.2 Specific engagement actions planned

Type of activities	Engagement actions
T3.2 – 1st Warm-up Event	Contact local stakeholders and people supported by LADAPT to introduce the SHL and invite participation.
T3.2 – 2nd Warm-up Event	Continue engagement with LADAPT networks and other local stakeholders identified during the first event.
T3.2 – Co-creation Workshop	Invite interested participants and relevant stakeholders. Communicate internally with people supported in LADAPT facilities in Évreux.
T3.4 – Small-scale Citizen Science Projects	Use LADAPT and partner networks to identify participants who can document access barriers and lived experiences.
T3.5 – Capacity-building Workshops	Reach out to SHL partners, local stakeholders and people supported by LADAPT facilities.
T3.5 – MOOCs	Promote access through LADAPT and partner networks, with support for users who face digital or cognitive barriers.

T3.2 – Awareness-raising Campaigns	Communicate during mental health events, internal meetings, partner meetings and through LADAPT social media.
T4.1 – Consultation Workshop	Include people supported by LADAPT facilities and relevant local stakeholders.
T4.3 – Piloting of Solutions	Test accessibility-oriented solutions with people supported by LADAPT and associated organisations.
T8.1 – Final Conference	Invite participants, partners and local stakeholders to share outcomes and lessons learned.
Monitoring indicators: Types and No. of accessible outreach channels used / No. of disability-support stakeholder organisations contacted or invited / No. of accessibility adaptations provided during engagement activities	

4.3 Engagement Strategy for Seville, Spain

4.3.1 Target groups, channels and rationale

The Seville Smart Health Lab will engage the Roma community and migrant populations through trusted community-based organisations, public health authorities and cultural mediators. Key stakeholders include the Consejería de Salud y Consumo, SAS, primary care centres, community mental health units, Agencia Digital de Andalucía, ACCEM, ASILA, Fakali, local Roma associations, FAISEM, ARETÉ, ASAENES, the University of Seville, Instituto de Biomedicina de Sevilla, Escuela Andaluza de Salud Pública, local tech labs and trusted Roma community figures such as Evangelical pastors.

The engagement strategy will combine institutional collaboration with grassroots community engagement. Public authorities will support policy alignment, scalability and coordination with public services. Community-based organisations will support trust-building, stigma reduction, outreach, recruitment and culturally adapted co-design. Digital engagement will use WhatsApp, closed social media groups, short videos, voice messages and online surveys, while offline engagement will take place through NGO facilities, community forums, mediation sessions and outreach events.

The Seville engagement strategy is grounded in the ecosystem profiling findings, which identified Roma communities and Latin American migrants as priority PVS groups. The profile showed that both groups face barriers that go beyond formal access to the public health system. These include poverty, residential segregation, precarious employment, administrative complexity, discrimination, limited mental health literacy, stigma, mistrust of institutions and insufficient cultural mediation within service pathways.

These findings justify the use of trusted grassroots organisations, Roma women's associations, migrant-support NGOs, cultural mediators and community figures as the main entry points for engagement. Organisations such as FAKALI, ACCEM, ASILA, FAISEM, ASAENES and ARETÉ are important because they already work with communities affected by social exclusion, mental health vulnerability, discrimination and labour-market precarity. Their involvement can help reduce mistrust, support culturally appropriate communication and ensure that the SHL is not perceived as a distant institutional initiative.

The profiling also showed that digital health infrastructure is strong in Andalucía, but digital and administrative skills are unevenly distributed. For this reason, the engagement strategy combines

digital channels, such as WhatsApp, voice messages, short videos and closed social media groups, with face-to-face outreach through community spaces, mediation sessions, NGO facilities and local forums. The action plan should therefore use low-threshold, culturally sensitive and assisted participation formats, particularly for participants who may have limited literacy, limited administrative knowledge or low trust in formal health services.

4.3.2 Specific engagement actions planned

Type of activities	Roma community	Migrant population
T3.2 – 1st Warm-up Event	WhatsApp announcements, closed social media groups, personal invitations by Roma mediators and posters in community spaces.	WhatsApp invitations through migrant NGO mediators, social media promotion, flyers during language/legal support sessions and personal invitations.
T3.2 – 2nd Warm-up Event	Follow-up Facebook/Instagram/Web posts, WhatsApp reminders and outreach during youth and women's groups.	WhatsApp reminders, NGO social media posts and outreach during counselling or community events.
T3.2 – Co-creation Workshop	WhatsApp audio invitations, trusted Roma facilitators, recruitment during mediation sessions and one-to-one invitations.	Registration forms, explanatory videos, recruitment during migrant NGO activities and one-to-one mediator outreach.
T3.4 – Citizen Science Projects	Simple online surveys, plain-language posts, mediator-supported field recruitment and group explanation sessions.	Online surveys, WhatsApp instructional videos, NGO presentations and easy-to-read participation sheets.
T3.5 – Capacity-building Workshops	Audio reminders, social media announcements and face-to-face recruitment through Roma women's groups and mediators.	WhatsApp reminders, simplified NGO social media posts and recruitment during legal/employment counselling.
T3.5 – MOOCs	Audio explanations, simplified module summaries, assisted registration and peer-support sign-up sheets.	WhatsApp enrolment support, tutorial videos, on-site digital support and printed login guides.
T3.2 – Awareness Campaigns	Short videos from Roma representatives, accessible social media posts, awareness talks and flyers.	Testimonial videos, WhatsApp infographics, posters and information during intercultural events.
T4.1 – Consultation Workshop	Voice invitations, closed-group reminders, direct recruitment and mediator follow-up calls.	Social media reminders, WhatsApp reminders and targeted recruitment through NGO services.
T4.3 – Piloting of Solutions	WhatsApp voice feedback, NGO social media updates and community feedback circles.	WhatsApp feedback, social media updates and feedback sessions in migrant NGO facilities.

T8.1 – Final Conference

Livestream via Roma NGO page, invitation videos, organised attendance and public recognition of contributors.

Livestream links, invitation videos, organised attendance and recognition certificates.

Monitoring indicators: Types and No. of outreach channels used / No. of Roma, migrant-support and social economy stakeholder organisations contacted or invited / No. of engagement activities implemented / No. of community mediators or trusted intermediaries involved

4.4 Engagement Strategy for Mannheim, Germany

4.4.1 Target groups, channels and rationale

The Mannheim Smart Health Lab will engage three main target groups: older migrants aged 65+, working-age migrants, and refugees. The strategy will rely on municipal actors, health and mental health providers, welfare organisations, migration and refugee counselling services, community organisations, religious communities, senior meeting points and neighbourhood/community centres. Key stakeholders include the Central Institute of Mental Health Mannheim (ZI), the City of Mannheim, municipal health and social administration, municipal integration services, outpatient psychiatric and psychotherapeutic providers, Caritas, Diakonie, AsylCafé Mannheim, migrant associations, cultural organisations, religious communities, community centres, senior meeting points and local psychosocial support services.

Engagement will be based on trusted community intermediaries, personal invitations, existing counselling contacts, senior and neighbourhood meeting structures, community venues, religious/community networks and accessible digital communication. For older migrants, senior meeting points, neighbourhood centres, family members, community organisations and religious communities will support outreach, communication and participation. For working-age migrants, migration counselling services, community organisations, cultural associations and digital community groups will support recruitment and follow-up. For refugees, refugee counselling services, AsylCafé Mannheim, welfare organisations and refugee/community initiatives will be key entry points.

The Lab will be presented as a practical and accessible space for orientation, dialogue and support around mental health access, rather than as a parallel clinical service. Its communication will focus on understandable and non-stigmatising topics, including stress, wellbeing, social isolation, family concerns, language barriers, difficulties navigating the health system, and where to seek support. Offline engagement will take place through counselling centres, community organisations, senior meeting points, religious/community venues and local events. Online engagement will use ZI communication channels, partner websites, Facebook, Instagram, WhatsApp or other messaging groups, multilingual digital flyers, email communication and telephone follow-up where needed.

The Mannheim engagement strategy reflects the profile's finding that the main access challenge is not the absence of mental health services, but the difficulty of entering and navigating the system. The profiling identified migrants, older migrants and refugees as priority PVS groups and showed that access is affected by language barriers, limited familiarity with the German health system, written and digital communication requirements, lack of routine interpreting, fragmented service responsibilities, waiting times and, for refugees, additional legal and administrative restrictions.

These findings explain why the engagement strategy relies on trusted intermediaries, welfare organisations, migration and refugee counselling services, senior meeting points, religious communities, community centres and migrant associations. These actors can help translate formal service availability into practical accessibility by supporting orientation, trust-building, communication and follow-up. The Lab should therefore be presented as a practical space for dialogue, service orientation and co-design, rather than as a parallel clinical service.

The profiling also showed that older migrants may face additional barriers linked to social isolation, age, reduced digital confidence and dependence on family or community networks. This has informed the use of senior centres, family-mediated communication, telephone follow-up and assisted digital access. For working-age migrants and refugees, engagement should make use of counselling contacts, multilingual information, community associations and digital groups, while ensuring that participation remains safe, voluntary and sensitive to legal or administrative vulnerabilities.

4.4.2 Specific engagement actions planned

Type of activity	Engagement approach for older migrants, migrants and refugees
T3.2 – Warm-up Events	Participants will be reached through senior meeting points, migrant and refugee counselling services, community centres, religious/community contacts, Caritas, Diakonie, AsylCafé Mannheim, migrant associations and ZI digital channels. Multilingual flyers, partner social media, WhatsApp/messaging groups and personal invitations will be used. Interested participants will be recorded for follow-up.
T3.2 – Co-creation Workshop	Participants from previous activities will be personally invited through trusted intermediaries. The purpose of the workshop will be explained in advance through counselling contacts, community meetings and partner organisations. Reminders will be shared by telephone, messaging groups and ZI/partner channels. Supported or accompanied participation will be offered where needed.
T3.4 – Citizen Science Projects	Recruitment will build on previous SHL activities and trusted community networks. Participants will share experiences on access barriers, language and administrative needs, service navigation, digital access and trusted support channels through guided discussions, simple mapping exercises, short forms or voice messages.
T3.5 – Capacity-building Workshops and MOOCs	Activities will take place in familiar and accessible settings, including senior centres, neighbourhood centres, community rooms and counselling-service venues. Topics will include mental health literacy, service navigation, referral pathways, digital confidence and administrative access. MOOC participation will be supported through guided group viewing, assisted registration and follow-up materials shared via WhatsApp, email and partner channels.
T3.2 – Awareness Campaigns	Awareness-raising will be carried out through community events, senior meeting points, migrant and refugee organisations, AsylCafé Mannheim, counselling services, ZI channels and multilingual materials. Messages will focus on wellbeing, stress, loneliness, stigma reduction, available support, service navigation and trusted help-seeking pathways.
T4.1 / T4.3 – Consultation and Piloting	Selected participants, community representatives, counselling services, municipal actors and mental health providers will be involved in consultation and piloting activities. The Lab will test accessible information formats, multilingual navigation support, referral guidance, supported digital/AI tool use and community-based service orientation.
T8.1 – Final Conference	Selected participants, community representatives, counselling services, municipal actors and service providers will be invited to share lessons

learned. Hybrid or accompanied participation will be supported where needed, and accessible summaries will be shared through trusted community and partner channels.

Monitoring indicators: Types and No. of outreach channels used / No. of migrant, refugee, and community organisations contacted or invited / No. of languages or adapted communication formats used

4.5 Engagement Strategy for Thessaloniki, Greece

4.5.1 Target groups, channels and rationale

The Thessaloniki Smart Health Lab will engage two main target groups: migrants, particularly the Albanian community, and older adults. The strategy will rely on grassroots organisations, NGOs, local authorities and public/community services. Key stakeholders include JETA, IRIDA, IOM, Solidarity Now, Metadrasis, Praksis, ARSIS, the Greek Council for Refugees, the International Rescue Committee, Red Cross, Naomi, Alkuoni, KAPI centres, Pnoi Zois, SOPSI, mental health organisations and the Deputy Mayors responsible for social policy and older adults.

Engagement will be based on trusted community mediators, cultural events, municipal venues, personal contact and collaboration with local authorities. For migrants, the president and cultural mediator of JETA will support outreach to the Albanian community. For older adults, KAPI centres, municipal representatives and older-adult organisations will support recruitment, communication and participation.

The Thessaloniki engagement strategy is shaped by the profiling findings, which identified migrants, particularly the Albanian community, and older adults as the main target groups for the Smart Health Lab. The profile showed that Thessaloniki has a dense ecosystem of public services, NGOs, community organisations, municipal structures and mental health actors, but that access remains affected by fragmented coordination, limited service visibility, inconsistent referral pathways, language and trust barriers for migrants, and social isolation and digital exclusion among older adults.

These findings justify the use of trusted community mediators, migrant organisations, municipal structures and older-adult support spaces as the main channels for engagement. For migrants, JETA and its cultural mediator provide an important entry point because they are already connected to the Albanian community and can support recruitment through trust-based and culturally familiar channels. For older adults, KAPI centres, municipal representatives and older-adult organisations are central because they provide accessible and familiar spaces for participation.

The engagement strategy should therefore focus not only on recruitment, but also on testing how the SHL can improve visibility of services, clarify access routes, build trust between communities and institutions, and support locally meaningful forms of participation. Activities should combine community events, municipal venues, personal contact, telephone follow-up and digital communication, with specific attention to older adults who may require assisted participation or intergenerational digital support.

4.5.2 Specific engagement actions planned

Type of activities	Migrants / Albanian community	Older adults
T3.2 – 1st Warm-up Event	Online invitation through JETA and cultural mediators;	Online invitation through Deputy Mayor, KAPI directors and citizen organisations;

	cultural/informative event at SEERC; creation of interested end-user list.	cultural/informative event at municipal premises; creation of interested end-user list.
T3.2 – 2nd Warm-up Event	Follow-up communication with the community created during the first event and targeted invitations for co-creation.	Follow-up communication with older-adult participants and targeted invitations for co-creation.
T3.2 – Co-creation Workshop	Personal communication by phone with community members, local authorities and mental health providers.	Personal communication by phone with older adults, local authorities and mental health providers.
T3.4 – Citizen Science Projects	Recruit through previous events and personal/community networks if needed.	Recruit through previous events and personal/community networks if needed.
T3.5 – Capacity-building Workshops	Workshops at SEERC in collaboration with communities, focusing on digital literacy and mental health access.	Workshops at SEERC, including intergenerational digital-skills learning between student volunteers and older adults.
T3.5 – MOOCs	Share MOOC links through community mediators and local authorities.	Share MOOC links through community mediators and local authorities.
T3.2 – Awareness Campaigns	Raise awareness through events, social media, email communication and collaborative events with NGOs and citizen communities.	Raise awareness through events, social media, email communication and collaborative events with older-adult organisations.
T4.1 – Consultation Workshop	Include SHL participants, community representatives and local authorities.	Include SHL participants, older-adult representatives and local authorities.
T4.3 – Piloting of Solutions	Engage Albanian community members recruited through previous events.	Engage older adults aged 65+ recruited through previous events.
T8.1 – Final Conference	Invite selected participants and community representatives.	Invite selected older adults, municipal actors and community representatives.
Monitoring indicators: Types and No. of outreach channels used (incl. including JETA networks, Albanian community channels, KAPI centres, etc.) / No. of engagement activities implemented with migrants, the Albanian community, older adults and relevant local stakeholders / No. of engagement activities implemented		

4.6 Engagement Strategy for Attica, Greece

4.6.1 Target groups, channels and rationale

The Attica Smart Health Lab will engage NGOs, civil society organisations, municipality-linked organisations, private mental health service providers, universities and research institutions. The input currently frames the action plan around stakeholder groups rather than PVS target groups; therefore, the strategy is presented as stakeholder engagement supporting vulnerable populations more broadly.

The engagement strategy will focus on improving access to services for vulnerable groups, strengthening coordination among organisations, exchanging good practices, and ensuring that SHL solutions respond to real needs on the ground. NGOs, CSOs and private mental health providers will support outreach, recruitment, co-design and knowledge sharing. Universities and research institutes

will contribute research feedback, technical knowledge, and support for digital health and community-based mental health approaches.

The Attica engagement strategy should be more explicitly linked to the profile findings, which identified young people and unaccompanied children as the priority PVS groups. The current action plan is organised around stakeholder categories, including NGOs, CSOs, service providers, universities and research institutions. This remains useful, but it should be clarified that these stakeholders are being engaged because they act as access points, intermediaries and safeguarding actors for vulnerable young people and unaccompanied children.

The profiling showed that the Athens and Attica ecosystem includes a broad range of public services, NGOs, community structures and specialised mental health providers, but that vulnerable young people may face difficulties due to fragmented information, unclear referral pathways, long waiting times, affordability barriers, stigma, low mental health literacy and weak continuity between health, social protection, accommodation, education and NGO support systems. For unaccompanied children, engagement must also account for ethical, legal and safeguarding requirements, meaning that participation should be mediated through organisations already responsible for their care and support.

The engagement strategy should therefore explain that NGOs, municipality-linked organisations, accommodation and child-protection actors, youth-support organisations, private mental health providers and universities will support both outreach and safe access to lived-experience input. Activities should be designed to gather insights on service navigation, referral bottlenecks, youth-friendly communication, digital access, trauma-informed support and practical pathways between NGOs, public services and mental health providers.

4.6.2 Specific engagement actions planned

Type of activities	NGOs / CSOs / service providers	Universities / research institutions
T3.2 – 1st Warm-up Event	Personal invitations to organisations; announcements through NGOs/CSOs; email invitations and reminders.	Personal invitations to university representatives; email invitations and reminders.
T3.2 – 2nd Warm-up Event	Follow-up invitations to previously engaged organisations; reminders via email, newsletters and partner channels.	Follow-up invitations to previously engaged institutions; reminders via email and partner channels.
T3.2 – Co-creation Workshop	Personal invitations; short preparatory explanation during meetings; email reminders.	Personal invitations; preparatory explanation of workshop aims; email reminders.
T3.4 – Citizen Science Projects	Introduce activities during meetings/calls; organise guided participation meetings; share simple instructions by email.	Introduce activities during meetings/calls; support guided participation and share instructions by email.
T3.5 – Capacity-building Workshops	Organise workshops with NGOs and CSOs; invite participants during meetings/calls and by email.	Invite university representatives during meetings/calls and by email.

T3.5 – MOOCs	Introduce MOOCs during meetings/calls; provide support for registration and navigation at the SHL; share course links and guidelines by email.	Introduce MOOCs during meetings/calls; provide access guidance and links by email.
T3.2 – Awareness Campaigns	Use the SHL information booth, community outreach and GIVMED's wider network for digital dissemination.	Support dissemination of digital information materials and campaign content.
T4.1 – Consultation Workshop	Targeted invitations through organisations; involve selected participants from previous SHL activities; email reminders.	Targeted invitations through institutions; involve selected participants; email reminders.
T4.3 – Piloting of Solutions	Recruit through partner organisations and test solutions through the SHL and community settings.	Provide feedback on feasibility, usability and evaluation of the solutions.
T8.1 – Final Conference	Invite selected participants via stakeholder partners; share hybrid participation link by email.	Invite selected representatives; share hybrid participation link by email.
Monitoring indicators: No of youth-focused and child-protection organisations contacted / No of stakeholder organisations supporting access to young people and unaccompanied children / No of engagement activities implemented;		

4.7 Engagement Strategy for Veliko Tarnovo, Bulgaria

4.7.1 Target groups, channels and rationale

The Veliko Tarnovo Smart Health Lab will engage two main target groups: Roma communities and ethno-religious minority communities in the municipalities of Strazhitsa and Pavlikeni. The strategy will rely on trusted grassroots actors, community mediators, schools, local authorities, social services and community-based organisations. Key stakeholders include Center Amalipe, Roma health mediators, educational mediators, school psychologists and pedagogical counsellors, the Municipalities of Strazhitsa and Pavlikeni, local branches of the Social Assistance Directorate, GPs and primary care providers, regional mental health professionals in Veliko Tarnovo and Gorna Oryahovitsa, chitalishta, informal community leaders and, where relevant, religious leaders.

Engagement will be based on personal contact, trust-building, existing community activities, school networks, local events and simple digital communication. For Roma communities, outreach will be supported by recognised Roma mediators from both municipalities, including Stefan Stefanov in Pavlikeni and Irena Mihaylova in Strazhitsa, together with educational mediators, school psychologists and Amalipe facilitators. Esil Ayhanova, as a young Roma activist linked to Center Amalipe's social media activities, will support the digital dimension of the Lab. For ethno-religious minorities, similar outreach channels will be used, complemented by trusted religious and community leaders, especially in communities where they have strong local influence.

The Lab will be presented through non-stigmatising language, such as "Meetings and Support", and will focus on everyday concerns including stress, discrimination, family wellbeing, school difficulties, stigma, access to help and trust in services. Offline engagement will take place through Amalipe activities, community meetings, school contacts, municipal/community venues and local events. Online engagement will use Amalipe's social media channels, local Facebook groups,

Viber/WhatsApp communication and personal digital contact through mediators and community representatives.

The Veliko Tarnovo engagement strategy is directly informed by the profiling of Strazhitsa and Pavlikeni, which identified Roma communities and ethno-religious minorities, including Millet and Rudari communities, as priority PVS groups. The profile showed that these groups face barriers linked to discrimination, stigma, low mental health literacy, poverty, limited local service availability, interrupted health insurance, digital exclusion, transport difficulties and mistrust of formal institutions. It also highlighted the absence of local community-based mental health teams and the concentration of specialised services in Veliko Tarnovo and other urban centres.

These findings explain why engagement will be organised through trusted community actors rather than through formal health services alone. Center Amalipe, Roma health and educational mediators, school psychologists, pedagogical counsellors, chitalishta, municipal actors, informal community leaders and, where relevant, religious leaders provide the most appropriate entry points for safe and locally accepted participation. Their involvement is essential for reducing stigma, explaining the Lab in accessible language and reaching people who may not normally engage with mental health services.

The use of non-stigmatising language, such as “Meetings and Support”, also reflects the profile findings. The Lab should focus on everyday concerns, including stress, family wellbeing, school difficulties, discrimination, stigma, trust and access to help. Engagement should combine community meetings, school-based contacts, Amalipe activities, local events and simple digital communication through Facebook, Viber, WhatsApp and mediator-supported contact. The action plan should also ensure that digital tools are introduced with guidance, given the low digital literacy and unequal access observed among some vulnerable groups.

4.7.2 Specific engagement actions planned

Type of activities	Roma communities	Ethno-religious minorities
T3.2 – 1st Warm-up Event	Informal presentation of the Smart Health Lab / “Meetings and Support” during an existing Amalipe activity in Pavlikeni/Vurbovka; personal invitations through Roma health and educational mediators; simple Facebook posts and visuals through Amalipe channels; creation of an interested end-user list.	Informal introductory meeting in Tsarski Izvor / Strazhitsa municipality; invitations through trusted mediators, community figures and relevant religious leaders; accessible messages through local Facebook and Viber groups; creation of an interested end-user list.
T3.2 – 2nd Warm-up Event	Follow-up activity during the “Open Heart” festival and/or linked community event; informal discussions with Roma families, youth and mediators on stress, stigma and access to help; targeted invitations for the co-creation workshop; follow-up posts through Amalipe channels.	Use the festival/workshop setting to reach minority participants through trusted local actors; informal discussion on barriers to support, trust and stigma; targeted invitations for co-creation; dissemination through local digital channels and personal networks.

T3.2 – Co-creation Workshop

Invite Roma community members, youth, parents, mediators, school psychologists and Amalipe facilitators; use simple group exercises to identify barriers, needs and Lab ideas; collect additional feedback through Facebook, Viber or WhatsApp.

Invite minority participants and trusted representatives; explore specific cultural, religious, trust-related and stigma-related barriers; allow participation through community representatives if needed; collect follow-up feedback through trusted contacts.

T3.4 – Citizen Science Projects	Recruit Roma youth, community members and mediators through previous events and Amalipe networks; document local barriers such as stigma, lack of information, transport and trust; use simple tools such as short interviews, story collection and mapping of support points.	Recruit participants through trusted community and religious contacts; collect lived experience on discrimination, stigma, access to support and trusted sources of help; use closed community channels for non-sensitive feedback and information gaps.
T3.5 – Capacity-building Workshops	Organise workshops for Roma mediators, youth leaders, parents and community facilitators on mental health literacy, stigma reduction, early signs of distress and referral pathways; share short materials through Amalipe social media and mediator networks.	Organise adapted workshops for minority representatives, focusing on family wellbeing, trust-building, stigma and how to seek support; distribute simple materials through local online groups and trusted intermediaries.
T3.5 – MOOCs	Identify Roma mediators, educational mediators, school staff and youth activists who may need support to access MOOCs; offer short in-person orientation sessions; share links and reminders through Amalipe's digital channels.	Support minority participants or community representatives with low digital literacy through guided access sessions; share simplified instructions and reminders through trusted community contacts and local digital channels.
T3.2 – Awareness Campaigns	Raise awareness through Amalipe events, school contacts, community meetings, printed materials, social media posts and mediator outreach; use simple messages on stress, stigma, discrimination, family wellbeing and asking for help.	Disseminate adapted campaign messages through minority networks, community events, religious/community contacts, Facebook and Viber groups; avoid medical jargon and focus on everyday wellbeing and support.
T4.1 – Consultation Workshop	Include Roma SHL participants, mediators, school psychologists, municipal representatives, social service actors, GPs and Amalipe facilitators; discuss useful local support pathways,	Include minority participants, trusted community/religious representatives and relevant local stakeholders; discuss access, trust, confidentiality and culturally acceptable forms of

	digital tools and community-based solutions.	support; validate findings through remote follow-up if needed.
T4.3 – Piloting of Solutions	Engage Roma participants recruited through previous events, Amalipe networks and mediator outreach; test mediator-supported referral pathways, local wellbeing meetings, information sessions and guided use of the digital/AI tool.	Engage minority participants recruited through previous events and trusted community contacts; test culturally appropriate support formats, simple information materials and digital messages; collect feedback on acceptability and usefulness.
T8.1 – Final Conference	Invite selected Roma participants, mediators, Amalipe representatives, schools, municipal actors and service providers; share local lessons learned and community-level results; disseminate final outputs through Amalipe and EQUICARES channels.	Invite selected minority participants, community/religious representatives, municipal actors and local stakeholders; share accessible summaries of results through trusted networks and digital channels.
Monitoring indicators: No. of Roma, Millet, Rudari, social service, community and social economy actors contacted or invited / No. of engagement activities implemented with Roma communities, ethnoreligious minorities, young people from ethnoreligious minority communities and relevant local actors / No. of community mediators, informal leaders, or trusted representatives involved		

4.8 Engagement Strategy for Hatay, Türkiye

4.8.1 Target groups, channels and rationale

The Hatay Smart Health Lab will engage earthquake victims and older adults in a post-disaster recovery context. The local ecosystem includes institutional partners, scientific and technical actors, professional organisations, NGOs, community outreach partners, social economy actors and cultural/community wellbeing organisations. Key stakeholders include Hatay Provincial Health Directorate, Public Health Services Presidency, Hatay Metropolitan Municipality, Hatay Mustafa Kemal University, Hatay Psychologists Association, Hatay Medical Chamber, Support to Life, Deprem Dayanışma Association, Buradayız Hatay Association, Antakya Nedime Keser Public Education Centre, women's cooperatives, Development Foundation of Türkiye, WHH and Hatay Symphony Orchestra Culture and Arts Association.

The strategy will combine institutional coordination, professional expertise, community outreach, social empowerment and arts-based wellbeing activities. The SHL will be positioned as a community-based platform that supports post-earthquake psychosocial recovery, improves access to mental health information and services, and strengthens local resilience.

The Hatay engagement strategy is shaped by the post-earthquake ecosystem profiling, which identified earthquake-affected adults and older adults as the main PVS groups. The profile showed that access to mental health and psychosocial support is strongly affected by damaged infrastructure, temporary settlements, relocated services, workforce shortages, long waiting times, reduced

continuity of care, financial hardship, transport difficulties, service fragmentation and the long-term psychological effects of displacement, bereavement and uncertainty.

These findings justify an engagement approach that combines institutional coordination with community outreach and recovery-oriented activities. Public health authorities, municipalities, universities, professional associations, NGOs, women's cooperatives, livelihood organisations, cultural actors and community associations should be engaged because the main needs in Hatay are not only clinical, but also social, economic, relational and place-based. The SHL should therefore function as a community recovery platform that improves access to information, supports service navigation, strengthens psychosocial resilience and creates opportunities for participation in affected neighbourhoods and temporary settlements.

The profiling also highlighted the importance of trauma-informed and age-sensitive engagement. For earthquake-affected adults, especially women and displaced households, activities should be organised through NGOs, cooperatives, community spaces and trusted recovery initiatives. For older adults, engagement should include phone follow-up, simple digital forms with support, accessible information, familiar community venues and support from organisations already working with older populations. The action plan should also capture feedback on housing transition, social isolation, service relocation, mental health literacy and the emotional impact of long-term reconstruction.

4.8.2 Specific engagement actions planned

Type of activities	Earthquake victims	Older adults
T3.2 – 1st Warm-up Event	Introductory meeting at the SHL; short webinar with stakeholders; dissemination through NGO social media and online communities.	Introductory meeting at the SHL; short webinar with stakeholders; dissemination through community and stakeholder networks.
T3.2 – 2nd Warm-up Event	Focus-group discussions on barriers to mental health care and expectations from the SHL; online feedback forms through NGOs.	Facilitate discussions on access to health services and psychosocial support; phone interviews or simple digital forms with support.
T3.2 – Co-creation Workshop	Participatory workshop at the SHL; remote participation by video meeting for those unable to attend.	Participatory workshop at the SHL; remote participation options where needed.
T3.4 – Citizen Science Projects	Short interviews, diaries and digital/mobile reporting tools to document daily barriers.	Guided storytelling, experience-sharing sessions, phone follow-ups and supported digital diaries.
T3.5 – Capacity-building Workshops	Capacity-building at the SHL; recorded sessions and short videos shared through NGOs and community groups.	SHL workshops; simple online sessions and recorded smartphone-accessible materials.
T3.5 – MOOCs	Promote MOOCs during community events; provide access support; disseminate through project website, NGOs and social media.	Promote MOOCs through organisations working with older adults; provide digital access support.
T3.2 – Awareness Campaigns	Awareness sessions in community spaces; collaboration with stakeholders; social media content	Information sessions with municipalities, the public health directorate and community centres;

	on mental health and help-seeking pathways.	accessible information via messaging groups.
T4.1 – Consultation Workshop	Include earthquake-affected people in identifying access barriers and co-designing solutions; collect additional online feedback.	Include older adults or organisations working with them; gather remote input through video or structured forms.
T4.3 – Piloting of Solutions	Recruit earthquake-affected participants to test SHL interventions; maintain engagement through NGO networks, messaging groups and social media.	Include older adults in testing solutions; support follow-up by phone and online tools.
T8.1 – Final Conference	Invite participants affected by the earthquake to share experiences; disseminate results online.	Invite older-adult representatives and organisations; disseminate accessible outcomes through stakeholder networks.

Monitoring indicators: No. of post-earthquake outreach channels used, including NGOs, municipalities, women’s cooperatives, community associations, temporary settlement-related contacts, etc. / / No. of engagement activities implemented with earthquake-affected adults, women, older adults and recovery stakeholders / No. of outreach activities implemented in affected neighbourhoods, community spaces, cooperative settings or temporary settlement-related contexts /

5. Cross-cutting insights

The profiling of the eight EQUICARES pilot ecosystems shows that mental health inequalities are shaped by a combination of structural, territorial, socio-economic, cultural, and service-related factors. Although each pilot site presents distinct local realities and target groups, several common patterns emerge across the profiles. These insights provide a shared basis for the design of the Smart Health Labs and for the next phases of co-creation, piloting, and policy-oriented work.

Access to mental health care remains unequal even where services formally exist

Across the pilot sites, the existence of mental health services does not automatically translate into effective access for people in vulnerable situations. Public services are often available in principle, but barriers such as long waiting times, fragmented referral pathways, limited information, high private care costs, transport difficulties, and lack of culturally appropriate support restrict actual use. This confirms the need to move beyond service mapping and focus on the real conditions under which vulnerable groups can identify, reach, afford, trust, and engage with care.

Vulnerability is intersectional and context-dependent

The profiles show that vulnerability is rarely linked to a single factor. Mental health risks are often intensified when poverty, discrimination, migration status, disability, age, gender identity, ethnicity, social isolation, housing insecurity, or disaster exposure overlap. This is visible across all pilot ecosystems, including LGBTQI+ people and refugees in Ireland, persons with disabilities in France, Roma women and migrants in Spain, migrants and older migrants in Germany and Greece, youth and unaccompanied children in Athens, Roma communities in Bulgaria, and earthquake survivors and

older adults in Hatay. The Smart Health Labs should therefore avoid one-size-fits-all approaches and apply tailored, trauma-informed, culturally sensitive, and rights-based engagement methods.

Fragmentation is a common weakness of local mental health ecosystems

A recurring finding across the pilot sites is the fragmentation between healthcare services, social services, municipalities, NGOs, community organisations, informal carers, and social economy actors. In several contexts, referrals depend on personal networks or ad hoc cooperation rather than structured coordination mechanisms. This weakens continuity of care, makes navigation difficult for service users, and increases the risk that vulnerable individuals disengage before receiving appropriate support. The Labs can respond to this by acting as coordination spaces that connect actors, clarify pathways, and support more integrated community-based responses.

Workforce shortages and service capacity constraints affect both access and quality

Many pilot ecosystems face shortages of mental health professionals, specialised staff, mediators, interpreters, community workers, or culturally competent providers. These shortages contribute to waiting lists, reduced follow-up, limited outreach, and a stronger reliance on NGOs or private providers. Capacity constraints are particularly problematic for groups requiring specialised support, such as transgender individuals, persons with disabilities, children and adolescents, refugees, older adults, Roma communities, and disaster-affected populations. Investment in workforce development, training, and community-based support roles is therefore a cross-cutting priority.

Social stigma and low trust continue to prevent help-seeking

Stigma remains a major barrier across the pilot sites, although it takes different forms depending on the local context. It may relate to mental health itself, disability, LGBTQI+ identity, Roma identity, migration background, ageing, poverty, trauma, or displacement. In several ecosystems, mistrust of institutions also limits engagement, especially among groups that have experienced discrimination, exclusion, or bureaucratic barriers. For this reason, the Labs should prioritise safe spaces, peer support, trusted intermediaries, cultural mediators, and community-based outreach rather than relying only on formal service channels.

Territorial inequalities shape mental health access in both urban and rural settings

Geography is a cross-cutting determinant of exclusion. Rural and peripheral areas often face limited transport, weaker service availability, lower digital connectivity, and fewer specialised providers. At the same time, urban areas may present other forms of exclusion, including overcrowded services, socio-spatial segregation, housing insecurity, and fragmented support ecosystems. The profiles show that territorial accessibility should be understood broadly, including distance, mobility, service concentration, local infrastructure, and the ability of vulnerable groups to participate in co-creation activities.

Digital innovation offers strong potential but must not reinforce exclusion

Digital tools, hybrid services, AI-supported guidance, online information, and remote support can help improve outreach, navigation, self-management, and continuity of care. However, the profiles also show that digital exclusion remains relevant, particularly for older adults, people with low literacy, persons with disabilities, rural populations, Roma communities, migrants, and people experiencing poverty. Digital solutions should therefore be designed as complementary tools rather than replacements for human support. Accessibility, language, usability, trust, data protection, and digital literacy must be embedded from the start.

Social economy and community-based initiatives are essential entry points for the Labs

Across the pilot ecosystems, NGOs, cooperatives, community organisations, peer-support structures, advocacy groups, cultural associations, social enterprises, and local initiatives already play a crucial role in reaching vulnerable groups. These actors often provide trust, proximity, lived-experience knowledge, informal support, and practical assistance that formal services cannot always offer. Their involvement is central for recruitment, co-creation, awareness raising, capacity building, and sustainability. The Labs should build on these existing assets rather than creating parallel structures.

Prevention, early intervention, and service navigation are shared priorities

The profiles point to a common need to shift from reactive and crisis-oriented models towards prevention, early identification of needs, accessible information, and timely community-based support. Many vulnerable individuals seek help only when distress has escalated, often because services are difficult to understand, approach, or trust. Strengthening mental health literacy, digital literacy, referral guidance, outreach, and low-threshold support can therefore reduce delays and improve engagement before crises occur.

Policy frameworks exist, but implementation gaps remain

Most pilot countries have relevant mental health, inclusion, disability, equality, or social protection frameworks. However, the profiles show that policy commitments are not always matched by sufficient resources, operational coordination, workforce capacity, or local implementation mechanisms. This creates a gap between policy ambition and lived experience. EQUICARES can generate added value by documenting these implementation gaps through the Labs, translating local evidence into policy-relevant insights, and supporting more inclusive and sustainable models of mental health care.

Engagement strategies must be locally tailored and ethically grounded

The diversity of pilot ecosystems confirms that stakeholder engagement cannot follow a uniform model. Recruitment and participation methods must reflect the realities of each target group, including language needs, mobility constraints, trauma exposure, digital access, care responsibilities, stigma, and trust levels. Successful engagement will require familiar locations, accessible formats, clear communication, continuous feedback loops, and meaningful involvement of PVS in decision-making.

This is particularly important from an evaluator perspective, as the credibility of the Labs will depend on whether vulnerable groups are genuinely engaged rather than only consulted.

The Smart Health Labs can act as practical bridges between analysis and action

Overall, the profiling confirms the strategic relevance of the Smart Health Labs as participatory, multi-actor, and locally embedded structures. Their added value lies in connecting evidence with implementation: identifying barriers, mobilising trusted actors, co-designing solutions with people in vulnerable situations, testing inclusive tools, and generating policy insights. The cross-cutting findings show that the Labs should prioritise accessibility, trust-building, service navigation, community-based support, cultural competence, digital inclusion, and stronger coordination between formal and informal care systems.

5.1 Ecosystem Readiness for Smart Health Lab Implementation

The ecosystem readiness assessment provides a qualitative overview of how prepared each pilot site appears for the establishment and operationalisation of the Smart Health Labs. This readiness assessment also highlights how the profiling exercise has produced an implementation-oriented synthesis, translating ecosystem findings into practical considerations for Smart Health Lab activation, adaptation and risk mitigation.

This assessment does not constitute a formal ranking or comparison of pilot sites. Instead, it synthesises the enabling conditions, operational strengths, and implementation risks identified across the ecosystem profiles. The readiness categories are based on the information available through the profiling exercise, and they should be used for planning and adaptation rather than performance comparison. The aim is to support planning, risk mitigation, and tailoring of Lab activities to the specific maturity and needs of each local context.

Table 64. Comparative readiness of EQUICARES pilot ecosystems for the establishment and operationalisation of Smart Health Labs.

Pilot Ecosystem	Readiness Profile	Main Enabling Conditions	Main Readiness Constraints	Recommendations
South Dublin / Wicklow / Dún Laoghaire–Rathdown, Ireland	Medium–High readiness	Strong LGBTQI+ community ecosystem; experienced pilot partner; favourable policy environment on mental health and inclusion; relatively good digital connectivity; existing peer-support and NGO structures.	Long waiting times; limited public service capacity; gaps in gender-affirming care; inconsistent LGBTQI+-inclusive provision; rural access barriers in parts of Wicklow.	Prioritise trusted LGBTQI+ community spaces, strengthen referral links with public and private providers, integrate hybrid participation options, and ensure specific attention to transgender people, LGBTQI+ refugees, and rural participants.
Évreux, Normandy, France	Medium–High readiness	Strong institutional and territorial governance structures; established disability and psychosocial rehabilitation ecosystem; presence of peer-support, housing-first, and social inclusion initiatives; strong relevance of LADAPT's expertise.	Fragmentation between health, social care, housing, employment, and disability systems; long waiting times; uneven territorial distribution of specialised services; digital exclusion among older or vulnerable groups.	Use the Lab as a coordination bridge between disability, mental health, housing, and employment actors; prioritise accessible formats; strengthen peer-support and self-determination approaches; support navigation across complex systems.
Seville, Andalucía, Spain	Medium–High readiness	Strong social economy and community-based ecosystem; relevant organisations working with Roma women, migrants, mental health service users, and social inclusion; strong potential for peer-led and culturally sensitive outreach.	Socio-economic vulnerability; stigma affecting Roma communities and migrants; uneven access to culturally appropriate services; potential fragmentation between health, employment, social care, and NGO support.	Build Lab activities around trusted community organisations; use culturally adapted communication; connect mental health with empowerment, employment, mediation, and social inclusion actions; ensure practical support for participation.
Mannheim, Baden-	High readiness with	Strong healthcare and research infrastructure; broad network of mental health professionals,	Navigation barriers for migrants, refugees, and older migrants; language and	Focus the Lab on service navigation, culturally sensitive access pathways, language

Württemberg, Germany	targeted access gaps	hospitals, counselling services, and community organisations; universal health insurance framework; strong institutional capacity through ZI.	cultural barriers; risk that formal service availability does not translate into effective access for specific vulnerable groups.	support, migrant-oriented outreach, and stronger links between formal healthcare and community-based support structures.
Thessaloniki, Central Macedonia, Greece	Medium readiness	Presence of public hospitals, university expertise, NGOs, migrant/refugee support actors, and community organisations; strong relevance for older adults, migrants, and refugees; good potential for multi-actor collaboration.	Fragmented coordination between services; limited structured community-based mental health support; financial barriers due to reliance on private care; language and trust barriers for migrants and refugees.	Position the Lab as a coordination and navigation mechanism; involve NGOs and municipal services early; combine face-to-face and digital formats; strengthen mental health literacy and culturally sensitive outreach.
Athens / Attica, Greece	Medium–High readiness with high system complexity	Broad mental health and social care ecosystem; concentration of public services, hospitals, NGOs, accommodation actors, and specialised support structures; strong relevance for youth and unaccompanied children.	Fragmented and difficult-to- navigate service landscape; long waiting times; private care costs; organisational complexity across healthcare, child protection, accommodation, and NGO systems.	Use the Lab to simplify access pathways, clarify referral routes, support youth-friendly and child- sensitive engagement, and improve coordination between healthcare, social care, child protection, and NGO actors.
Veliko Tarnovo / Strazhitsa and Pavlikeni, Bulgaria	Medium readiness with strong community- entry potential	Strong role of AMALIPE; established trust with Roma communities; relevance of community mediators, local initiatives, and cultural/community centres; strong potential for grassroots engagement.	Limited local mental health service capacity; rural and territorial barriers; stigma and discrimination affecting Roma communities; digital and material deprivation; weaker specialist availability.	Build Lab activities through trusted community mediators and local organisations; prioritise outreach, low-threshold support, mental health literacy, digital inclusion, and links with municipal and social inclusion programmes.

Antakya, Hatay Province, Türkiye	Context-sensitive emerging readiness /	Strong community solidarity and post-earthquake recovery initiatives; active NGOs and local associations; strong relevance of community-based psychosocial support for earthquake survivors and older adults.	Post-disaster disruption; housing insecurity and displacement; trauma exposure; damaged or overstretched infrastructure; high psychosocial needs; possible instability in participation and service continuity.	Apply trauma-informed and flexible engagement methods; use familiar community spaces and NGO networks; avoid overburdening participants; connect mental health support with recovery, social inclusion, livelihoods, and community rebuilding.
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5.1.1 Overall readiness interpretation

Across the eight pilot ecosystems, conditions for Smart Health Lab implementation are generally positive, but uneven. All pilot sites present relevant local actors, identifiable target groups, and clear access barriers that justify the Lab approach. However, readiness differs according to the maturity of local stakeholder networks, service capacity, digital inclusion, trust levels, and the degree of system fragmentation.

The ecosystems showing stronger immediate readiness are those where strong institutional capacity is combined with active community or civil society structures, such as Mannheim, Ireland, France, Seville, and Athens. These sites appear well-positioned to launch Lab activities, provided that specific access barriers are addressed through tailored engagement and navigation support.

Other ecosystems, including Thessaloniki, Bulgaria, and Hatay, require stronger preparatory attention to outreach, trust-building, coordination, and accessibility. In these contexts, the Labs should not be introduced only as innovation spaces, but also as enabling structures that help connect vulnerable groups with existing support systems, build confidence, and create low-threshold entry points for participation.

This readiness assessment demonstrates that EQUICARES has identified not only the needs and barriers of each pilot ecosystem, but also the operational conditions required for effective implementation. It confirms that the Smart Health Labs should follow a shared methodological logic while remaining locally adapted, proportionate, and responsive to the maturity, risks, and capacities of each ecosystem.

6. Conclusions

Deliverable D3.1 provides a comprehensive and operationally relevant overview of the mental health ecosystems in the eight EQUICARES pilot sites. By combining desk research, partner knowledge, contextual data, and structured profiling, the report identifies the main factors influencing access to mental health and care services for people in vulnerable situations. It also clarifies the local conditions that will shape the establishment, engagement processes, and implementation of the Smart Health Labs.

The analysis confirms that mental health inequalities are not only linked to the presence or absence of services. In many pilot sites, services formally exist, but access remains limited due to long waiting times, unclear referral pathways, workforce shortages, fragmented coordination, financial barriers, territorial inequalities, language obstacles, stigma, discrimination, low trust, digital exclusion and limited service visibility. These findings underline the need to move beyond service availability as the main indicator of access and to focus instead on whether services are approachable, understandable, affordable, acceptable, inclusive and usable by people in vulnerable situations.

The report also confirms that vulnerability must be understood as dynamic and intersectional. The priority groups identified across the pilot sites experience different combinations of disadvantage, shaped by disability, age, migration status, minority background, poverty, social isolation, trauma, housing insecurity, rurality, digital exclusion and exposure to discrimination. This reinforces the importance of locally tailored interventions that respond to real-life barriers rather than applying generic models of mental health support.

A central conclusion of the profiling exercise is that the Smart Health Labs are highly relevant to the needs identified across the pilot ecosystems. The Labs are positioned to serve as practical bridges between analysis and action by bringing together people in vulnerable situations, service providers, NGOs, community organisations, researchers, municipalities, policymakers and social economy actors. Their added value lies in supporting co-creation, improving service navigation, building trust, testing inclusive tools, strengthening mental health and digital literacy, and generating locally grounded evidence for policy and practice.

The findings also highlight the importance of social economy and community-based initiatives. In all pilot sites, trusted local actors already play an important role in reaching groups that may remain outside formal mental health systems. These actors provide proximity, cultural understanding, peer support, mediation, practical assistance and community trust. The Smart Health Labs should therefore build on existing community assets rather than creating parallel structures. This approach will increase the feasibility, legitimacy and sustainability of the Labs.

Digital tools and hybrid models offer important opportunities for improving access, but they must be implemented with caution. The report shows that digital exclusion remains a significant barrier for several target groups. For this reason, digital innovation within EQUICARES should remain inclusive, accessible, multilingual where needed, user-friendly and supported by human interaction. The AI Assistant and other digital tools should be positioned as complementary mechanisms that support navigation, awareness and self-management without replacing personal contact, professional support or trusted community mediation.

The readiness assessment shows that all pilot ecosystems have sufficient relevance and potential for Smart Health Lab implementation, but their starting points differ. Some sites benefit from strong institutional capacity, mature civil society ecosystems or well-established community networks. Others face greater implementation risks linked to service scarcity, post-disaster disruption, rurality, mistrust, stigma or fragmented coordination. This means that Lab activation should be proportionate to each local context, with additional attention to preparatory outreach, ethical engagement, accessibility and risk mitigation where needed.

Overall, D3.1 establishes a clear evidence base for the next phases of EQUICARES. It supports the transition from ecosystem analysis to implementation by identifying who should be engaged, which barriers need to be addressed, which actors can support participation, and where innovation can have the greatest added value. The deliverable directly informs the operationalisation of the Smart Health Labs, the design of co-creation activities, the development of awareness-raising and capacity-building actions, and the future testing of inclusive digital and community-based solutions.

Annex

6.1 Pre-profiling Exercise Template

Community-driven Healthcare Access and Mental Health Promotion for Inclusive, Equitable, and Resilient European Societies																
EQUICARES																
Apr-25																
Pilot partner	Country	NUTS2 level	NUTS3 level	Targeted Municipality/Community	Location in Map	Identified target groups (people in vulnerable situations)	Accessibility challenges/ barriers faced	Target groups unmet needs & gaps	Available mental health services	Local context: Socio-economic factors	Local context: Environmental factors	Local context: Regulatory & Policy factors	Local context: Technological infrastructure	Key stakeholders	Current innovations and/or interventions	Remarks
		consult NUTS 2024 xls	consult NUTS 2024 xls	The specific municipality, town, or community where the pilot will take place	(google maps picture pinpointing the exact pilot site location)	specific and defined group	Identify the key obstacles preventing PVS from accessing mental health services, e.g. Financial: Cost of services, lack of insurance, Geographical: Distance to clinics, lack of transport, Social: Stigma, discrimination, Legal/Policy: Restrictive laws, lack of government support. For each barrier/challenge add in parenthesis whether it's	main mental health needs	Examples: Public hospitals and mental health clinics, private therapy services, community-based mental health programs, online/telehealth mental health support	Example: Unemployment rates and economic stability, Health insurance coverage for mental health care, Poverty levels and affordability of services, Education levels impacting mental health awareness, Mental Health Workforce & Capacity	How environmental conditions impact mental health, e.g.: Urban vs. rural disparities in access to services, Pollution and climate-related stressors affecting mental well-being, Housing stability and overcrowding issues	Policies and regulations impacting mental health services, e.g.: National mental health strategies and funding, Laws protecting (or restricting) mental health rights, Policy support for community-based mental health initiatives, Funding Sources for Mental Health Services	Availability of technology supporting mental health care: Telemedicine availability (online counseling), Digital literacy levels among the population, Electronic health records and data-sharing across providers	Examples: Local and national health authorities, NGOs and advocacy groups, Universities and research institutions, Community leaders and grassroots organizations	Any ongoing or planned programs aimed at improving mental health care, such as: new digital tools (e.g., AI-driven mental health assessments), community-driven peer support programs, social economy initiatives supporting mental health (e.g., employment programs for people with mental illnesses) etc.	Any additional comments or relevant information that does not fit in other columns.
KU																
SEERC																
GIVMED																
AMALIPE																
LADAPT																
LGBTI																
FISEVI																
ZI																

6.2 Profiling Exercise Template

Profiles of EQUICARES Pilot Cases: Mental Health Ecosystem of [name of Pilot Site]

Geographical Context

Guiding notes:

Indicate the location where the pilot activities will take place. Specify:

- *Country and region (using NUTS 2024 classification where applicable)*
- *Municipality, town, or community (NUTS 3 level)*
- *Key physical features (coastal, mountainous, etc.)*
- *Please include an image that highlights the pilot site location.*

Demographic Overview

Provide a short demographic snapshot of the pilot area:

- *Population size*
- *Age distribution*
- *Key demographic trends [if applicable] (ageing, youth bulge, migration, depopulation, etc.)*

**Emphasise demographic aspects that are particularly relevant for mental health needs and inequalities.*

Techno-Economic Context

Summarise **key technological** and **socioeconomic conditions** in your pilot site affecting mental health, such as:

- Digital infrastructure (e-services, digital skills and literacy, e-government tools)
- Innovation ecosystem (tech incubators, digital hubs, research centres)
- Unemployment rates and economic stability
- Poverty levels and affordability of services
- Health insurance coverage for mental health care
- Education levels affecting mental health awareness
- Dominant industries

Describe the **mental health workforce and service capacity**, where relevant.

Ecological and Environmental Factors

Please describe ecological and environmental conditions that may affect mental health in the pilot area, such as:

- Urban vs. rural disparities in access to services
- Pollution, climate-related stressors, or environmental risks
- Housing instability, overcrowding, or poor living conditions

Elaborate and explicitly link factors to **mental health stressors and outcomes**, particularly for PVS.

Regulatory and Policy Landscape

In this section, please summarise:

- Relevant **national, regional or local policies and regulations** impacting mental health services
- Existing mental health strategies, action plans, or funding frameworks facilitating or hindering mental health access/laws protecting (or restricting) access to mental health care and rights
- Social inclusion policies (poverty, youth, persons with disabilities, etc.)
- Employment and training programs (reskilling/upskilling, etc.)

*Where relevant, highlight policy gaps, fragmentation or implementation challenges, **especially those affecting PVS.***

Priority PVS and Current Mental Health Needs

*Please identify the **main groups of PVS** you will prioritise in your **Smart Health Lab**. Consult p.121/201 of the GA. Indicate them [here](#).*

For each group, briefly describe:

- Who they are
- Population size in the pilot area
- Their main mental health needs
- Key structural or systemic challenges they face in accessing care
- Existing initiatives/structures that support them
- Justify why you prioritised them?
- How will they benefit from the Smart Health Lab activities?

Local Mental Health Ecosystem

Please provide a structured overview of the local mental health ecosystem, including:

- Organisation of mental health care (public, private, community-based)
- Governance and coordination mechanisms
- Role of primary care, specialised services, NGOs, and informal actors

Service Exclusion Trends

Please identify and describe the **main barriers preventing access to mental health services** for your target group(s).

Structure your response according to the following categories:

- **Financial** (e.g. cost of services, lack of insurance)
- **Geographical** (e.g. distance to clinics, lack of transport)
- **Social** (e.g. stigma, discrimination, cultural barriers)

Priority Areas for Investment within the Mental Health Care System

Please identify:

- Key **system gaps** affecting mental health service delivery and access
- Priority areas where **investment or innovation is most needed**

Explain how these priorities align with the **objectives of the Smart Health Labs**, such as prevention, inclusion, digital solutions, or community-based care.

Social Economy Initiatives to Be Prioritised by the Smart Health Labs

Please describe:

- Existing or planned **social economy initiatives** relevant to mental health (e.g. NGOs, cooperatives, employment programmes)
- Their role in supporting people with mental health needs
- Their relevance for inclusion, empowerment, or service innovation

Explain why these initiatives are **particularly suitable to be supported through the Smart Health Lab**.

Local Engagement strategy for Smart Health Lab in [name of Pilot Site]

Key Stakeholders/Local Stakeholder Ecosystem

Please identify the **key stakeholders** involved in the local mental health ecosystem, such as:

- Public and national health authorities
- NGOs and advocacy organisations
- Universities and research institutions
- Community leaders and grassroots organisations
- Key stakeholders involved in a specific local community that could participate/potentially host the Smart Health Labs

Focus on stakeholders who are **relevant for collaboration and co-creation** within the Smart Health Lab.

Please fill in the table below with specific examples:

Example of key stakeholder category	Expected Role in the SHL
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Strategy for Stakeholder Engagement

[per Stakeholder group you will focus on and physical & digital SHL dimension]

Stakeholder group [1]:

Stakeholder group [2]:

Action Plan

Focus on feasible actions that can be implemented during the pilot phase.

Table 65. Stakeholder Engagement Action Plan

Related Task	Events and Activities (as per the GA)	Timeline	Engagement Actions (online & offline) for Target Group 1	Engagement Actions (online & offline) for Target Group 2
T3.2	1st Warm-up Event	M18		
T3.2	2nd Warm-up Event	M20		
T3.2	Co-creation Workshop	Early M21 (at the latest)		
T3.4	Small-scale Citizen Science Projects	Preparatory: M14–M22 Implementation: M22 onwards (after <i>Smart Health Labs</i> establishment)		
T3.5	Capacity-building Workshops (3 per pilot – for people with difficulties attending MOOCs)	Preparatory: M14 - M22 Implementation: M22 onwards (after <i>Smart Health Labs</i> establishment)		
T3.5	MOOCs	M14 - M48		
T3.2	Pilot-level awareness-raising campaigns	M14 - M48		
T4.1	Consultation workshop (≥20 participants, including people in vulnerable situations and relevant stakeholders)	M18 - M22		
T4.3	Piloting of innovative community-based solutions as real-life service demos	M20 - M36		

T8.1	Final Conference	End of the project		
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Guiding Notes

- Engagement actions should be **tailored** to the selected **target groups**.
- For each activity, include **a minimum of two online and two offline engagement actions**.
- Use **existing channels, trusted intermediaries, and networks** that your target groups already engage with.
- Ensure that engagement actions are **pilot-specific and target-group-specific**; generic actions should be avoided.
- Prioritise **feasible, low-burden actions** that can be realistically implemented during the pilot phase.



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Collaborating for Digital Health and Care in Europe



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